91st Congress 2d Session } SENATE { Report No. 91-875

DEVELOPMENTS IN AGING 1969

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

PURSUANT TO

S. RES. 316, FEBRUARY 16, 1970

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

TOGETHER WITH

MINORITY VIEWS

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[1] Senator Everett McKinley Dirksen, Illinois, served as ranking minority member of the committee from 1961 until his death Sept. 7, 1969. Senator Ralph T. Smith, of Illinois, was named to fill the vacancy on Oct. 9, and was assigned to serve on the same subcommittees that Senator Dirksen had served.

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LETTER OF TRANSMITTAL

MAY 15, 1970.

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

DEAR MR. PRESIDENT: I have the honor of submitting to you the report of the Special Committee on Aging in compliance with the requirements of Senate Resolution 76, adopted February 17, 1969.

The committee, charged by that resolution "to make a full and complete study and investigations of any and all matters pertinent to problems and opportunities of older people" initiated several new studies and continued several inquiries during 1969.

This report reviews the work of the committee and its subcommittees; and it reports on other developments in aging which have occurred since the last committee report, "Developments in Aging," was filed on April 3, 1969.

Senate Resolution 316, which was passed unanimously by the Senate on February 16, 1970, gives the committee new authority to continue its work on matters of direct importance to 20 million Americans now past 65 and the many millions who are nearing that age. Much of that work, as clearly indicated in the following report, is of considerable urgency. The committee will do all in its power to direct public attention to important areas of concern and to make recommendations for action by appropriate congressional units.

On behalf of the members of the committee and its staff, I should like to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

HARRISON A. WILLIAMS, *Chairman*

SENATE RESOLUTION 76, 91ST CONGRESS, 1ST SESSION

Resolved, That the Special Committee on Aging, established by Senate Resolution 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through January 31, 1970.

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

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

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

SEC. 5. For purposes of this resolution, the committee is authorized (1) to employ on a temporary basis from February 1, 1969, through January 31, 1970, such technical, clerical, or other assistants, experts, and consultants as it deems advisable: *Provided,* That the minority is authorized to select one person for appointment, and the person so selected shall be appointed and his compensation shall be so fixed that his gross rate shall not be less by more than $2,400 than the highest gross rate paid to any other employee: and (2) with the prior consent of the executive department or agency concerned and the Committee on Rules and Administration, to employ on a reimbursable basis such executive branch personnel as it seems advisable.

SEC. 6. The expenses of the committee, which shall not exceed $200,000 from February 1, 1969, through January 31, 1970, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

SEC. 7. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than January 31, 1970. The committee shall cease to exist at the close f business on January 31, 1970.

FOREWORD

Are older Americans losing the struggle to secure and maintain adequate retirement income?

That question necessarily overshadows all other issues on the pages that follow. And rightly so.

Over the past year, the Committee on Aging has issued reports and taken testimony on the "Economics of Aging: Toward a Full Share in Abundance."

Never before has such intensive congressional attention been paid to what might be called the personal economics of the elderly in this Nation.

We've paid attention, yes, to the national statistics.

But we have also heard directly from the elderly themselves, or from people who work with them every day.

We have met the widow who tries to live on less than $100, or even $60 a month.

We've heard, again and again, from elderly individuals and couples who say they must choose each day between food for the table or prescription drugs for their ailments.

We've listened to homeowners who say they can't afford to pay the property taxes that double or triple in just a few years.

Many who speak have been poor, or nearly poor, all their lives. Many did not become poor until they became old.

But, no matter what their prior history, more than one-third of all Americans past age 65 live in poverty or near poverty.

And for those whose incomes are well above such levels, retirement security is too often elusive.

Medicare covers less than 50 percent of total medical expenses of the elderly; the threat of losing the "nest egg" because of health problems is still very real.

Inflation takes a severe toll among those who try to live on fixed income.

For those ready to find a substitute for homeownership, there may be no rental units at prices they can afford.

The Committee on Aging has not yet completed its hearings on "Economics of Aging." It has not yet decided what its final recommendations will be.

But already it is clear that the committee has a major responsibility. It must alert the Nation to the fact that a retirement income crisis exists. Today, the great majority of this Nation's 20 million older Americans feel its consequence. And, unless major policy changes are made, the number will increase markedly.

Today's workers—men and women only 15 or 20 years away from retirement—thus have a major stake in the "Economics of Aging."

Vast as that subject is, however, it cannot encompass all developments in aging for 1969. Neither can this brief introduction.

Other major happenings and decisions are described on the following pages. But here, one additional issue is worthy of note. Very briefly, it is this:

There appears to be some danger that a psychology of retrenchment is taking hold in programs meant to serve the elderly. That psychology should be resisted, especially in view of the fact that a White House Conference on Aging is to be conducted in November 1971. What is needed in the months before that Conference is bold and farsighted planning and action, not a spirit of retreat or apology.

Concern about the future is caused partially by statements [1] atrributed to high-ranking members of the Administration which took office in January 1969. In essence, the statements seem to suggest that the Federal commitment to the elderly be reduced in favor of a greater commitment to the youth of this Nation.

Sharp criticism [2] has been directed at such statements because the comparison of the Federal commitment has been inaccurate and misleading and because it is clear that there should be no "either-or" decisions made on behalf of one group at the expense of the other.

Fortunately, the present U.S. Commissioner on Aging has said that such reports do not accurately state the views of the present Administration.[3] In addition, the Commissioner has made other statements clearly indicating that he believes the U.S. Administration on Aging should fulfill a much more far-ranging mission than it now does.[4]

Such statements are heartening, but nevertheless there is reason for concern. Funding for the Administration on Aging suffered sharp setbacks during 1969. Housing programs for the elderly have apparently received lower priority, and may be in danger. Research on aging is underfunded. The Age Discrimination in Employment Act has not been implemented as fully as it should have been. And, despite Medicare, health care is sometimes not available—or too costly.

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[1] The Wall Street Journal of June 10, for example, gave prominent position to an article which began with these words: "The Nixon Administration is embarking on a determined but politically difficult campaign to shift the Federal welfare focus from aiding the aged to caring for kids." The same article quoted Robert Finch, Secretary of Health, Education, and Welfare, as saying: "I'd like to see a great chunk of resources put in at the lower end of the age spectrum and hold (spending) at the top end."

Parade magazine of June 15, 1969, in an article called: "As Secretary Bob Finch Sees It: Serve the Young First," quoted Secretary Finch as saying: "There are four times as many young people as aged in the United States, but Federal benefits and services of all kinds in 1970 will average about $1,750 per aged person and only $190 per young person." The article added "In the language of the moment, he (Secretary Finch) wants to 'realine the priorities'."

The Washington Post, in an article on September 9, 1969, entitled "New Health Plan Puts Emphasis on the Young," said: "Nixon Administration planners have devised a 5-year blueprint that would expand federally financed health care for the young, rather than for elderly persons who already have the benefits of Medicare."

[2] For example, Mr. Theodor Schuchat, retirement editor of the North American Newspaper Alliance, said the following in testimony before the U.S. Senate Special Committee on Aging: "He (Secretary Finch) does not explain that 85 percent of the Federal expenditures for older people currently come from trust funds to which the elderly themselves contributed heavily during their working years * * *. He (Secretary Finch) has tried to tell the American people that the Federal Government is spending $10 for each older person and only $1 for each child. The ratio of 10 to 1 that he apparently decries falls to a ratio of only 2 to 1, however, if we exclude the trust funds expenditures and stick to expenditures from general revenues.

Delegates present on the final day of the 22d Annual University of Michigan Conference on Aging made similar criticisms in a resolution passed on June 11. The resolution called upon President Nixon "to express the philosophy and the commitment of the present Administration to the interests and problems of the more than 20 million Americans now age 65 or over and the many other millions soon to reach that age."

[3] John Martin, present Commissioner of Aging and Special Assistant to the President on Aging, on June 29 issued a statement responding to the resolution approved at the annual Michigan conference on aging. (See footnote 2.) He said: "I can assure you that Secretary Finch has no intention of downgrading the aging. This whole idea arose out of some figures used in connection with the creation of an Office of Child Development in HEW. His comments were aimed at the importance of adequate attention to the earliest years of child life and he did not intend in any way to pit the needs of older Americans against those of younger Americans."

[4] See ch. 11 for additional discussion.

Cost cutting in Federal programs may be necessary, of course. But the prospect of wholesale scuttling of programs—many of them just beginning to yield important social dividends after years of "tooling-in"—is something else.

The people of the United States now face a period of reevaluation in our thinking about Federal efforts on behalf of older Americans.

That period can be a healthful, stimulating interval leading to a productive and pioneering White House Conference on Aging to be held, at the request of Congress, in November 1971.

Or, that period can be one of uncertainty and lost opportunities. Gloomy as that prospect is, it is possible.

There are, however, strong arguments against it. For one thing, the field of aging has strong dynamics. It is growing as the number of older Americans grows. It grows, because our understanding of the social and personal meaning of aging is increasing. It grows because the United States wants a full and satisfying life for all its citizens, no matter how many, or how few, birthdays they have had.

For these reasons, we can be confident.

But for the next 15 months in particular, we should also be watchful.

HARRISON A. WILLIAMS, Jr.,
Chairman, Special Committee on Aging.

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EVERY TENTH AMERICAN [1]

At the turn of the century, there were 3 million older Americans—those aged 65 and over—comprising 4 percent of the total population. Today, 20 million older individuals make up 10 percent of the total population—every 10th American. The largest concentration of older persons—more than 11 percent of a State's total population—occurs in the agricultural midwest, in New England, and in Florida. California, New York, Pennsylvania, and Illinois each have more than a million older people. By 1985, when the older population will have increased to 25 million, California and New York will each have more than 2 million persons aged 65 and over. Florida, Illinois, Ohio, Pennsylvania, and Texas will have over 1 million.

What is this growing population like, and how does it change? Some answers:

ON NUMBERS. During the past 70 years, the total population of the United States grew to almost three times its size in 1900. The older population has grown to almost seven times its 1900 size—and it is still growing. Older Americans increased in number throughout the Nation by approximately 15.5 percent between 1960 and 1968, according to recent Census Bureau estimates. Greatest percentage growth occurred in Arizona, Nevada, Florida, Hawaii, and New Mexico. Florida had the highest growth percentage, 13.3; and New York had the largest number, 1.9 million.[2]

ON AGE. Most older Americans are under 75; half are under 73, a third are under 70. Well over a million are 85 and over.

ON HEALTH. Eighty-one percent get along on their own; only 14 percent have no chronic conditions, diseases, impairments of any kind, but the majority of those that do still manage by themselves. Older individuals are subject to more disability, see physicians more often, and have more and longer hospital stays. In 1968 older Americans spent a total per capita of $590 for medical expenses: $282 went for hospital care; $97 for physicians services; $27 for other professional health services; $67 for drugs; $92 for nursing home care; and $26 went for miscellaneous health items. Of the total amount spent for health care, $414 was taken care of by public sources, but the elderly still had to pay $176 from their own limited incomes.

ON AGGREGATE INCOME. Almost $60 billion a year. More than half from retirement and welfare programs (52 percent), less than a third from employment (29 percent), and about a fifth from investments and contributions.

[1] Adapted from information provided by Mr. Herman B. Brotman, Chief, Reports and Analysis, Administration on Aging, HEW, April 1970.
[2] For full information on population of all ages and 65 plus, by State, July 1, 1968, as well as other statistical information on older Americans, see app. II, p. 325.

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ON PERSONAL INCOME. Older persons have less than half the income of the younger. In 1968, median income of older families was $4,592; median income of older persons living alone or with nonrelatives was $1,734. About a quarter of the elderly live below the poverty line. Many do not become poor until they reach old age.

ON EXPENDITURES. Older Americans spend proportionately more of their incomes on food, shelter, and medical care. They do not necessarily need other things so much less; they simply cannot afford them—and often cannot find needed items, such as clothing, in the marketplace.

ON LIFE EXPECTANCY. At birth—70 years, 67 for men but 7 years longer or 74 for women. At age 65—15 years; men can expect another 13 years but women can expect another 16 years.

ON SEX. Most older individuals are women, over 11 million; men are over 8 million. For the total 65-plus population, there are 135 women per 100 men; from the ages 65 through 69 the ratio increases to 120 women per 100 men; for 85 plus, 165 women per 100 men.

ON MARITAL STATUS. Most older men are married; most older women are widows. There are almost four times as many widows as widowers. Of married older men, more than 40 percent have under-65 wives. An estimated 16,000 older women and 35,000 older men marry in the course of a year. Both bride and groom are over 65 in approximately 14,000 marriages; the remaining 2,000 older brides and almost 22,000 older grooms take under 65 partners.

ON EDUCATION. Half never completed elementary school. Some 3 million older people are functionally illiterate, having had no schooling or less than 5 years. Approximately 6 percent are college graduates.

ON LIVING ARRANGEMENTS. Seven out of every 10 older persons live in families; about a quarter live alone or with nonrelatives. Only 1 in 20 lives in an institution. Most older men live in families that include their spouse, two-thirds; but only one-third of the older women live in families that include their spouse. Three times as many older women live alone or with nonrelatives than do older men.

INTRODUCTION AND SUMMARY

A far-reaching and deepening retirement income crisis continues to be the No. 1 problem confronting most of the Nation's 20 million older Americans.

Moreover, the evidence is abundantly clear that this retirement income gap is not a transitional problem that, given present trends, will resolve itself in the foreseeable future.

Approximately 5 million senior citizens live in poverty; yet, many did not become poor until they became old.

Recognizing the need for comprehensive and prompt action to meet these formidable problems, the Senate Special Committee on Aging will seek innovative and far-reaching solutions in the finale of its overall study of the "Economics of Aging: Toward a Full Share in Abundance" during 1970.

The committee, however, also recognizes that health care problems are intensifying other problems affecting older Americans, despite the vital protection given by Medicare.

In addition, this report describes chronic problems faced by the older worker, the emerging awareness of neglected nutritional needs among elderly Americans, the special problem of transportation for aged Americans in both rural and urban areas, the potential usefulness of the model cities program to those in later years. and the place and problems of the elderly in rural America.

These developments—and committee studies—are taking place as advance planning begins for a White House Conference on Aging in November 1971.

I. MAJOR LEGISLATIVE AND ADMINISTRATION ACTIONS

A 15-percent across-the-board increase in Social Security benefits provided a stopgap measure to prevent further erosion of retirement income because of inflation. Further improvements and reforms will be considered by the Congress during 1970.

Other major developments during 1969 include—

- Enactment of the Older Americans Act Amendments of 1969 to provide new programs to meet the needs of senior citizens and to increase substantially the authorizations for existing programs.
- Reduction in appropriation levels for programs under the Older Americans Act in comparison with fiscal 1969.
- Passage of a Tax Reform Act which will benefit many older persons by removing millions of elderly persons from the tax rolls through a new low-income allowance and by increasing the personal exemption deduction in three steps for persons 65 and older from $1,200 to $1,500.

- A $4.8 billion authorization for housing and urban development programs through fiscal year 1971, including an authorization of $150 million in direct loans for housing for the elderly and an increase from $100 million to $125 million for amounts authorized in fiscal 1970 and 1971 in contract authority for the section 235 low-income homeownership program and the section 236 low-income rental assistance program.
- Extension of the SOS (senior opportunities and services) and Mainstream programs under the Economic Opportunity Act.
- Improvements in the civil service annuity program.
- Announcement for the holding of a White House Conference on Aging in November 1971.
- Appointment of John B. Martin as Commissioner on Aging and Special Assistant to the President on Aging.
- Investigation of profiteering and laxity in the Medicare and Medicaid programs.
- Announcement of an increase in premiums under part B (medical insurance) of Medicare to be effective July 1, 1970—from $4.00 per month to $5.30.

II. COMMITTEE AND SUBCOMMITTEE STUDIES

Members of the Senate Special Committee on Aging were involved in many of the developments listed above. In addition, the following hearings were conducted during 1969:

Economics of Aging: Toward a Full Share in Abundance:
- **Part 1. Washington, D.C., April 29–30, 1969**
- **Part 2. Ann Arbor, Mich., Consumer Aspects, June 9, 1969**
- **Part 3. Washington, D.C., Health Aspects, July 17–18, 1969**
- **Part 4. Washington, D.C., Homeownership Aspects, July 31–August 1, 1969**
- **Part 5. Paramus, N.J., August 14, 1969**
- **Part 6. Cape May, N.J., August 15, 1969**
- **Part 7. Washington, D.C., International Perspectives, August 25, 1969**
- **Part 8. Washington, D.C., National Organizations, October 29, 1969**
- **Part 9. Washington, D.C., Employment Aspects, December 18–19, 1969**

The Federal Role in Encouraging Pre-Retirement Counseling and New Work Lifetime Patterns: Washington, D.C., July 25, 1969

Trends in Long-Term Care:
- **Part 1. Washington, D.C., July 30, 1969**
- **Part 2. St. Petersburg, Fla., January 9, 1970**
- **Part 3. Hartford, Conn., January 15, 1970**

Older Americans in Rural Areas:
- **Part 1. Des Moines, Iowa, September 8, 1969**
- **Part 2. Majestic-Freeburn, Ky., September 12, 1969**
- **Part 3. Flemming, Ky., September 12, 1969**
- **Part 4. New Albany, Ind., September 16, 1969**
- **Part 5. Greenwood, Miss., October 9, 1969**
- **Part 6. Little Rock, Ark., October 10, 1969**

Usefulness of the Model Cities Program to the Elderly:
- **Part 6. Boston, Mass., July 11, 1969**
- **Part 7. Washington, D.C., October 14–15, 1969**

Usefulness and Availability of Federal Programs and Services to Elderly Mexican Americans:
Part 4. Washington, D.C., January 14-15, 1969
Part 5. Washington, D.C., November 20-21, 1969

Hearings before the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, available from the Special Committee on Aging:
Amending the Older Americans Act of 1965—S. 268, S. 2120, and H.R. 11235, Public Law 91-69, June 19, 1969.

Hearing held by Select Committee on Nutrition and Human Needs in cooperation with the Senate Special Committee on Aging, Nutrition and the Aged, Washington, D.C., September 9-11, 1969.

III. CONCLUSIONS OR RECOMMENDATIONS

Chapter	*Conclusions or Recommendations*	*Page*
I	A far-reaching and deepening income crisis remains as major policy changes are made—the elderly of the future.	1
I	Major reform in the Social Security system is recommended in order that older Americans today and in the future may share in the economic abundance they have created.	16

In thus recommending, the committee is in complete agreement with the following basic conclusions of its task on the Economics of Aging:

- A reasonable definition of adequacy demands that the aged population, both now and in the future, be assured a share in the growth of the economy.
- Such assurance can best be provided, or can only be provided, through governmental programs, particularly the social insurance system of OASDHI, which carry commitments for future older Americans—the workers of today—as well as for this generation of the aged.

Use of general revenues, as a more equitable basis for financing part of the costs of an improved Social Security system, should receive serious Congressional consideration.

We should now be exploring methods whereby retirement benefits can be adjusted to reflect productivity, not just rising prices.

And at a minimum and without further delay, these urgently needed changes in the Social Security system should be made:

- A widow's benefit at age 65 equal to 100 percent of the husband's benefit.
- An increase in minimum benefits.
- A higher base for taxing and crediting earnings.
- A modernization and liberalization of the retirement test.

Chapter	*Conclusions or Recommendations*	*Page*
II	Coinsurance and deductibles continue to be a major problem to users of the Medicare program. Action should be taken by the Social Security Advisory Council at the earliest possible date to review costs of reducing or eliminating these features of Medicare, beyond estimates now available. The advisory committee should also provide a thorough analysis of the costs of combining parts A and B and removing the part B premium. Included in their presentation should be some discussion of the best possible use of general revenue funding to achieve these objectives.	24
II	More than 3 years have passed since establishment of an HEW task force on prescription drugs under Medicare. To date, the new administration has not offered legislation to carry out recommendations of the task force or its own review committee. It is urgent however, that legislation be introduced at the earliest possible date for thorough evaluation before appropriate congressional units. This legislation should provide, as the Committee on Aging Advisory Committee recommended, for extension of Medicare benefits to cover those drugs that are important for treatment of chronic diseases that commonly affect the elderly.	27
II	"Nonassignment" is causing serious problems for many Medicare patients. Those physicians who *do* accept assignment, moreover, may decide in increasing numbers that they should discontinue the practice to ease their own work pressures. Serious consideration should be given to legislation or other steps which will provide incentives for physicians to take assignment.	28
II	The HIBAC recommendations on home health services would reduce costs to the Medicare program and to individual older Americans. Utilization review mechanisms for home health agencies should be developed, and the Social Security Administration should take additional steps to provide models for the development of home health services as major resources in communitywide health service systems.	30
II	Recognizing that older Americans are especially hard-hit by deficiencies in the Medicaid program—and yet fully aware of the alarming rise in costs of this program, the Senate Special Committee on Aging believes that thoroughgoing reform, rather than sporadic and highly damaging cutbacks, is required. Evaluations now under-way—together with pledges by the present Administration to implement reforms—hold out the hope that such action will be undertaken.	34
II	The Senate Committee on Aging renews its recommendation that the Medicare requirement of 3 days of hospitalization before extended care can begin be re-examined, along with other barriers to full utilization of alternatives to costly hospital care. Incentives to expansion and utilization of prepaid group health practice should also be implemented.	37

Chapter	Conclusions or Recommendations	Page
II	National discussion about the need for a national health insurance program can serve a vital function if it turns public, professional, and governmental attention to actions that must be taken to remedy deficiencies which have become more apparent as more and more Federal funds have been committed to health care. The people of this Nation now have an opportunity to transform public concern into positive action and reform. Corrective action should begin with Medicare and Medicaid, and it should aim at long-range improvement, rather than hasty retrenchment.	41
III	A new national nutrition survey—now underway—should be used to document and dramatize food needs and problems of the elderly. Every effort should be made by the Administration on Aging—and by other appropriate Federal agencies—to get the facts to both the old and the young.	49
III	Lessons learned from the AoA nutrition projects are too important to be overlooked. Additional efforts should be made by the AoA—working in conjunction with State and local government, as well as private agencies, to establish permanent arrangements for meal service programs as an important part of community service programs for the elderly.	51
IV	Significantly, no funds were requested by the Administration for 202 (Direct Loan Housing Program) and the Appropriations Committees of the Congress accordingly deleted even the diminutive $25 million appropriation that 202 had received in fiscal year 1969.	78
VI	Transportation problems among older Americans have reached the critical stage in many metropolitan and rural regions of the United States. Federal agencies have made a beginning in identifying problems, initiating research, and conducting pilot programs to test systems and concepts. The overall problem, however, is so serious that the following additional actions should be taken: • Technical assistance should be provided by appropriate Federal agencies to acquaint municipal governing bodies and private transportation managers with facts about transit barriers, special needs of the elderly and the handicapped, and new transportation concepts which would benefit, not only the elderly, but all persons who use public transportation.	100

Chapter	Conclusions or Recommendations	Page
IV	• The Urban Mass Transit Administration should submit to the Congress its recommendations for removing travel barriers and using existing and potential mass transit legislation to promote worthwhile social purposes, including those discussed in this chapter. • Provision should be made in planning the 1971 White House Conference on Aging for a preliminary report on transportation, to be prepared by a panel capable of giving adequate attention to sociological, technical, and psychological aspects of the subject. Every attempt should be made to show the relationship of transportation to service programs, existing or contemplated, for older Americans.	101
VII	Additional study will be given by the Committee on Aging to the elderly in rural areas of this Nation. Hearings thus far indicate that this subject should also receive intensive attention at the White House Conference on Aging in 1971 and in preliminary State conferences.	105
VIII	Additional attention will be given by this committee in the near future to the usefulness of the model cities program to the elderly. For this interim summary, it is enough to say that (1) The new administration has taken steps which indicate an awareness of the need for the program to serve the elderly, and (2) Additional attention must be paid, however, to unique problems and opportunities that exist among this vulnerable group.	112
IX	If current labor force participation trends continue, one out of every six men in the 55-to-64 age category will no longer be in the work force by the time he reaches his 64th birthday. Ten years ago this ratio was only one out of eight.	113
IX	Many older workers are unemployed because: • They are not equipped for the jobs in modern technology. • They lack the necessary training to move in to gainful employment. • They live where jobs no longer exist. • They are seeking the employment of a bygone era. Many of these older persons can become as productive as their younger counterparts with a flexible and comprehensive training program which is adequately funded and staffed.	116

Chapter	*Conclusions or Recommendations*	*Page*
	Within the next 10 years, our Nation will have to train and retrain substantially more people for jobs than we do now, since industries will be changing manufacturing techniques and products more rapidly than 10 years ago. Ten years from now that pace will be even more accelerated.	116
IX	Although some progress has been made since the ADEA became operational, a great deal more remains to be done in order to achieve compliance with the act. A rapid increase in staff to enforce the act is urgently needed if the law is to be enforced effectively. Secondly, the study regarding the institutional and other arrangements giving rise to involuntary retirement should be undertaken as expeditiously as possible. If specific funding is necessary to undertake the study, it is incumbent upon the Department to request the needed appropriations.	121
IX	Although employment opportunities are limited for many disadvantaged older workers, several measures can at least help to equalize the older worker's opportunities for employment with those of others in the work force. First, it is recommended that a Middle-Age and Older Workers Full Employment Act, similar to that introduced in the Senate (S. 4180) in 1968, be enacted and adequately implemented in order to provide a comprehensive program of employment services and opportunities for persons 45 years of age or older. Second, there are effective ways of training and retraining older persons if we have the will to do it. Third, additional efforts must be taken to encourage policies that will keep mature workers effectively informed about the labor market. Fourth, the matter of pension rights needs prompt and definitive action. Fifth, experimentation should be undertaken to provide workers 55 and over with extended unemployment benefits when they lose their jobs because of plant shutdowns, layoffs, relocations, or mergers.	123
IX	The 2-year period for the Senior AIDES program is drawing to an end, and limited funding may soon threaten others. Therefore, a vital need exists for establishing the national program to continue and broaden the fine work so well demonstrated in the pioneering projects. The committee renews its recommendation for enactment of legislation for a national Older Americans Community Service program.	126

Chapter	*Conclusions or Recommendations*	*Page*
XI	The cutback in the fiscal 1970 appropriations for programs for the aging represents a serious turn of events, which could possibly nullify to a substantial degree the accomplishments made under the Older Americans Act during its first 4 years. It is recommended that the funding for the AoA programs be increased substantially to fulfill the intent of the Congress as expressed in the 1969 amendments.	137
XI	Four years of successful operations have amply demonstrated the need for title III programs, but significant increases in appropriations are necessary to enable many more older Americans to benefit from these successful projects.	138
XI	Many pilot programs have already demonstrated that older persons can make valuable contributions in a wide variety of public service type activities. However, without funds for RSVP, many older Americans will continue to be excluded from purposeful activities in their communities.	139
XI	The need for personnel with specialized knowledge in the field of aging is reaching emergency proportions. An immediate all-out effort on the part of Government and educational institutions is essential if the situation is to be improved. Implementation of the recommendations contained in "The Demand for Personnel and Training in the Field of Aging" should be the very minimum action taken to meet the need for trained personnel in programs serving the elderly. Omnibus legislation for this purpose should be introduced at the earliest feasible date.	
XI	The variety of issues, policy questions, and research areas present cogent reasons for continuing work in the field of research and demonstration. Identification of such questions can be a significant step in continuing to expand our knowledge about the problems of the elderly and recommendations for improvement. To make this goal a reality, vitally needed funding will be necessary to meet the policy goals established in authorization legislation.	142
XI	At the end of 1969 only 23 months remained before the scheduled (White House) conference in November 1971. Because of the substantial number of activities to be planned, coordinated, and carried out during this time, it is essential that additional steps must be taken immediately to lay the groundwork for the conference. Additional funding and planning will be necessary to enable private organizations, individuals, and Federal, State, and local governments to plan and develop action programs to identify and make recommendations to meet the needs of older Americans.	143

Chapter	*Conclusions or Recommendations*	*Page*
XI	In terms of policy enunciation, the AoA commissioner has set major tasks for that agency. The role of AoA, however, remains ambiguous. Its funding levels are lower than required for healthy growth of State and community programs. It does not have the visibility envisioned for it by the Congress. Serious thought should be given, before and during the White House Conference on Aging in 1971, to far-reaching proposals for constructive change that will enable the AoA to fulfill the vital missions assigned to it.	145
XII	It is increasingly apparent that legislation will be necessary to provide the impetus for the Federal Government to prepare older workers for their retirement years. Prompt enactment of the Federal employees Retirement Assistance Act, S. 2554, would be a major step in helping Federal employees make the crucial adjustments in preparing for their retirement.	149
XII	Several pilot programs conducted by the Federal Government and private nonprofit organizations have amply demonstrated the benefits to be derived from a preretirement planning program.	150
XII	As traditional work lifetime patterns change very rapidly and dramatically, new knowledge is essential to consider these issues in their proper perspective. It is recommended that Federal actions be taken in order to provide valuable pilot projects and research findings that will prove useful for future policy decisions in this crucial area.	152

91ST CONGRESS 2d Session } SENATE { REPORT No. 91-875

DEVELOPMENTS IN AGING—1969

MAY 15, 1970.—Ordered to be printed

Mr. WILLIAMS of New Jersey, from the Special Committee on Aging, submitted the following

REPORT

[Pursuant to S. Res. 316, 91st Cong.]

CHAPTER I

ECONOMICS OF AGING AND RETIREMENT INCOME

Year's end brought enactment of a 15-percent, across the-board increase in Social Security payments.

This much-needed action, welcome as it is, should not obscure an important fact which cries out for attention by all Americans, no matter what their age:

A far-reaching and deepening income crisis remains as the major problem facing today's elderly and—unless major policy changes are made—the elderly of the future.

The extent and nature of that crisis came under intensive scrutiny during 1969 in a Senate Committee on Aging investigation which has resulted in the publication of several noteworthy "working papers," [1]

[1] "Economics of Aging: Toward a Full Share in Abundance" issued in March 1969 as a working paper by a task force appointed by Senator Harrison A. Williams, Chairman, U.S. Senate Special Committee on Aging.
"Health Aspects of the Economics of Aging" issued in July 1969 as a working paper in conjunction with the overall study.
"Homeownership Aspects of the Economics of Aging" issued in July 1969 as a fact sheet in conjunction with the overall study.
"Social Security for the Aged: International Perspectives" issued in August 1969 as a working paper for a hearing on "International Perspectives on the Economics of Aging," August 25, 1969.
"Employment Aspects of the Economics of Aging" issued in December 1969 as a working paper in conjunction with the overall study.
"Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions" issued in January 1970 as a working paper in conjunction with the overall study.

volumes of testimony,[2] and dozens of recommendations for immediate and long-range action.

Still several months away from its final report, the Committee on Aging can nevertheless present this interim summary of major developments during 1969 on "The Economics of Aging: Toward a Full Share in Abundance."

I. THE STATISTICS AND THEIR MEANING

A knowledgeable and concerned task force opened the committee deliberations in March by issuing a working paper [3] which began with a declaration and several troublesome questions:

> Every American—whether poor or rich, black or white, uneducated or college-trained—faces a common aging problem: How can he provide and plan for a retirement period of indeterminate length and uncertain needs? How can he allocate earnings during his working lifetime so that he not only meets current obligations for raising children and contributing to the support of aged parents but has something left over for his own old age?

The task force made it clear that the answers to those questions will not be forthcoming unless we recognize two distinct elements in the retirement income crisis.

One element arises from generally inadequate public and private provision for security in old age. Savings dwindle far faster than anticipated. Private pensions serve comparatively few, and not those in greatest need. Social Security has become an increasingly inadequate mainstay for most recipients.

The other element arises from drains which hit hard at fixed income after retirement: medical costs; rising property taxes (most of the elderly own their own homes); higher transportation costs; and rising prices—caused in part by economic growth, and, to an alarming degree, by inflation.

A. The Inadequate Base

To support its declaration that there is a rising gap between retirement income and income during the work years, and to document its conclusion that the barebones income of older Americans is likely to become even more inadequate unless bolstered by significant national action, the task force offered these arguments:

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[2] Hearings held in 1969:
Economics of Aging: Toward a Full Share in Abundance:
Part 1. Washington, D.C., April 29, 30, 1969.
Part 2. Ann Arbor, Mich., Consumer Aspects, June 9, 1969.
Part 3. Washington, D.C., Health Aspects, July 17, 18, 1969.
Part 4. Washington, D.C., Homeownership Aspects, July 31, August 1, 1969.
Part 5. Paramus, N.J., August 14, 1969.
Part 6. Cape May, N.J., August 15, 1969.
Part 7. Washington, D.C., International Aspects, August 25, 1969.
Part 8. Washington, D.C., October 29, 1969.
Part 9. Washington, D.C., Employment Aspects, December 18, 19, 1969.
Hearings planned for 1970:
Economics of Aging: Toward a Full Share in Abundance:
Private Pensions, Washington, D.C., February 17, 18, 1970.
Final hearings, May 4, 5, 6.

[3] See footnote 1, March 1969 working paper prepared by task force. Task force members are: Dorothy McCamman, Consultant; Juanita M. Kreps, Ph.D.; James H. Schulz, Ph.D.; Harold L. Sheppard, Ph.D.; Agnes W. Brewster.

—The "gap" is widening: Median income of families with an aged head was 51 percent of that for younger families in 1961, but only 46 percent in 1967.
—Three out of 10 people 65 and older—in contrast to one in nine younger people—were living in poverty in 1966, yet many of these aged people did not become poor until they became old.
—An additional one-tenth of our aged population was on the poverty borderline.
—About five in 10 families with an aged head had less than $4,000 income in 1967; about one in five was below $2,000.
—Of older people living alone or with nonrelatives in 1967, half had incomes below $1,480, and one-fourth had $1,000 or less.
—Even the level of living set by the Bureau of Labor Statistics in its Retired Couple's Budget is well beyond the means of most older people, especially for those who retired years ago. The average Social Security benefit of a couple retiring in 1950 met half the BLS budget cost then, but today it meets less than one-third.
—Half of all people now 65 and over are about 73 or older. In the years ahead, the increase will be particularly great at the oldest ages. With the population 65 and older projected to rise 50 percent between 1960–85, the population 85 and older may double.
—Increasingly, the rising population of widows is attempting to live independently, even if independence is purchased at the price of poverty.
—Our "retirement revolution" reflects two trends: at one end an increase in the number of very old aged persons; at the other, earlier departure from the labor force.
—The margin for saving—the excess of income over consumption expenditures—has been small for most families during most years of the worklife, especially for workers in the less skilled occupations.
—In addition, with an outlook for sustained economic growth, how realistic is it to expect today's workers voluntarily to forego consumption in order to save for the years ahead when this requires that they significantly reduce their present standard of living to provide adequately for an uncertain and "distant" old age?
—The overwhelming proportion of people retiring today receive total pension income—from both public and private pensions—which is only 20 to 40 percent of their average earnings in the years prior to retirement.
—Of families retiring in the next decade and a half, it has been projected that almost 60 percent of those with preretirement earnings between $4,000 to $8,000 will receive pension income of less than half these earnings.
—Projections to 1980 indicate that about half the couples and more than three-fourths of the unmarried retirees will receive $3,000 or less in pension income. And these projections use relatively liberal assumptions with respect to increases in private and public benefit levels.
—The same projection found that more than two-thirds of retired couples could be expected to receive less than $3,000 in Social Security benefits in 1980.

—Even under earlier projections, now known to be too optimistic, only a third to two-fifths of all aged persons in 1980 were expected to have income from private group pensions.
—In addition, private pensions cover less than half the work force and this coverage is concentrated among higher paid workers; those in the greatest need in old age will be least likely to receive these pensions.
—Early retirement is a developing trend that could seriously impede attempts to improve the income position of future aged populations. (In recent years, more than half of the men retiring have done so before age 65.)

B. The "Drains"

Inadequate as the base may be, it is subject to unique erosive forces. Later chapters in this report will deal with several such problem areas in more detail, but the major drains on retirement income are:
—National economic growth, while putting added dollars into pockets of the working group, increases pressures on the retiree. A rise in earnings of 4 percent annually—a not unrealistic assumption in view of recent performance—means consumption levels would approximately double in two decades, placing those on fixed income at a seriously deepening disadvantage in the marketplace.
—Earnings drop as advanced age further curtails already limited earnings opportunities. (In comparison to the age group 65–72, only half as many men 73 and over and a third as many women worked in 1962, and the earnings of the oldest workers were significantly lower.)
—Assets are reduced—in some cases, exhausted. Homeownership—the most important asset of the elderly—becomes especially difficult to maintain with advanced age, mounting taxes and other rising costs.
—Medical needs and the costs of meeting these needs rise with declining health. The rise in these costs is only partly met by Medicare, which covered 35 percent of health costs of the aged in 1967 (and 45 percent in 1968).
—Inflation erodes already inadequate incomes over longer retirement periods. (An annual rise of only 2 percent will reduce the purchasing power of fixed incomes by 18 percent after one decade and by 33 percent after two decades.)

II. PROPOSALS FOR CHANGE

Task force members did not consider or offer specific policy changes or legislative proposals.

But they did offer a context—guidelines with respect to basic public policy determinations—for the many specific suggestions made at hearings later in the year:

(1) The facts clearly show that the basic problem of low income in old age is not a transitional problem that, given present trends, will solve itself in the foreseeable future.

(2) To the extent that older people are to be "assured" of adequate income, the assurance must come through governmental action. Private pension plans and voluntary savings provide a promise of income, not a guarantee.

(3) Since the income security of each generation of retirees derives basically from a claim on the current production of the working population, it would appear that the emphasis on alternative methods of financing this claim has been exaggerated.

(4) The accepted level of income adequacy should be flexible enough to permit older people to share in the growth of the economy.

This is in part a question of equity: "Whose growth is it?" Increases in productivity of the currently employed result—not altogether from their own efforts—but in large part because of the capital accumulations and advances in technology that derive from past efforts.

(5) The existing social insurance system is a fast and effective way to deliver an income assurance that carries commitments for the future as well as for the current generation of the aged.

Impressed as they are with the existing social insurance system as a major vehicle for reform, the task force nevertheless recognized that the following specific issues should receive careful attention:

(1) By how much should the general level of cash Social Security benefits be increased to provide a basic floor of protection?

(2) Should benefits be raised for special groups of beneficiaries, particularly for widows, for those now drawing the minimum benefit, and for those who will become entitled in the future who have had earnings significantly above the present maximum earning base that is credited for benefits?

(3) Should the eligibility age for benefits be lowered? Should benefits payable before age 65 be computed without an actuarial reduction?

(4) Should the test that results in the withholding of benefits because of earnings be liberalized? Eliminated?

(5) Should benefit adjustments be made automatically or through legislative amendments? And should adjustment be to a level that merely preserves—or restores—purchasing power, or to a level that provides a share in the Nation's increased productivity?

(6) How appropriate are the available indexes, including the Consumer Price Index, as measures of the need for adjustment and the amount of adjustment in retirement benefits?

(7) What improvements are needed in Medicare benefits? Should the voluntary medical insurance portion (part B) be financed—as is the hospital insurance portion (part A)—through rising earnings of workers rather than through premiums paid by the aged?

(8) What role should general revenues play in the financing of the Social Security system?

III. THE HEARINGS: MAJOR PROPOSALS

Social Security and Income Maintenance

That the working paper "Economics of Aging" provided a firm base for the committee's survey hearings was confirmed repeatedly during 2 days of testimony.[4]

[4] See hearing cited in footnote 2, Economics of Aging: Toward a Full Share in Abundance: Pt. 1.

Robert M. Ball, Commissioner of Social Security, stated that the working paper "has identified the key factors in this problem of the economics of aging—that is, the basic question of income security and an equitable sharing by the aged in our increasing national output." He said:[5]

> To my mind, all of the other problems—and there are many other problems of older people—are really secondary to the question of an adequate continuing income paid as a matter of right and under conditions which contribute to human dignity. What we are struggling with in this country is to develop a series of arrangements that will guarantee on into the future that older people will have the income necessary to support an acceptable level of living.

Commissioner Ball, in describing administration proposals for a cost of living adjustment in benefits and a change in the retirement test, predicted that more fundamental changes would be studied by the statutory Advisory Council on Social Security, appointed shortly thereafter.

Former Social Security Commissioner Charles I. Schottland recommended a number of specific steps to increase substantially the level of Social Security benefits, to improve and liberalize the system, and to transfer the recipients of old age assistance into the Social Security program. He called for a major attack on the problem of inadquate income in old age, saying:[6]

> But more important than these specific recommendations I believe that Congress should make it very clear that the time has come to stop incremental and minor program changes which still keep the aged living on a poverty level.
>
> We must adopt as an objective the goal of getting every aged man and woman in the United States out of poverty and with sufficient income to live on a standard of health, decency, and comfort. These are the aims of my recommendations and suggestions.

A negative income tax system in combination with Social Security benefits that are related strictly to wages, was recommended as an eventual goal by the authors of "Social Security: Perspectives for Reform" (Joseph A. Pechman, Henry Aaron, and Michael K. Taussig). They proposed:[7]

> For the long run, we recommend a dual system of benefits to implement the two major objectives of the Social Security system—prevention of destitution among the aged poor and, for those with adequate incomes before retirement, benefits that are related to their previous standard of living.
>
> The latter function should be performed by a strictly wage-related benefit, with the replacement rate roughly the same at all earnings levels between subsistence and the median earnings level. The income support function should be transferred to a negative income tax system or to a comprehensively reformed system of public assistance.

[5] See hearing cited in footnote 2, Economics of Aging: Toward a Full Share in Abundance; Pt. 1, p. 12.
[6] See pp. 102–103 of hearings cited in footnote 2.
[7] See p. 115 of hearings cited in footnote 2.

PRIVATE PENSIONS

A working paper "Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions," by James H. Schulz, served as a springboard for discussion at 2 more days of hearings.[8] This working paper provided disturbing evidence on at least two important points:

1. That private pensions, while performing a major service to the economy and to millions of Americans, now serve far fewer than is commonly assumed and will continue to fall short of expectations unless greatly improved.
2. And that many common assumptions about the level of private pension projection are based more on wishful thinking than upon hard fact.

Witnesses at the hearings differed widely in their outlook and expectations as to the future contribution of private pensions to economic security. The same projections were thus labeled both overly optimistic and overly pessimistic.

Regardless of the viewpoint, witnesses recognized the need for major reform if private pensions are to fulfill their real potential.

Prof. Merton C. Bernstein, author of "The Future of Private Pensions," characterized private pension plans as a "lottery." To transform the private pension system into a sound method of retirement savings, he:

—Called for a national group pension plan to make pension coverage available to employees of small companies.

—Called for a national pension clearinghouse to enable employees to preserve pension credits although they move from job to job.

—Proposed neutral trustees—probably government appointed—to assure employees that pension plans will be designed and operated in their interests.

Dr. William C. Greenough, chairman, Teachers Insurance and Annuity Association and College Retirement Equities Fund, proposed a shift in emphasis in the tax treatment of private pensions to give primacy to the individual and the social objectives which can help solve the problem of income for the aged. His specific recommendation for earned retirement income tax deferral (ERITD) is based on this new study "Pensions Are for People."

Tax deferment for the individual taxpayer and a universal private retirement system was also proposed by Edwin Shields Hewitt, partner in Hewitt Associates, who said:

> Expansion of private pension coverage is vital, and we believe the time is appropriate to consider new measures to accomplish the desired expansion. We suggest consideration should be given to the encouragement of voluntary saving for retirement, either through individual saving or employee group saving. Such encouragement could be expressed by extending tax deferment to funds saved for retirement beyond the scope of the present deferment granted only to employer payments to qualified retirement plans.

[8] See hearing cited in footnote 2.

In effect we are proposing a universal system for private retirement income accumulation which would permit every working taxpayer to exempt from current taxes a portion of his earned income if it is held or invested in a bona fide retirement income arrangement. The portion of income exempt would take into account payments made on behalf of the taxpayer by his employer (as currently permitted), payments made by the taxpayer to employer-sponsored plans (not currently permitted), and payments made by the taxpayer to any approved retirement income arrangement (not currently permitted except under tax-sheltered annuities available only to employees of certain tax-exempt organizations).

A universal private retirement system would offer a solution to the major deficiency of the present system; namely, its apparent inability to achieve broad coverage. Adoption of a universal system with the tax privilege related to the individual taxpayer rather than limited to application through the employment relationship would appear to lead to the natural achievement of the goals of flexibility, freedom of choice, portability, vesting, and funding.[8a]

EMPLOYMENT

The price the Nation pays for failure to maximize employment opportunities for older workers is increased dependency. We do not see an increase in dependency as a good tool with which to fight inflation. We all have much more to gain through a national effort to raise our productive capacity and simultaneously provide meaningful job opportunities for older people.

This was a major conclusion of the working paper "Employment Aspects of the Economics of Aging," prepared for the committee by the National Council on the Aging's National Institute of Industrial Gerontology.

Despite this heavy cost, the United States does not yet have a clear cut, effective policy for maximum utilization of Americans now regarded as "older workers."

Testimony at the hearings on employment aspects made all too clear this lack of policy. Witnesses included air pilots forced by Federal regulations to retire at age 60 while still in their physical prime. All too evident, too, was the failure of the Federal Government to move ahead on two fronts that would permit formulation of a positive policy,

Two primary recommendations of the writers are that—

(1) the study of institutional and other arrangements giving rise to involuntary retirement called for by section 5 of the Age Discrimination in Employment Act be undertaken promptly, and

(2) a Middle-Aged and Older Workers Full Employment Act, similar to that introduced in the Senate last year (S. 4180), be passed and adequately implemented in order to provide a comprehensive program of employment services and opportunities for middle-aged and older Americans.

Chapter IX presents further detail on employment.

[8a] Testimony at "Pension Aspects" hearings, February 18, 1970, cited in footnote 2.

CONSUMER ASPECTS

A hearing in Ann Arbor, Mich.,[9] provided an opportunity for eloquent testimony by elderly consumers themselves, as well as by the experts, on the Consumer Aspects of the Economics of Aging. One conclusion was inescapable: the Bureau of Labor Statistics moderate budget for a retired couple is little more than a rigid austerity budget but even this level of living is far out of reach for most elderly Americans today. Problems of homeownership, explored at hearings on the Homeownership Aspects of the Economics of Aging on July 31–August 1, 1969; are discussed in Chapter IV of this report (pp. 68–79).

HEALTH

> Deficiencies in the delivery system for health care services play a direct role in creating dollars-and-cents problems for the elderly.
>
> They, along with other age groups, suffer not only in terms of inconvenience, but also in terms of direct dollar outlays, because of irrational or outmoded delivery systems for medical care and services. A special cause for concern for the elderly is the lack of decent alternatives to expensive hospital care.

This was among the major findings and conclusions of the Advisory Committee that prepared the working paper "Health Aspects of the Economics of Aging."

Another of the conclusions sounded the climate of the two days of testimony:[10]

- There is some danger that the current investigations of fraud and near-fraud in Medicaid and Medicare may lead to a defeatist or negative attitude toward each program.

  There is also a danger that such emphasis may well thwart efforts to deal with more fundamental deficiencies in each program.

  Reform is needed, but it should be thoroughgoing and it should be positive. This Nation has declared that high-quality medical care is the right of every American. We should be innovative and positive in making changes. We should be as insistent upon upgrading quality as we are insistent that wrongdoing be recognized and punished.

Witnesses concentrated on positive suggestions for improving the quality and the organization and delivery of health care in the Nation and on specific proposals to permit the programs of Medicare and Medicaid to achieve their full potentials.

Chapters II and V present further detail on health and health care.

IV. TAX REFORM TO HELP ELDERLY

A comprehensive Tax Reform Act, providing the most far reaching changes ever made in the Federal income tax law, was signed into law on December 30, 1969. Several measures in the new law will provide urgently needed tax relief for the elderly:

[9] See hearing cited in footnote 2.
[10] See hearing cited in footnote 2.

Increase in personal exemption deduction.—The act provides for a three step increase in the personal exemption deduction from $600 to $750 by 1973. Older Americans will benefit doubly from this increased deduction. Under existing law a person who is at least 65 years old is entitled to the regular personal exemption of $600 plus an additional $600 deduction for age—for a total of $1,200. When this provision becomes fully effective, an elderly taxpayer would be entitled to a $1,500 personal exemption deduction—$300 more than under present law.

Increase in standard deduction.—A three stage increase in the standard deduction will provide significant relief for moderate-income elderly taxpayers. The present 10 percent standard deduction with a $1,000 ceiling will be increased to 15 percent with a $2,000 limitation by 1973.

Low income allowance.—Older Americans will also benefit substantially from the new low income allowance (equivalent to the minimum standard deduction plus an additional amount which would equal $1,100), which will have the effect of removing more than 5 million tax returns from the tax rolls. The maximum $1,100 low-income allowance would go into effect in 1970, but would be reduced in two steps to $1,000 by 1972 to correspond to the $100 increase in the personal exemptions deduction for 1972. This low-income allowance together with the personal exemption deduction would be almost equivalent to the poverty standard, and would remove virtually all persons in the poverty category from the tax rolls.

Revision in tax rates for single individuals.—The new revised tax structure for single persons who do not support a household in which a dependent lives will benefit many elderly widows and widowers. (Approximately 3.6 million elderly women are widows and live alone.)

Under present law the tax rate for a single individual is substantially higher than for a married couple filing a joint return with the same taxable income. In some instances a single taxpayer will pay 41 percent more in taxes than a married couple filing jointly. The new rate structure in the Tax Reform Act will help to relieve this inequity by providing a tax for single persons which will not be more than 20 percent of the tax paid on a joint return with comparable taxable income.

V. THE FAMILY ASSISTANCE PLAN AND THE ELDERLY

Present adult assistance programs—aid for the aged, blind, and disabled—provide a wide latitude in average monthly benefits, ranging from $39.80 in Mississippi to $144.65 in California. The following table illustrates the scope of these variances:

Average monthly payments (March 1969)

	Highest payment	Lowest payment	National average
Old age assistance (OAA)	[1] $139.00	[2] $39.80	$70.65
Aid to the blind (AB)	[3] 144.65	[4] 55.35	94.25
Aid to the permanently and totally disabled (APTD)	[5] 134.35	[2] 49.20	84.60

[1] Wisconsin.
[2] Mississippi.
[3] California.
[4] Utah.
[5] Iowa.

Nearly 3 million individuals received assistance from these three programs in 1969:

OAA	2,030,000
AB	80,400
APTD	728,000

A. Nixon Welfare Reform Message

In transmitting his welfare reform message to the Congress in August 1969, President Nixon recommended changes in the adult assistance programs, including:

—"uniform Federal payment minimums for the present three categories of welfare aid to adults—the aged, the blind, and the disabled." [11]

—"a minimum payment of $65 per month for all three of these adult categories, with the Federal Government contributing the first $50 and sharing in payments above that amount." [12]

B. Family Assistance Act

In October H.R. 14173—the Family Assistance Act—was introduced to implement these recommendations. One significant change was made in the adult assistance program as originally proposed by the President. H.R. 14173 provided a minimum monthly payment of $90 for the aged, blind, and disabled rather than the $65 recommended by the President.

In financing the program, the Federal share would amount to $63.75, and the remainder would be borne by the States. However, States would be ineligible to receive the Federal contribution unless their adult assistance program met the $90 minimum monthly requirement.

Under existing law, the Federal share for these three separate categories amounts to $31 of the first $37 in benefits and 50 to 65 percent of the balance, depending upon a State's per capita income. In addition, the maximum Federal share is $75 a month per recipient, and each State determines its own cost share.

H.R. 14173 also provided for a combined Federal-State program to replace the three separate existing programs. Presently, the programs

[11] Congressional Record, vol. 115, No. 116, Aug. 11, 1969, p. H7239.
[12] See footnote 11, p. H7240.

are administered by State and local governments which determine eligibility and the amount of payment.[13]

VI. ACTION ON SOCIAL SECURITY IN 1969

President Johnson, in his January 14 State of the Union Message, said that the time had come for Congress once again to recognize the necessity "to make more adequate provision for aged persons." He asked for an overall increase in benefits of at least 13 percent and an increase in the minimum from $55 to $80 monthly.

A. President Nixon's Proposals

First word on President Nixon's intentions was given in his April 4 message to Congress on his domestic legislative program. He asked for "an increase in Social Security benefits, to take account of the rise in living costs;" and White House sources were quoted in press accounts [14] as saying the President's specific goals were a 7-percent across-the-board increase and liberalized "retirement test" standards.[15] (Price rises, projected on any reasonable basis, would have wiped out a 7 percent increase months before it would reach the Social Security beneficiaries.)

On September 25, the President delivered a Social Security message which asked for a 10-percent increase in payments, effective with checks mailed in April 1970 "to make up for increases in the cost of living."

Other major proposals:

—Future benefits "be automatically adjusted to account for increases in the cost of living."

—"An increase from $1,680 to $1,800 in the amount beneficiaries can earn annually without reduction of their benefits, effective January 1, 1971," and other liberalizations in the retirement test.

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[13] On March 11, 1970, the House Ways and Means Committee reported out favorably the Family Assistance Act of 1970 (H.R. 16311), which also includes far-reaching changes in aid for the aged, blind, and disabled. In discussing the need for revision of the present programs, the committee report expressed deep concern about the "inadequacy and unevenness" of assistance payments for these three groups. Major provisions affecting the elderly:

$110 Minimum Monthly Assistance Benefits for the Aged, Blind, and Disabled.—A combined Federal-State program for the needy aged, blind, and disabled would replace the three separate existing programs. Under the new program, the States would be required to provide a payment sufficient to bring an individual's total income up to at least $110 per month, or, if higher, the standard presently in effect. Federal matching payments would amount to 90 percent of the first $65 to eligible individuals and 25 percent of the remainder, with a maximum limit established by the Secretary of Health, Education, and Welfare.

Earnings Exemption.—Under existing old-age assistance law a State may disregard the first $20 of monthly earnings of an aged person plus one-half of the next $60 before assistance is reduced. This "optional disregard" provision would be increased to exempt the first $60 per month plus one-half of the remainder.

The earnings exemption for the severely disabled was also liberalized and made consistent with the present mandatory exempt amount for the blind, $85 per month plus one-half of the remainder.

Pass Along Provision.—Under the Social Security Amendments of 1969 (title X of the Tax Reform Act of 1969—Public Law 91-172), provision was made for passing along a portion of the 15-percent increase in benefits to public assistance recipients. Section 1007 of the act requires the States to assure that every adult public assistance recipient who receives a Social Security benefit will receive a $4 monthly increase in total income. This would be achieved by disregarding that part of the Social Security benefit increase and passing it along to the recipient or by raising the State's standard of assistance for all recipients. This provision was only made applicable through June 1970. Under the Family Assistance Act, it would continue indefinitely.

[14] The Washington Post of Apr. 15, citing "administration sources," said that the Social Security trust fund could absorb a 7-percent increase, "but as an inflationary curb, consideration has been given to speeding up the time table for payroll tax increases."

[15] For additional discussion of the "retirement test" see pp. 14–16 of this chapter.

—An increase in the contribution and benefit base from $7,800 to $9,000 beginning in 1972,[16] with automatic adjustment thereafter to reflect wage increases.

Critics of the President's proposals said that they made no special provision for raising minimum benefits, that adjustment in benefit would be better geared to changes in productivity rather than just cost of living, and that a 10-percent increase would raise average retirement benefits only by about $10 a month.

B. Congressional Alternatives

With support from the AFL–CIO and the National Council of Senior Citizens, legislators in both the House of Representatives and the Senate moved to introduce far-reaching omnibus legislation including among its major changes a 44-percent increase in cash benefits to be accomplished in two steps by January 1972.

Representative Jacob H. Gilbert, in introducing his bill, H.R. 14430, on October 21 said:

> My new bill would maximize the potential of Social Security. Up to now we have not used Social Security to anywhere near its real potential.
>
> We can do much more than we are doing to provide economic security for the elderly and, in so doing, make this a better Nation.[17]

Senator Harrison A. Williams, introduced an identical bill, S. 3100, on November 3, declaring that the Committee on Aging study of the "Economics of Aging" had already established "a fundamental truth" which was:

> The economic problems of old age are not only unsolved for today's elderly, but they will not be solved for the elderly of the future—today's workers—unless this Nation takes positive, comprehensive actions going far beyond those of recent years.[18]

In summary, these are the major changes proposed by the Gilbert-Williams bills:

—An immediate increase of 5 percent in monthly cash benefits (to bring the recently enacted 15-percent increase up to 20 percent), with a further 20-percent increase effective January 1, 1972. The two-step increase would raise the minimum benefit to $120 a month in 1972. The maximum benefit (now approximately $190 a month) would go to $340 a month in 1974.

—Thereafter, automatic increases geared to increases in living costs.

—A widow's benefit at age 65 equal to the husband's benefit.

—Improved benefits for workers retiring before age 65.

—Liberalized disability benefits.

—An increase from $1,680 to $1,800 a year in earnings permissible for retirees without loss of any Social Security benefits and a liberalization in the treatment of earnings above $1,800.

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[16] For details of the President's proposals, and comparison with congressional alternatives, see appendix 3, item 3, p. 332.

[17] Congressional Record, Oct. 21, 1969, p. H9769.

[18] Congressional Record, Nov. 3, 1969, p. S13573.

—Elimination of the monthly premium—slated to rise to $5.30 this July—for Medicare part B (doctor insurance).
—Extension of Medicare to out-of-hospital prescription drugs.
—Coverage under Medicare of disabled persons under age 65.
—Earnings up to $15,000 a year credited for Social Security benefits with benefits based on 10 years of the 15 years of highest earnings.
—A more equitable financing method through a higher earnings base for payroll taxes and through a gradually increasing Government contribution eventually equal to approximately one-third the total cost of the cash benefits program.

The Gilbert-Williams bills differ with the administration proposals (as incorporated in H.R. 14080) markedly, as shown in appendix 3, item 3, page 332.

C. The "Stop-gap"—A 15-Percent Increase

The House Ways and Means Committee, in reporting out a bill to increase Social Security benefits by 15 percent, made clear that the need for an across-the-board increase to compensate for rapidly rising living costs was so urgent that it should not be delayed pending detailed consideration of more complex proposals for Social Security reform.

The benefit increase applies after January 1, 1970, but the first checks at the higher rate would not be received until April, covering March benefits. An additional check covering the increase for January and February will be mailed later in April.

From the time the preceding benefit increase had been enacted—at the end of 1967—to the time beneficiaries will actually receive the 15-percent increase, the cost of living will have risen by an estimated 13 percent. Unless there is a significant slackening in the price rise, the 15-percent benefit increase could be outdistanced by late summer. Benefits would again lag behind current prices, to say nothing of failing to compensate for all the erosion during the years between adjustment.

The cost of the 15-percent benefit increase was met out of an actuarial balance in the fund without need for an increase in contribution rates.

Social Security amendments going beyond a benefit increase appear certain during 1970. When the 15 percent was before the House, Committee Chairman Mills assured the House that the 15-percent increase was not the final recommendation of the Ways and Means Committee and that it was his firm intention to report a comprehensive Social Security bill by March 1970.

President Nixon too accompanied his proposals for a benefit increase and retirement test liberalization with recognition that the Social Security is in need of long-range reform, to make it better serve those who contribute now for benefits in future years. An Advisory Council on Social Security appointed by the Secretary of Health, Education, and Welfare in May 1969, will report its findings and recommendations to the Secretary, for transmittal to the Congress by January 1, 1971.

D. The "Retirement Test"—New Proposals

The retirement test that limits the amount a beneficiary may earn and still receive full benefits is certain to receive attention during any consideration of Social Security reform.

Public concern about the retirement test and one proposal for liberalizing the test was discussed in "Developments in Aging, 1968" (pp. 14–15). This proposal, transmitted by Secretary Wilbur J. Cohen to Congress on January 3, 1969, recommended:

1. That the amount a Social Security beneficiary can earn in a year and still get all of his benefits, be raised from $1,680 to $1,800, to bring this restriction up to date with the increase in earnings levels that have occurred since the $1,680 figure was adopted.
2. That there be a corresponding increase from $140 to $150 (one-twelfth of the annual exempt amount) in the monthly exempt amount—the amount of wages which, regardless of his annual earnings, a beneficiary can earn in a given month and still receive his benefit for that month.
3. That the band within which $1 of benefits would be lost for every $2 of earnings be raised to $1,800—$3,000 (from the present $1,680—$2,880).
4. That there be a loss of $3 of benefits for every $4 earned over $3,000 a year, in lieu of the present requirements that $4 of benefits be forfeited for each $4 earned above the 2 for 1 band.
5. That there be provision for automatically adjusting the exempt amount to rises in earnings levels.

The Secretary estimated the cost of this entire package as 0.07 percent of taxable payroll.

The above is the retirement test provision proposed by the Gilbert-Williams bills.

President Nixon, in his proposal for first steps to improve Social Security, included a recommendation to liberalize the test of earnings. As in the proposal of the preceding administration the exempt amount would be increased to $1,800 to bring it up to date with wage increases. Above the exempt amount, the $1-for-$2 reduction would apply regardless of the amount of earnings.

In comparison to the Cohen proposal, the proposal of the Nixon administration is both more liberal and simpler to administer and to understand. Its long-run cost is estimated at 0.08 percent of taxable payroll.

That there is so little difference in the estimate of the costs of these two proposals—and that their cost is so small in comparison to the cost of completely eliminating the test—is explained in part by a Social Security Administration study of the effects of the 1966 retirement test changes on the earnings of workers aged 65–72 (Research and Statistics Note No. 1, January 30, 1970). The test effective in 1966 raised the exempt amount from $1,200 to $1,500 and applied the $1-for-$2 withholding band to earnings between $1,500 and $2,700 (formerly between $1,200 and $1,700). The conclusions of this study were:

—a fairly large number of workers responded to the higher annual exempt amount by increasing their annual earnings or earnings plans from about $1,200 to about $1,500 a year.

—extension of the $1-for-$2 and $1-for-$1 provisions did not alter their earnings level.

—extension of the $1-for-$2 and $1-for-$1 provisions for benefit withholding to higher earnings amounts apparently had the effect of inducing some men to reduce their earnings.

The findings of this study thus tend to support the claim that many retired workers feel that the completely exempt amount is "all they are allowed to earn" and that others hesitate to earn above the exempt amount because of fear that they will not immediately get back on the benefit rolls after a period during which benefits have been withheld because of earnings.

Significantly, strong support for maintaining a retirement test came from the National Council of Senior Citizens when its executive board approved a study "The Retirement Test in Social Security" which concluded:

> It would appear evident from the facts and figures cited above that the elimination of the retirement test in the Social Security program is neither practicable nor desirable since it would help a comparatively small number who are least in need and deprive a very large number, including those most in need of the benefit, of possible improvements in the program.

RECOMMENDATIONS

Major reform in the Social Security system is recommended in order that older Americans today and in the future may share in the economic abundance they have created.

In thus recommending, the committee is in complete agreement with the following basic conclusions of its task force in the Economics of Aging:

- **A reasonable definition of adequacy demands that the aged population, both now and in the future, be assured a share in the growth of the economy.**
- **Such assurance can best be provided, or can only be provided, through governmental programs, particularly the social insurance system of OASDHI, which carry commitments for future older Americans—the workers of today—as well as for this generation of the aged.**

Use of general revenues, as a more equitable basis for financing part of the costs of an improved Social Security system, should receive serious congressional consideration.

We should now be exploring methods whereby retirement benefits can be adjusted to reflect productivity, not just rising prices.

And at a minimum and without further delay, these urgently needed changes in the Social Security system should be made:

- **A widow's benefit at age 65 equal to 100 percent of the husband's benefit.**
- **An increase in minimum benefits.**
- **A higher base for taxing and crediting earnings.**
- **A modernization and liberalization of the retirement test.**

CHAPTER II

HEALTH: HIGH COSTS AND CHRONIC INADEQUACIES

"Americans of age 65 and over—though drawing substantial, essential economic assistance from Medicare, and to a much lesser extent, from Medicaid—nevertheless continue to be the *major victims of unresolved problems related to the costs, quality, and availability of medical care in the United States today.*" [Emphasis added.]

—Advisory Committee report, "Health Aspects of the Economics of Aging," for the Senate Special Committee on Aging, July 1969.

Not quite 5 years ago—after a struggle lasting more than two decades—the Congress of the United States enacted Medicare and Medicaid into law.

From the beginning, it was generally recognized that both programs had serious shortcomings.

But for older Americans, 1965 was a landmark year in which the promise of protection against illness-caused financial disaster seemed to be on its way, if not fully assured.

And yet, by mid-1969 an Advisory Committee for the Senate Committee on Aging reached the conclusion excerpted above.

Events later in the year seemed to confirm the advisory group's conclusion.

The rise in health care costs continued. (See charts on pp. 18–19 for details on the increase and impact upon the elderly.)

Organization of the health industry, criticized during the year by President Nixon himself, was the subject of harsh critiques from Congress and elsewhere.

And finally, an announcement that a new rise in Medicare (part B) premiums would take place in July 1970 caused widespread concern.[1]

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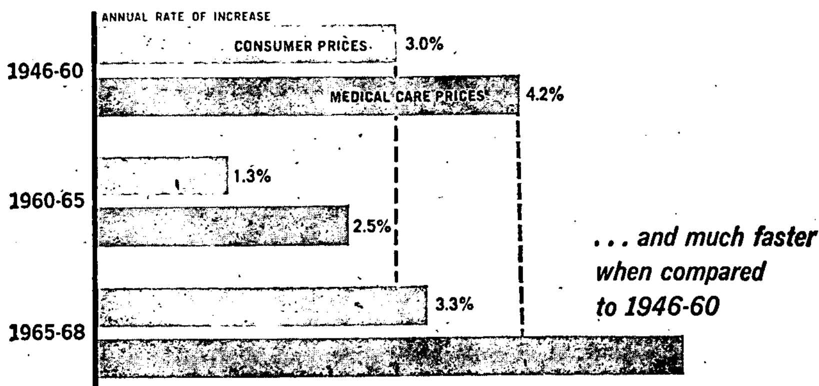
[1] In his Social Security message of September 17, President Nixon warned that:

"The voluntary supplementary medical insurance * * * often referred to as part B Medicare coverage is not adequately financed with the current $4 premium. Our preliminary studies indicate that there will have to be a substantial increase in the premium * * * beginning July 1970.

On December 27, HEW Secretary Robert H. Finch announced that the part B premium would be increased from $4 to $5.30 as of July 1, 1970. In addition, the coinsurance payment required of the beneficiary will increase from $11 to $13 a day for the 61st through the 90th day of hospitalization. At extended care facilities, stays of more than 20 days will increase from $5.50 to $6.50 a day.

In the last 3 years, medical care prices have jumped almost twice as fast as prices for all consumer items



WHAT CAUSED THE GROWTH IN THE MEDICAL CARE DOLLAR?

Increases in expenditures for health may result from several factors: (1) A rise in the price per unit of health service; (2) a growth in the population; and (3) an increase in the use of health services and availability of new medical supplies and techniques.

In the 19-year period since fiscal 1950 health expenditures rose $48.2 billion. Of this rise—

About 50 percent, or $24.4 billion, can be attributed to the increase in prices;

Another 19 percent, or $9.1 billion, is the result of population growth;

The remaining 31 percent, or $14.7 billion, is due to increased use of services, such as seeing the doctor and dentist more often or going to the hospital more, and having access to many miracle drugs not available in 1950 and life-saving, but expensive new techniques, such as open heart surgery or kidney dialysis.

Source: Social Security Publication 69–41 (November 1969).

To at least one leader in the field, the present health cost crisis raised the spectre that Medicare and Medicaid could be "repealed by runaway costs." [2]

On the other hand, perhaps the very severity of the problem would become a force for far-reaching reform.

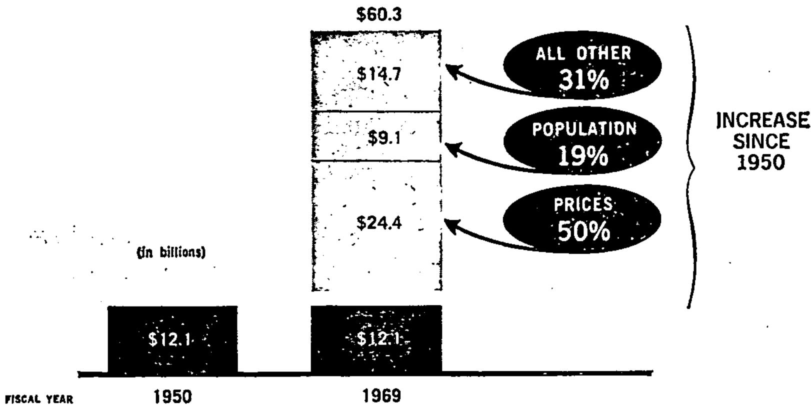
As one witness told the committee, the crisis offers:

> * * * a magnificient opportunity to improve Medicare for 20 million Americans, and use that experience to develop fine programs which will protect the ruggedly individualistic doctor and the hospital director and the nurse and all those people, 3 million and more who work in the health sector and who by 1970 will form the largest single employee group in this country.[3]

[2] Hearing on "The Economics of Aging: Toward a Full Share in Abundance (Health Aspects)," pt. 3, Washington, D.C., July 17–18, 1969, p. 533, testimony of Nelson H. Cruikshank, President, National Council of Senior Citizens.

[3] Dr. John H. Knowles, p. 587 of hearings cited in footnote 2.

Higher prices caused half the 19-year growth



WHAT HAS HAPPENED TO MEDICAL CARE PRICES?

With rising prices responsible for the largest portion of the increase in medical care expenditures, it is apparent that the sizable growth in medical care prices is a matter of concern. A dollar of health care spent today does not go nearly as far in paying for a day of care or a unit of service as it would have several years ago.

Since World War II, the consumer price index (CPI) and its medical care component have been continuously rising, with the latter rapidly outpacing the former. In recent years, however, the gap between the relative increases of these two price indexes has widened considerably. From 1960 to 1965 medical care prices jumped nearly twice as fast as prices for all consumer items and the wide gap has continued. For the 3-year period 1965–68, medical care prices increased at the annual rate of 5.8 percent compared with a 3.3-percent increase for all consumer items.

Source: Social Security Publication 69–41 (November 1969).

I. MAJOR ISSUES RAISED BY ADVISORY COMMITTEE

Advisory Committee members saw health care expenditures as a major element in the immediate and long-range ability of the elderly to maintain themselves financially:

> What is discussed in this report are * * * matters that must, as a prerequisite for any realistic plans for economic security in retirement now and in the decades to come, be dealt with as quickly and as thoroughly as possible.[4]

In a joint preface to the report, Senators Harrison A. Williams (Committee on Aging chairman) and Edmund S. Muskie (chairman of its Subcommittee on Health) also linked health problems to financial insecurity:

> * * * the threat of costly, catastrophic, disabling illness remains all too real among our aged population. That threat, intensified by today's rapid rise in medical costs, cannot be disregarded in any evaluation of the economics of aging in the United States today. If we in this Nation ever hope to

[4] Pp. 1–2, "Health Aspects of the Economics of Aging," July 1969. Working Paper. A separate committee print is incorporated in appendix of hearing cited in footnote 2.

establish an adequate retirement income maintenance program, we will have to resolve medical cost problems that otherwise will remain an intolerable drain upon the limited resources of the elderly *and forestall every alternative in providing adequately for the economic security of the aged.*[5] [Emphasis added.]

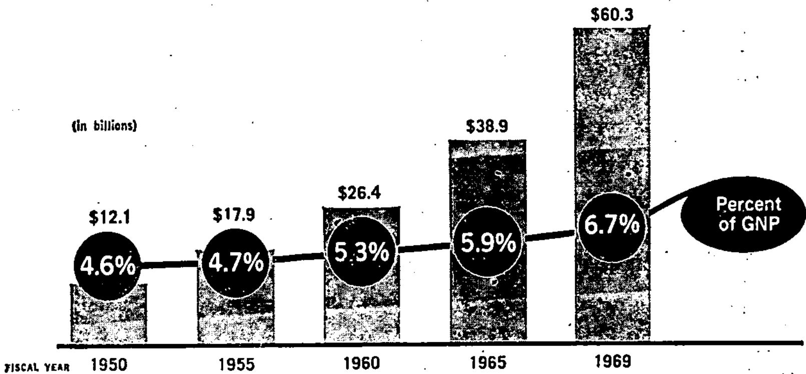
In a Nation which "can ill afford to add to the burdens of the elderly by neglecting unresolved problems related to their health care," the most urgent of those problems—as seen by the Advisory Committee and later by witnesses at 2 days of hearings—were these:

A. Medical Cost Inflation

Health care expenditures per aged person in the United States average about 2¾ times those of people under age 65.

It stands to reason, then, that sharp medical costs will have especially great impact upon this age group. Medicare helps absorb some of the rising costs, but not all, by any means (see next section).

Today's medical care dollars total $60.3 billion . . . 6.7% of GNP



How Big Is the Medical Care Bill?

The medical care dollar today is a large one, amounting to $60.3 billion in fiscal 1969. Its growth has been at a rapid pace—faster than that of the economy in general. In fiscal 1950, medical care expenditures amounted to $12.1 billion and represented 4.6 percent of the Gross National Product (the total market value of the Nation's annual output of goods and services). By fiscal 1960, its share of GNP had reached 5.3 percent and today it is up to 6.7 percent. Part of the increasing share of GNP is the result of the higher prices for medical care compared with other items.

The growth in the size of the medical care dollar, especially in the last few years, has evoked much concern. Are we receiving more and better services for these large outlays? Are rising prices for medical care eating up the growing expenditures? Can efficiency in the health industry be improved?

Medical economists and health experts throughout the country are trying to better understand the underlying reasons for the growth in the medical care dollar and are seeking ways to mitigate these rising costs while still continuing to improve health services.

Source: Social Security Publication 69–41 (November 1969).

[5] P. VI, Working Paper cited in footnote 4.

The preceding Chart depicts the rise in all medical costs, but it cannot show the extraordinary increases in many services or surgery common to the elderly, though not limited to them.[6]

Advisory Committee members recognized that Medicare may have contributed to inflationary pressures by increasing demands.[7] But they proposed reforms and broadening of that program, rather than its abandonment.

What Costs Mean in Personal Terms.—However significant and imposing the national statistics may be, they must be translated into individual terms for full understanding of the medical cost problems facing millions of older Americans today. Advisory Committee members saw uneven distribution as the most striking characteristic of such problems:

> The amount of hospital care required annually varies from none for 87 percent to two or more stays for some of the elderly. Older persons with $10,000 or more income were heavier than average users of hospitals. Those with two or three hospital episodes required more than two or three times as many days of care as those hospitalized only once.
>
> Visits to doctors also vary by age, sex, and by physical condition, as well as by city and by income. The per capita visits rise with age. This is one reason why aged females average more doctor visits than males. Only 27–30 percent of the population aged 65 and over goes through a year without seeing a doctor—7 percent see a doctor 13 or more times a year, or more than once a month.
>
> *Thus, costs can range from nothing to $400 or more, just for doctor visits outside the hospital.*
>
> Prescribed drug usage varies widely; those with chronic illnesses require more than the average number of prescriptions, so their costs can be sizable. This is one of the gaps in Medicare; it is one of the large segments of expenditures under Medicaid. And it is the largest area of per capita private expenditure by the aged.[8]

Information about medical cost problems in urban centers was provided by a panel[9] of senior AIDES.[10] Describing "unmet needs that I see and hear about almost every day," an aide from Miami said that she knows of many elderly individuals who go without foot care or dental care—neither covered by Medicare—because they can't afford it.

"Some of the elderly," she said, "do not eat properly because they can't afford dentures. There is a 3-year waiting list at the local dental clinics."

Prescription drugs, in particular, are often beyond financial reach of the elderly. An aide from Pittsburgh told of a retired steelworker, aged 78, and his 74-year-old wife. For drugs needed to treat his heart condition and her diabetes, they pay between $35 and $40 a month from a $139 monthly income:

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[6] The Advisory Committee Working Paper (pp. 21-22) cites a Social Security Administration study showing sharp increases of 17 to 21 percent in three such surgical procedures and two in-hospital services for the 36 months ending December 1968.

[7] Pp. 22–23 of Working Paper cited in footnote 4.

[8] Pp. 14–15 of Working Paper cited in footnote 4.

[9] Pp. 539–552 of hearings cited in footnote 2.

[10] See ch. IX for a description of the AIDE program.

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> So they have little left for food. As a result, they both suffer from severe malnutrition.[11]

Two examples, provided by another AIDE indicate that many elderly persons need direct help in obtaining badly needed care:

> The Senior Citizens Service Corps AIDES found an 87 year old man, also at Braddock, Pa., who was hospitalized twice in the past year. He had suffered a stroke and, in trying to get from his bed into a wheelchair, he broke his hip.
>
> When we got him to the hospital, he developed other ailments. By the time he got out of the hospital, his medical and hospital bills came to around $500.
>
> This man lives alone. He has no known relative. He cannot read or write, but he has always been self-supporting and most particular about paying his bills. So, at his request, I have arranged to pay a certain amount of his income on his medical bills. I might say his income is $123.70 a month.
>
> His latest problem is dental care. He got false teeth. So, with the money he turns over to me, I pay $5 a week on this bill.
>
> You might say the Senior Citizens Service Corps has all but adopted this fellow.
>
> Not long ago, our AIDES discovered a couple—he is 76 and she is 75. He suffered a broken hip in a fall. This man had served 7 years and 8 months in the Navy prior to World War I. When his case came to my attention, my first thought was to get him admitted to the Veterans' Administration hospital in our area. So, we arranged to have an ambulance take him there. The hospital refused to take him in because he had not served in the military service during wartime. That is what they told me.
>
> So, he had to be transferred to a general hospital where he is under care.
>
> This man and his wife have a total income of $182 a month. However, he has been disabled since 1960 and his wife has a heart condition and is mentally deranged. As a result, doctor bills and medication account for a big part of their income and, in such a situation, $182 a month does not go very far.
>
> The Senior Citizens Service Corps AIDES find that the condition of the elderly poor gets worse as they grow older.[12]

B. Medicare Gaps

Medicare paid out $6.3 billion for health care during fiscal year 1969, contributing greatly to the health and security of the 20 million older citizens served by that program.[13]

"But," said the Advisory Committee report, "because *it* [*Medicare*] *now covers only 45 percent of all health costs of the elderly*—the door is still open to catastrophic or steady, gnawing financial difficulties so

[11] Mrs. Ruth M. Tucker, p. 545 of hearing cited in footnote 2.
[12] P. 546, hearings cited in footnote 2.
[13] A detailed Social Security Administration report on the Medicare program appears in appendix 1, p. 297.

serious as to be a source of great concern to all but the wealthy among the elderly citizens of this Nation." [Emphasis added.][14]

One Advisory Committee member later spelled out the problem:

—The average single retired worker on Social Security today (1969) receives less than $100 a month and a couple, approximately $150:

> Their financial problem would be serious enough if Medicare covered all their health costs. The fact is that Medicare pays for less than one-half of the health care costs of the elderly. For the great majority of the elderly who live on very low incomes, this represents a crushing financial burden. For many it also means an inability to finance urgent medical care needs which results in avoidable discomfort, pain, and yes, even death.

—Since health care costs of the elderly are approximately 2¾ times as much as for younger age groups, even if Medicare paid for half the health care costs of the elderly, they would still be paying out of their own pockets 37½ percent more on the average than those still working.

—And yet, their incomes on the average are only about half of those of the nonelderly.[15]

Advisory Committee members and witnesses at the hearings identified the following major unresolved problems in Medicare:

Deductibles and Coinsurance.—Under part A (hospital insurance) the patient pays the first $44 of the hospital coinsurance in the later days of hospital and extended care. The Advisory Committee felt that the part A deductible and coinsurance for long stays affected a relatively small portion of the aged population in the course of a year. The major problem lies in part B (physicians' services), for which the elderly must pay (1) $4 a month premium (to rise to $5.30 in July), (2) the first $50 of the cost of doctor bills each year, (3) and 20 percent of the remaining cost.

Criticism of deductibles and coinsurance has been expressed with increasing intensity since the advent of Medicare.[16]

The Advisory Committee—calling for elimination of all deductibles and coinsurance under Medicare—was supported by several prominent witnesses at the hearing.[17]

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[14] P. 3, Working Paper cited in footnote 4.

[15] Pp. 494–95, hearing cited in footnote 2, testimony of Bert Seidman, Director, Department of Social Security, AFL–CIO.

[16] See p. 23, "Developments in Aging, 1968" and pp. 43–46, "Developments in Aging, 1967" for summary of earlier criticisms.

[17] Nelson Cruikshank, President of the National Council of Senior Citizens called them "cruel barriers between the elderly poor and health services which they need." (P. 533.) He described the annual $50 deductible and 20 percent coinsurance for part B as "particularly cumbersome and burdensome." Mr. Seidman (see footnote 15) said that parts A and B should be combined, the part B premium dropped, and coinsurance and deductible be eliminated. Perhaps the most blunt critique was given by Dr. John Knowles, general director, Massachusetts General Hospital (p. 580), "I would like to say something about deductibles and coinsurance. How in the Lord's name we ever got the idea in this country that people will make a run on doctors and hospitals and that the average citizen really enjoys going to a hospital and fleecing and banging on doctors' doors all day, I shall never know. There are occasional neurotic patients and what have you, and shoppers who for lack of other entertainment will go from one doctor to another and have a good time of it, but most of us, 99.99 percent of us, have no desire to see a doctor or go to a hospital. Deductibles and and coinsurance are based on flimsy premises and compound bureaucratic redtape. It results in an unnecessary expansion of the bureaucracy, it may even cost more to carry it out than it serves for the taxpayer." See hearing cited in footnote 2.

A physician who practices in a small North Carolina community (Dr. Amos Johnson, p. 643, hearings cited) said "in excess of half of my patients can ill afford to pay" the the coinsurance and deductibles.

Weighing the same question earlier in the year, the Health Insurance Benefits Advisory Council[18] (HIBAC) summed up the situation in this way:

> Decisions about deductibles and coinsurance are particularly difficult. On the one hand they are said to be a barrier against excessive use of services, and a means of helping to prevent escalation in prices and costs. But if they are sufficiently high to achieve this result for large number of beneficiaries they may also become, especially for lower income beneficiaries, a barrier to the use of needed services and a financial hardship.
>
> * * * * *
>
> The aged who find the deductible an effective barrier and a financial hardship are those least likely to be able to buy complementary insurance or to have this coverage provided to them through an employer group. They may then need to seek aid from State or local public assistance programs, a step which most wish to avoid and may not take.
>
> * * * * *
>
> It seems likely, although not demonstrable from the available data, that the deductible and coinsurance provisions of the law applicable to medical services have a more powerful effect on use of services than do the hospital cost-sharing requirements. However, eliminating the medical insurance deductible would require an increase in premiums equal to the reasonable charge of increased services and the increased administrative costs associated with paying many small bills which appears to be the only major additional coverage which would result.
>
> The Council has been advised that the cost of eliminating the $44 inpatient hospital deductible would be 0.09 percent of taxable payroll (which would have amounted to $230 million in 1969). If, in addition, hospital and extended care coinsurance were eliminated, the cost would be 0.17 percent of payroll. Removal of the $50 deductible and the coinsurance under the supplementary medical insurance program would require a $3.95 increase in the monthly premium, with equal matching by the Government.[19]

The Council had no recommendations for changes in the law, but said that the deductible and coinsurance provisions need further study and should receive the attention of the Social Security Advisory Council.[20]

Coinsurance and deductibles continue to be a major problem to users of the Medicare program. Action should be taken by the Social Security Advisory Council at the earliest possible date to review costs of reducing or elimi-

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[18] HIBAC is composed of individuals drawn from fields related to hospital, medical, and other health activities, and from the general public. It is charged with advising the Secretary of HEW on general policy matters related to the Medicare program.

[19] Pp. 17–18, report of HIBAC, July 1, 1966 to Dec. 31, 1967, see footnote 18.

[20] The Social Security Advisory Council is established by statutory requirement. Mr. Arthur S. Fleming was appointed as Chairman for the current Council, which is to make a report by January 1, 1971.

nating these features of Medicare, beyond estimates now available. The advisory committee should also provide a thorough analysis of the costs of combining parts A and B and removing the part B premium. Included in their presentation should be some discussion of the best possible use of general revenue funding to achieve these objectives.

Prescription drugs not covered.—"Shall we buy food for the table, or shall we pay for the drugs we need to live?"

The words may differ slightly, but at practically every hearing conducted on the economics of aging, that question has been asked by witnesses before the Senate Special Committee on Aging.

Medicare does not pay for out-of-hospital prescription drugs.

And yet, drug expenditures by those over age 65 average three times higher than those for all Americans.

A task force established by the Secretary of Health, Education, and Welfare in 1967 reported early in 1969 that "there is a need for an out-of-hospital drug insurance under Medicare." [21]

That conclusion was based on findings including the following:

—The "average" prescription cost outlay, while high, actually does not tell the whole story. Costs fall most heavily upon those likely to be already under heavy financial pressures.

—Per capita expenditure for the elderly with severe disabilities was nearly three times greater than that for those with none.

—A 1968 estimate indicates that 20 percent of the elderly have no drug expenses, while the costs will be less than $50 for 41.5 percent, between $50 and $99 for 19 percent, between $100 and $249 for 15.5 percent, and $250 or more for 4 percent.

(*NOTE: Half of all older people living alone or with nonrelatives, during 1967, had annual incomes of less than $1,480; one in four had as little as $1,000 or less.*)

—The average number of acquisitions for elderly women was nearly 50 percent more than for the men, and the per capita expenditure for elderly women was more than one-third higher than that for elderly men.

(*NOTE: Six of 10 of all widows and other aged women living alone have incomes below the poverty line.*)

—For the elderly with one or more chronic conditions, the annual costs of prescribed medicines was $48.80; for those with conditions which limit major activity completely, costs averaged $78.80. Prescription expenses of those of the elderly with severe chronic conditions—*about 15 percent of all elderly persons*— were over six times as great as the expenses of younger people.

—Only 10 percent of the 65+ population had private health insurance for out-of-hospital prescription drugs at the end of 1966. Where such coverage is purchased, it is financially helpful only in so-called "catastrophic illnesses." It is generally included only in major medical policies involving deductibles of $100, $250, or $500 which the aged must pay himself.

—Income tax deductions provide relief for only an estimated 8 percent of drug expenditures of the elderly, and such relief

[21] P. 33, Working Paper cited in footnote 4, HEW Task Force on Prescription Drugs, final report, Feb. 7, 1969.

benefits only those elderly individuals who receive enough income to have income tax payments.

After surveying such data and studying the patterns of drug use among the elderly—for "therapeutic," "diagnostic," or "maintenance" purposes—the HEW Task Force concluded that the disproportionately high expenditures among the elderly, combined with a widespread inability to pay for such drugs "may well be reflected in needless sickness and disability, unemployability, and *costly hospitalization which could have been prevented by adequate out-of-hospital treatment.*" [Emphasis added.][22]

Furthermore, declared the Task Force, the problem is destined to become increasingly serious as unit prices of prescriptions increase, and the armamentarium of useful drugs expands.

Testimony from a Baltimore hospital administrator [23] provided vivid insights into the meaning of the Task Force findings, and showed that many elders suffer because the Medicare and Medicaid programs do not "mesh":

> Just this week in my office I saw two patients who typify the kind of problems older persons have in meeting drug costs. One patient is a 62-year-old secretary, an anxious depressed person with smoker's emphysema. She has been on necessary drugs and I have been following her for 3 years, and for 10 years she has had an immense drug bill. "Last year I spent $235," she spontaneously told me.
>
> I said, "What will you do when you retire?" and she answered, "I don't know what I'm going to do." She has a marginal income at best. She must work and she should work for emotional reasons. But when she finally retires, $235 a year for drugs, paid out of Social Security benefits and savings will be a major problem.
>
> The other patient is a hard working butcher who just reached 65, and retired. He has asthma, emphysema, and recurrent respiratory illnesses. This year while under my care he spent $250 for drugs—also necessary drugs, I want to assure you.
>
> Medicaid in some States pays for drugs but many needy aged persons have incomes above the State Medicaid levels and with the restrictive Social Security Amendments of 1967 many, many millions of aged persons are being denied the opportunity to become eligible for Medicaid. In addition many aged persons refuse to go through what is for them a demeaning means test required for Medicaid.
>
> Maryland has a $1,800 limit for eligibility for a single person for Medicaid. If the income per year is $1,900, one is not eligible; $150 a month is the maximum income allowed. Anything above that makes one ineligible for Medicaid.[24]

THE DUNLOP REPORT

Health, Education, and Welfare Secretary Robert H. Finch named a 14-member committee on March 24 to review the findings of the

[22] P. 33, Working Paper cited in footnote 4.
[23] Frank F. Furstenberg, M.D., associate director for program development, Sinai Hospital, p. 597 of hearings cited in footnote 2.
[24] P. 599, hearing cited in footnote 2.

earlier task force on prescription drugs. The review committee, in a report[25] issued in July, said it was complying with the Secretary's request that he "receive the judgment of groups outside Government who are directly and vitally concerned with the place of prescription drugs in health care—the medical and pharmacy professions, industry, economics and the consumers of health services, that is the American people."

While agreeing with only one dissent, that the Secretary should "recommend an administration decision for an out-of-hospital drug insurance program under Medicare," the review committee concurred with the earlier task force conclusion that considerable time would be required to develop all the necessary administrative mechanisms.

The Review Committee added:

> A decision to proceed with more detailed administrative planning and legislative proposals is necessary if a program is to be operative *in 2 years or so.* [Emphasis added.] [26]

Seeing a need, too, for "further work in this area [cost controls] with more precise cost estimates as legislative proposals and regulations are developed," the Review Committee warned that "lack of effective cost constraints may well jeopardize legislative approval of any out-of-hospital prescription drug program.[27]

> **More than 3 years have passed since establishment of an HEW task force on prescription drugs under Medicare. To date, the new administration has not offered legislation to carry out recommendations of the task force or its own review committee. It is urgent, however, that legislation be introduced at the earliest possible date for thorough evaluation before appropriate congressional units. This legislation should provide, as the Committee on Aging Advisory Committee recommended, for extension of Medicare benefits to cover those drugs that are important for treatment of chronic diseases that commonly affect the elderly.**

The "Assignment" Problem.—The advisory committee to the Senate Committee on Aging reported that only about half of the physicians caring for medicare patients accept assignment of the benefits. "Assignment of benefit" means that the aged person has instructed the Medicare fiscal intermediary to pay his doctor directly. But first, the doctor must bind himself not to send an additional bill directly to the patient. Instead, he collects 20 percent of the bill from the beneficiary and 80 percent from the trust fund by way of the fiscal intermediary.

Five major disadvantages, said the advisory committee, arise when a physician refuses to accept assignment:

1. The aged person must pay the doctor's charges, whatever their level, without such deterrents as are imposed by having the fiscal intermediary screen for reasonableness and relationship to other doctors' charges;

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[25] Report of Secretary's Review Committee of the task force on Prescription Drugs, July 23, 1969. The chairman is John T. Dunlop, a David A. Wells Professor of Political Economy, Harvard University.
[26] P. 5, report cited in footnote 25.
[27] P. 6, report cited in footnote 25.

2. The aged must themselves complete forms, submit claims, pay the bill, et cetera;
3. The higher charges soon become the accepted level of charges and are subsequently paid by the fiscal intermediary;
4. The dollar cost of the coinsurance of 20 percent mounts; and
5. Workers pay more Social Security taxes as demands on the trust fund rise.

As an example of "how a comparison of a surgeon's bill can work with and without assignment," the advisory committee offered the following:

CATARACT OPERATION WITH OPHTHALMOLOGIST'S BILL AMOUNTING TO $700

WITH ASSIGNMENT

Fiscal intermediary finds $700 exceeds usual and customary by $150:	
Intermediary pays 80% of $550	$440
Patient pays 20% of $550	110
Total paid	550

WITHOUT ASSIGNMENT

Doctor sends bill to patient who pays $700 to doctor and sends bill to fiscal intermediary:	
Intermediary pays patient	$440
Patient has to pay balance	260
Total paid	700

The committee also commented:

> Prior to Medicare, physicians often showed an understanding of their patients' economic circumstances and did not raise the fees they had been charging old patients for years on end. With Medicare, fees have been "adjusted" upward so that it is not too unusual to have the aged family spending as much out of pocket as before the program began, or even more, especially if the $48 in part B premiums is counted among their expenses, as it should be.[28]

Mrs. Agnes Brewster, consultant on medical economics and a member of the Advisory Committee, later testified: [29]

> The committee * * * considers that Medicare has established itself in the daily lives of millions of Americans; physicians should no longer be permitted to refuse to recognize it by not taking assignment of benefits.[30]

"Nonassignment" is causing serious problems for many Medicare patients. Those physicians who *do* accept assignment, moreover, may decide in increasing numbers that they should discontinue the practice to ease their own work pressures. Serious consideration should be given to

[28] P. 16. Working Paper cited in footnote 4.
[29] P. 492 of hearings cited in footnote 2.
[30] For a summary of other HIBAC recommendations, see appendix 4, item 3, p. 339.

legislation or other steps which will provide incentives for physicians to take assignment.

Other Non-Covered Needs.—Medicare does not now cover dental, food and eye care, eyeglasses, hearing aids and most types of medical appliances. In addition, there are limitations on the length of stay in a hospital or nursing homes and the number of home health visits which are paid for.

"These [including prescription drugs] are the principal limitations which require the elderly even under Medicare to meet more than half of their health care costs," said Advisory Committee member Bert Seidman.[31]

Dental needs, in particular, received Advisory Committee attention. Among the reasons for concern are National Health Survey data [32] which show that over half of the 65+ group have not seen dentists in more than 5 years, and that even in high- or middle-income groups the average number of visits to the dentist is no higher than among those with less adequate income. Among those 65 and over, between 50 and 60 percent have lost all their teeth; the proportion increases as age advances. The Advisory Committee declared:

> * * * we give too little heed to what may be a growing demand for dental services for individuals in the upper age groups * * * This demand could be a natural component of the current insistence on high-quality medical care for all, and it is a health demand which should be met.
>
> Such prepayment of dental care as there is, holds little promise for those whose teeth have been neglected over the years.[33]

Dr. John Knowles, director of Massachusetts General Hospital, spoke of difficulties in providing insurance coverage for dental care:

> I don't think really that you can cover dentistry at this point in this country. The shortage of dentists is absolutely prohibitive and it is all that any of us can do to get an appointment to see the dentist. We have to take more long-range steps to supply dentists and dental assistants before we can prime the pump, raise expectations on the part of 20 million people who need more dental care than anyone else in this room.
>
> Let me say right off the bat that most people by the time they reach 70 or 80 have false teeth or they ought to. If their dental condition is poor, many are eating baby food and are not well nourished. The medical field has neglected the subject of nutrition.[34]

Home Health Coverage.—Medicare provides for some home health care coverage, but—as pointed out by Advisory Committee members—

[31] P. 494, hearing cited in footnote 2.
[32] Series 10, No. 29.
[33] P. 34, Working Paper cited in footnote 4.
[34] P. 581 of hearings cited in footnote 2.

such service is scattered and uneven.[35] The Health Insurance Benefits Advisory Council, in an annual report issued in June, pointed out that home health care is far less expensive than hospitalization and, in most cases, far more beneficial to the patient. HIBAC recommended enactment of legislation which would:

—Place all home health benefits under part A, with a maximum eligibility of 200 visits per year;
—Remove the 3-day hospital stay requirement for home health benefits; and
—Provide for coinsurance for the second 100 visits per year.

The HIBAC recommendations on home health services would reduce costs to the Medicare program and to individual older Americans. Utilization review mechanisms for home health agencies should be developed, and the Social Security Administration should take additional steps to provide models for the development of home health services as major resources in communitywide health service systems.

Geographic Variations in Utilization.—Per enrollee Medicare benefits vary widely by State, from $66 in Mississippi to $191 in Nevada for part A and from $23 in Alabama to $72 in California for part B. The advisory committee commented:

> Differences of this magnitude cannot be explained solely in terms of charges per unit of service. Because of higher charges, more people in California meet the deductible, and thus a greater proportion of their cost is covered by Medicare than in the Southern States.[36]

C. How Medicaid Deficiencies Affect the Elderly

Medicaid—a program enacted in 1965 to provide medical assistance for those Americans in need—continued to grow in 1969. Three States began Medicaid programs, bringing the total to 41 States and four jurisdictions in which reside 83 percent of the population over 65.[37] For the fiscal year, Federal expenditures under Medicaid totaled more than $2.2 billion.

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[35] On January 24, 1970, Senator Harrison A. Williams introduced a bill in the U.S. Senate, to amend title XVIII of the Social Security Act to authorize payment under the program of health insurance for the aged for services furnished an individual by a household aide as part of a home health service plan (S. 3333). In his introductory statement, the Senator commented:

"Institutional care continues to be a costly expenditure under Medicare. This expenditure could be reduced significantly if appropriate alternatives were available for the care of older persons. For instance, many elderly nursing home residents are unnecessarily institutionalized because there is no alternative method of care for them. Many could be returned to their homes if supportive services were covered under Medicare. Moreover, many hospital patients could be released much earlier if these services were available. Coverage of these services under Medicare would be beneficial for both the patient and the Nation. For the individual living at home, rather than being institutionalized, may be of important therapeutic value in improving his emotional well-being. Society would also benefit in being able to meet the needs of the elderly more efficiently and economically."

His bill is almost identical to H.R. 1029, introduced by Representative Jacob Gilbert (D-N.Y.).

[36] P. 17. Working Paper cited in footnote 4 (For Sate-by-State satistics on Medicare benefit payment variations, see table 3, report by the Social Security Administration, appendix 1, p. 303.

[37] Until Dec. 31, 1969, federally supported medical assistance for the aged was provided through Medicaid (title XIX, medical assistance for the aged) Kerr-Mills and medical vendor payments paid out of public assistance grants. But after that date, Medicaid superseded the two other programs. For a report on the Medicaid program from the Social and Rehabilitation Service, HEW, see appendix 1, p. 290.

Medicaid came under increasing fire during 1969 because of rising costs, complaints about "cheating" or waste of funds caused by administrative problems, and lack of clear goals.[38]

Proposed cost controls for Medicaid are discussed later in this chapter, but the program can also be analyzed in terms of its effect upon individual elderly persons who try to make use of the assistance it was meant to provide.

To the Advisory Committee members, the Medicaid program is riddled with contradictory policies in its implementation, and very uneven in the protection it provides.

In addition, uncertainty about the future of the program is causing widespread cutbacks, much to the detriment of those the program is supposed to serve. Said the report:

> Prescribed drugs and home health services are made available in 36 States, with 23 of the 36 paying for them for both categories of needy. Thus over half the States do nothing to help the low-income aged with drugs. Lesser numbers of States furnish dental services, appliances, and types of treatment not included as physicians' services. The medically needy aged citizen living in California or Connecticut, Minnesota, New York, or North Dakota is eligible for 19 or 20 kinds of services while his counterpart in Alabama or Tennessee, Alaska, or Indiana has not been eligible for any title 19 services.
>
> * * * * *
>
> The lack of coverage of many needed services that poor, ill people should have and the fragmentation in the delivery of the services that are provided are both disturbing. All too often, when a question of funding comes up, cuts are made in Medicaid at the expense of the clients, not the providers.[39]

United Auto Workers Social Security Department Director, Melvin A. Glasser, a member of the advisory committee, made an additional critique at the hearing:

1. Medicaid is achieving only a small part of its promise and its potential. Early HEW estimates foresaw "comprehensive high quality medical care for as many as 35 million medically needy people."

   Three and a half years later, only 10.8 million persons had been declared eligible for services.

2. In both range of services and categories of persons served, there is the widest possible variation.

3. "The basic problem derives from the fact that Medicaid is neither a health care nor a medical care program; it is a payments program for a limited number of medical services."

4. Primarily because of the cost situation, *medical care available to the medically indigent is becoming progressively poorer instead of better.*

Mr. Glasser gave this explanation:

> Most cost savings are being made at the expense of the needy through cutting benefits and eliminating classes of

[38] For a summary of the recommendations by an HEW Task Force on Medicaid and Related Problems (November 1969), see appendix 1, p. 312.

[39] P. 17, Working Paper cited in footnote 4.

eligibility or through requiring sharing of payments. These widely practiced approaches of the States overlook the main source of escalation, which is the cost of providing the services. Two factors are at work: (1) The charges of nursing homes, hospitals and physicians; and (2) an alarming increase in utilization, much of it questionable justification.

There seems to be little doubt that a not insignificant number of physicians are taking grossly unfair advantage of the program, and we have had many illustrations. Let me cite from the July 11, 1969, issue of the Detroit News. One Michigan physician received $169,000 in one year in Medicaid payments alone. By his own statement this represented about one-half of his work. By a rough calculation this physician apparently devoted an average of 160 seconds to each of his Medicaid patients as he delivered the high quality of medical care which is the objective of this program. 160 seconds.

Cost savings measures such as those adopted by New York State through a coinsurance program and by other States through barring the medically indigent who are not receiving public welfare grants have the self-defeating purpose not only of denying needed care but of driving large numbers of persons and families into indigency as they struggle to meet unavoidable health care bills.[40]

Similar appraisals were made by other witnesses. One, a physician who serves on a Federal advisory committee for Medicaid, described [41] the program as "an administrative montrosity" which seemed to him "analagous to a fairy castle containing 50 rooms (50 States) and three closets (Puerto Rico, Guam, and the Virgin Islands)." He added:

Up to the present time, less than 90 people have been assigned to this Federal administrative staff for title XIX. Is there any wonder that the "Corporal's Guard" could not prevent the gold being stolen from the walls, sills, and underpinnings.[42]

The Medicaid means test came under fire from Dr. John Knowles as very costly, highly inefficient, inhuman, and undignified.

Asked by Health Subcommittee Chairman, Edmund Muskie, why he regarded the means test as costly, Dr. Knowles said that in Massachusetts

"*it costs between $200 and $300 * * * to find out whether a person qualifies for welfare or not.* In this country, we constantly set out to catch the occasional chiseler. Most people in this country are not chiselers. To have somebody come into our house, look under the bed, look in the closet for the television set, see if you can find the old man's pants out in the garage and so on, is inhuman, undignified, and an insult to the human condition. [Emphasis added.][43]

[40] Pp. 496–497, hearing cited in footnote 2.

[41] Amos Johnson, M.D., of Garland, N.C., is a member of the Medical Assistance Advisory Committee mandated by the Congress to consult with the Secretary of HEW regarding the administration of Medicaid. (His testimony appears on pp. 637–645, hearings cited in footnote 2.)

[42] P. 643, hearing cited in footnote 2.

[43] P. 583 of hearings cited in footnote 2.

Like the other witnesses, Dr. Knowles said that cutbacks in Medicaid services will not reform the program. He asked for positive actions instead:

> The program must be improved. You can also save money in certain areas. However, if you improve this program you are going to ultimately have to spend more money without any question. Only the acute part of the Medicaid program has been implemented, that is, that portion devoted to acute diagnosis and therapy while the other desirable parts of the legislation which cover prevention have been largely neglected. The difference, as I said before, between State reimbursement nursing home care and Federal reimbursement favors Medicare over the Medicaid patient and this leads to decisions which do not favor the best interests of the patient.
>
> When a Medicare patient runs out of his benefits and his facility he may be sent back to our hospital, he may be sent somewhere else or he may be transferred to another and less adequate nursing home facility. This gets expensive. It is inhuman and not in the best interest of the patient or the doctor. These financial considerations should not be the prime determinant of whether you and I are able to obtain health care, and without health there is little enjoyment in life.
>
> In summary, the Medicaid program must establish quality controls and standards at least to the level of Medicare and beyond. Secondly, it must be turned over to State public health departments in terms of medical care and public health programs.
>
> Third, I believe it must have trust fund financing and be separate from general tax revenues.[44]

Mr. Glasser, too, had recommendations:

> The team approach of physicians and ancillary personnel working together to provide comprehensive health services has been urged by numerous major groups which have studied the problem. This approach is of particular importance to the elderly * * * Such care, in the judgment of the committee, can and should be arranged for under present Medicaid programs.
>
> More effective controls should be instituted on charges of hospitals, nursing homes, and physicans.
>
> Vigorous efforts can and should be undertaken for more effective utilization review not only in hospitals and nursing homes but in physicians' offices.[45]

While such action would improve the Medicaid program, Mr. Glasser said that even these changes:

> represent palliative treatment of symptoms that the Medicaid program should be phased out, and that the basic answer will have to come through a universal health insurance system which will make possible the reorganization of the methods of delivering health services and elimination of a separate,

[44] Pp. 583–84, hearing cited in footnote 2.
[45] P. 497, hearing cited in footnote 2.

demeaning, inferior system of fragmented health services for those of the poor who fit into the constantly changing categories of State programs.[46]

Recognizing that older Americans are especially hard-hit by deficiencies in the Medicaid program[47]—and yet fully aware of the alarming rise in costs of this program, the Senate Special Committee on Aging believes that thoroughgoing reform, rather than sporadic and highly damaging cutbacks, is required. Evaluations now under way[48]—together with pledges by the present administration to implement reforms—hold out the hope that such action will be undertaken.

D. The Elderly as Victims of a "Nonsystem"

Again and again, witnesses at hearings before the Senate Committee on Aging and other congressional units[49] have said that the health industry in the United States is a "nonsystem" in which Government programs and private resources contradict each other's purposes, in which heavy investments are made in facilities and apparatus which may be redundant, and in which the person in need of medical help may find himself the victim of severe deficiencies and contradictions in the delivery mechanisms for medical care.

Even with Medicaid and Medicare, the older persons stands to suffer the most in inconvenience and even despair when the "nonsystem" takes its toll.

The nature and causes of that toll were cogently put into perspective at the hearing by Simon Axelrod, M.D., director of the Bureau of Public Health Economics at Michigan University (and a member of the "Health Aspects" Advisory Committee):[50]

—First, "high and rising costs of medical care are an inevitable accompaniment of our increased technology," and therefore add to the heavy economic burden of the elderly and others. Dr. Axelrod added, however, "* * * simply putting in more money into our medical care system as it is currently constituted does not guarantee increased effectiveness nor increased productivity."

—The second major problem has to do with shortages of all kinds of health manpower, and these shortages are accentuated again by the increased technological base in the delivery of medical care:

> It takes more kinds of people with more skills to deliver modern medical care and we are very far from having an adequate supply of physicians and all kinds of health workers.

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[46] P. 497, hearing cited in footnote 2.

[47] "Medicaid, Selected Statistics, 1951–1969" NCSS Report B–6 reports that a monthly average of almost 2.2 million individuals aged 65 and over received medical assistance in the form of either a direct payment to medical vendors or a per capita payment to an insurance system, principally OASDHI. About 42 percent of the total expenditure for medical assistance under the three federally aided assistance programs in existence during fiscal year 1969 was sent on the aged. See SRS Report. Appendix 1, p. 290, for details.

[48] See Appendix 4, Item 2, for summary of "McNerney Report" recommendations on Medicaid.

[49] The Subcommittee on Executive Reorganization, Senate Committee on Government Operations, was scheduled to issue a report in mid-1970 based on its 1968 hearings, "Health Care in America."

[50] Pp. 498–9, hearing cited in footnote 2.

—Variations in the quality of care were seen as a third major factor:

> While the quality of medical care in the United States is generally satisfactory, all of us recognize there are some important deficiencies and we are just beginning to bring some of these to light, particularly outside the hospital.

—Fourth, "* * * Health services are not continuously available to people. It is difficult to get a physician to give care at nights and on weekends. In increasing fashion the emergency rooms of hospitals are being used in place of the family physician, and there is some question about the adequacy of the staffing of the emergency rooms in our larger hospitals:

> Health services are not available to people in the ghetto. There has been a migration of physicians out of the ghetto. Health services are not readily available to people in rural areas where there are great shortages. * * * In addition, we know there is inappropriate use of personnel and facilities.

Dr. Axelrod said that special needs of the elderly—resulting in more long term illness, for example—accentuate the more generalized problems he described.

Much the same conclusion was reached by Administration on Aging Commissioner John B. Martin:[51]

> The administration is also concerned about another set of problems which plague the older American who needs medical care; the problems produced by the complex and sometimes confusing system by which he purchases and consumes his health services.
>
> Complex drugs purchased in combinations that may be not only ineffective but harmful; brand name drugs sold at widely varying prices despite identical wholesale costs; patent medicines sold because of exaggerated claims of relief from pain and the debility of age; worthless potions and devices designed to exploit the fear of illness and death; loophole-ridden health insurance plans sold to supplement Medicare—these are examples of the medical maze our system has produced.

Long Term Care Problems.—Chapter V of this report provides a detailed examination of developments in long term care during 1969, but several statements made at the hearing relate directly to health care organizational deficiencies in this area of medical care.

Dr. James Haughton, First Deputy Administrator of the New York City Health Services Administration, said:

> Institutional care for the aging has been and continues to be under both titles XVIII and XIX, a major element of expenditure. Much of this expenditure is inappropriate and related to our serious lack of appropriate social alternatives for the care of the aging. *It is estimated that at least 10 percent of the nursing home residents in New York City are unnecessarily institutionalized for this reason.* Many of them could

[51] P. 504, hearing cited in footnote 2.

be discharged to their homes, and many hospital stays could be reduced by days and sometimes weeks if homemaker services could be provided.

Although it is true that homemakers are not always available, even when they are, neither Medicare, Medicaid, nor voluntary or private insurance will pay for their services. As a result, *aging persons remain expensively institutionalized in nursing homes and hospitals at public expense.*[52] [Emphasis added.]

Dr. Knowles reported on the consequences of Medicare policy and nursing home shortages to Massachusetts General Hospital:

The Medicare Act continues to drive people into higher cost hospitals without any question. For example, to qualify for extended care you have got to come to the high cost hospital for an acute episode of illness before you can go to extended care facility and stay there for the 30 or 90 days as a result of your hospitalization. You cannot obtain the benefits of extended care unless hospitalized first.

Now that is not intelligent use of tax money. It would be much easier to allow patients—nursing home care is not covered adequately at the present time by Medicare but must be in due course—to go direct to these extended care facilities from home rather than come by the acute care hospital. It is very hard to be admitted to a hospital for just 3 days anyway and if the stay was this short, we should seriously question whether extended care was needed. On top of all this, because of a general lack of adequate extended care facilities, there may be long delays in discharging the now admitted patients to the appropriate facilities. For example, 10 days at $100 a day is $1,000 per patient that could be saved were they to go directly to the extended care facility where it might be $20 a day for the same 10 days, or $200. This is a very large issue.

At the Massachusetts General Hospital in the month of June 1969, we had an extra $60,000 of "day delays" to get into extended care facilities. *This is as much as a half million dollars a year that could have been saved the taxpayers if we could have gone direct to nursing homes.*[53] [Emphasis added.]

THE NEED: ALTERNATIVES TO HOSPITALIZATION

As the advisory committee and witnesses made clear, less costly alternatives to hospitalization should be major components in any strategy to reduce overall health costs. And yet, a recent Social Security Administration survey [54] provided this list of barriers to full implementation of this strategy:

1. In many communities the less costly alternatives to inpatient hospital care, such as hospital and other outpatient services, home health services, extended-care facilities, and nursing homes are often in short supply.

2. In some communities, there is often an excess in supply—resulting in wasteful duplication of certain services and facilities,

[52] P. 609, hearing cited in footnote 2.
[53] Pp. 581–2, hearing cited in footnote 2.
[54] "Annual Report on Medicare", pp. 16 and 43.

including some very expensive hospital services that involve heavy stand-by costs. Health facility planning is not now performed adequately.

3. Services, especially costly hospital services, are sometimes utilized unnecessarily; i.e., they are not medically necessary.

4. Many private health insurance plans produce undesirable incentives to use the most expensive methods of care.

5. Many possible hospital management improvements have not been adopted.

6. The growth of group practice has been retarded by legal bars and restrictive attitudes.

7. Productivity in the provision of medical care has not been defined and measured.

8. Insufficient attention is given to financing preventive care and health education.

9. There are insufficient financial incentives to restrain mounting hospital costs while maintaining high-quality medical care.

The Senate Committee on Aging renews its recommendation that the Medicare requirement of three days of hospitalization before extended care can begin be reexamined, along with other barriers to full utilization of alternatives to costly hospital care. Incentives to expansion and utilization of prepaid group health practice should also be implemented.[55]

II. WORKING TOWARD "ACCOUNTABILITY"

Many of the problems discussed thus far in this chapter—conflicts or omissions in Federal policy, and antiquated (and expensive) organizational oddities, and shortages of personnel where they are needed most—can be related to the conclusion reached by Dr. Axelrod at the hearing:[56]

> I would say that our American medical care system is characterized by the fact that there is no identifiable point of public accountability. To whom can the older patient or indeed any patient go and say, "I don't like what's going on; who is going to do something about it?"

The older person is not the only person who asks for accountability. The Federal Government, with annual expenditures of $10 billion in Medicare and Medicaid, also has the responsibility to ask:

Are we getting full value for public money?

Fortunately, that question is being asked with increasing frequency. But it was the hope of the "Health Aspects" advisory committee—and it is the hope of the Committee on Aging—that reevaluation will not be expressed solely in terms of cutbacks or shortsighted, temporary, and possibly deleterious readjustments within the health industry.

[55] For additional discussion of health maintenance and incentives for prepaid group health care, see pp. 28–29 "Developments in Aging—1968".
[56] P. 499 of hearings cited in footnote 2.

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Instead, Federal officials, the Congress, and the public should insist that cost-cutting be accompanied by reforms which improve medical care while it makes such care more available.

A. Critiques From Congress and HIBAC

Major criticisms against the Medicare and Medicaid programs were expressed during 1969 by members of the Senate Finance Committee and by witnesses who appeared at hearings [57] by that committee.

Among those criticisms:

—Costs of Medicare and Medicaid are far above original estimates, partially because of rising costs in general, but also because certain ambiguities or omissions in legislation and administration cause overutilization of expensive facilities or practitioners' services.

—Some physicians, including supervisory physicians in teaching hospitals, are receiving excessively large yearly incomes for services.

—Many nursing home costs were excessive, and some services charged for were not provided (see chapter V of this report for additional details).

—Laxity in administration of both programs was adding needlessly to total costs.[58]

HEW Response.—John A Veneman, Under Secretary for HEW, told the Finance Committee on July 1 that Secretary Robert Finch had taken four new initiatives: [59]

> 1. The Secretary has directed the Commissioner of Social Security, on the basis of experience with Medicare, to provide assistance to the Social and Rehabilitation Service in the monitoring of intermediary services and the provision of technical assistance to the States in effective use of intermediaries under Medicaid. Twenty-seven States, out of 44, use fiscal intermediaries for at least some part of their program. Thus, Social Security Administration expertise in this area is a resource which can make a contribution. Furthermore, more specific efforts are being made to assure closer coordination in States where both use the same intermediary.
>
> 2. Secretary Finch has directed changes in regulations to eliminate the allowance to providers—2 percent to nonprofit and 1½ percent to profit institutions—for unidentified costs. A flat percentage allowance that increases as all other costs rise may, in effect, reward an institution for increasing its cost. This administrative change will apply to the Medicaid program, as well as to the Medicare program, since both programs pay hospitals on the basis of reasonable cost. We are working with the American Hospital Association and other representatives of providers to reexamine our entire reimbursement process to be sure that, with this change, and others

[57] "Medicare and Medicaid," hearings before the U.S. Senate Committee on Finance, July 1 and 2, 1969.

[58] "Medicare and Medicaid, Problems, Issues and Alternatives", a report of the staff to the Committee on Finance (February 9, 1970), gives a detailed description of the criticisms, together with recommendations for change. A summary of major findings and proposals appears in Appendix 5, item 1, p. 342, along with a response from HEW.

[59] Pp. 56–57 of hearings cited in footnote 57.

we expect to make, reimbursement that will be fair to all concerned.

3. The Secretary has published a new regulation to control escalating costs of payments made to physicians, dentists, and other medical practitioners who serve Medicaid patients. This regulation holds a State to the level of fees allowed under the payment structure it used on January 1, 1969, unless those payments represented a prevailing level at less than the 75th percentile of customary charges. States may increase the level with the approval of the Secretary but not to exceed the 75th percentile. In seeking ways to reduce the cost of program expenditures for physicians' services under Medicaid, we considered limiting payments to the amounts established under Blue Shield fee schedules in the various States.

Upon analysis by a special task force we found that most Blue Shield plans cover primarily surgery and in-hospital medical services. On the contrary, most Medicaid plans cover physicians' home and office visits, dental services, eye care, etc. So even if a Blue Shield schedule were utilized, it would still be necessary to develop another system of payment for a significant part of the total services covered by Medicaid.

Many Blue Shield plans make payments to physicians on the basis of their customary and prevailing charges. Most of the plans now offered to large group contractors include a provision for reimbursement on the basis of usual and customary charges. Where this is done, the payments tend to be higher than those authorized under Medicaid. In view of the increasing trend among the plans toward paying on the basis of customary and prevailing charges, tying Medicaid payments to Blue Shield plans could well result in increased Medicaid costs.

An important consideration of any Medicaid proposal to control rising costs is the participation of a substantial proportion of practicing physicians. We believe that our decision to limit physician reimbursement under Medicaid to a level that will cover charges made at the 75th percentile in a locality for a given service will generally serve to make medical services available to Medicaid participants and at the same time assure an appropriate limitation on program expenditures.

4. Secretary Finch has also announced the formation of a Medicaid task force, chaired by Walter J. McNerney,[60] to investigate rising costs, fraud, inferior management, and other problems in the system.

These actions, or promises of action, did not, however, satisfy those who believe that more far-reaching reforms were needed.

Walter P. Reuther, president of the United Automobile Workers, had said in a statement to the Committee on Aging that he was disappointed in high-level appraisals of health needs made by the present administration: [61]

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[60] See appendix 4, item 2, p. 338 for summary of McNerney Report, issued November 1969.
[61] P. 669 of hearings cited in footnote 2.

> It is a source of deep disappointment that nowhere in the White House report on health care needs is a reference made to safeguarding and improving the quality of the care made available through public and private programs. It is possible from reading the report to envisage that we shall know "the cost of everything and the value of nothing". We do not know of any other sector of government programs where huge payments are made to purchase materials or services without quality controls. Neither government nor industry can afford not to have such controls. The government quite properly stipulates with precise detail the kind of equipment required for the automobiles it purchases, and for the tanks and the planes—but not for health services so vitally required by the people. There is indignation expressed when physicians receive hundreds of thousands of dollars annually in public funds for treating patients, but there is no outcry about the lack of quality care provided by physicians who may see patients an average of 2 minutes and 40 seconds each.

He had also said:

> We do not agree that the "revolutionary" changes which the Administration calls for can be effected through tightening up Federal administrative procedures in Medicare and Medicaid, pleading with physicians and hospital directors to become far more cost conscious than they are at present and exhorting the private health insurance industry to do a better job than they are now doing. Solutions to the problems will be found through courageous facing of the issues of: financing, coverage and benefits, delivery system and quality controls.[62]

The HIBAC Appraisal.—The Health Insurance Benefits Advisory Council [63] warned in its annual report, "There are limits to the time during which medical cost can continue to rise as rapidly as in recent years without creating serious issues of the priority of allocation of further resources to medical care rather than to housing in the inner city, to education, or to the multitude of other demands not now fully satisfied. The ways that Medicare sets the amount it will pay for covered services may have very important effects on the entire health care industry."

Major cost-cutting recomendations by HIBAC members may be found in appendix 4, item 3, p. 339. One recommendation, however, will receive special attention here:

> The Council recommends that legislation be enacted authorizing the Secretary to negotiate capitation reimbursement payments to group practice prepayment plans.

This concept was later advanced in 1970 by HEW Secretary Finch in what could become a major improvement in the Medicare program.[64]

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[62] P. 667 of hearings cited in footnote 2.

[63] P. 27, HIBAC report, July 1, 1966–Dec. 31, 1967.

[64] In April 1970, Secretary Finch proposed that Medicare be broadened to provide persons past age 65 with preventive health care and other types of comprehensive care available through prepaid group health insurance programs. This kind of coverage, of course, would be available only in the relatively few metropolitan areas where prepaid group health programs are available.

CONCLUSIONS

The Advisory Committee on Health Aspects of the Economics of Aging emphatically expressed the belief that a comprehensive, compulsory health insurance program for all age groups—a program with built-in cost controls, standards for quality care, incentives for prepaid group practice, and other badly needed reforms—"offers the best hope that this Nation has for living up to the oft expressed declaration that good health care is the right of every man, woman, and child who lives in this land."

But, before such a program can be established, "public and private efforts should immediately be made to deal with demonstrated deficiencies in Medicare."

These reasons were given:

1. Health-care problems of the elderly are still widespread, and they remain urgent.
2. Three years of experience under Medicare have provided invaluable lessons in the operation of a major public health insurance program. The time has come to heed those lessons.
3. Current investigations into profiteering under Medicaid and Medicare have helped focus attention upon the need for cost controls and establishment of uniform standards of care. Such reforms can have a beneficial effect upon the entire health industry and can combat medical cost inflation.
4. Success in improving Medicare will lead to more general acceptance of steps necessary to provide higher quality health care to our entire population.
5. The lack of sufficient consumer representation in Medicare and its almost total absence from State advisory committees for Medicaid is deplorable.

National discussion about the need for a national health insurance program can serve a vital function if it turns public, professional, and governmental attention to actions that must be taken to remedy deficiencies which have become more apparent as more and more Federal funds have been committed to health care.

The people of this Nation now have an opportunity to transform public concern into positive action and reform. Corrective action should begin with Medicare and Medicaid, and it should aim at long-range improvement, rather than hasty retrenchment.

III. REORGANIZATION: A CAUSE FOR CONCERN

The past year saw the creation of a new institute and an expansion in the activities of another within the National Institutes of Health. Both moves are important to the health of the elderly. At the same time, however, a reorganization within the Public Health Service could result in a reduced visibility for serious health problems facing older Americans.

1. A National Institute of Environmental Health Sciences was created within NIH, thereby eliminating the Division of Environmental Health Sciences. Through the establishment of a

separate institute, greater emphasis will be placed upon the serious problems of environmental assaults which face the Nation, such as air and water pollution.

2. The National Heart Institute became the National Heart and Lung Institute in November, expanding the duties of the original Institute to include research into the causes, prevention and methods of diagnosis and treatment of diseases of the lungs as well as the heart and circulation.

3. The Public Health Service Division of Chronic Disease—an area of vital concern to the elderly—is to be eliminated from the Regional Medical Programs Service Division of that agency, as of June 30, 1970. At that time, five valuable research investigations—Heart Disease and Stroke, Cancer Control, Neurological and Sensory Disease Control, Arthritis and Metabolic Diseases and Chronic Respiratory Diseases—are to be assimilated into three new divisions, which may be established on July 1, 1970.

The new divisions include: Clearing House for Nutrition, Clearing House for Smoking and Health, and Division of Kidney Disease Control. According to the Public Health Service, those programs not picked up by the new divisions will be handled by other divisions of the Regional Medical Program Services. In addition, the committee was informed, the National Institutes of Health will assume some of the responsibilities previously held by the Chronic Disease Division—within the National Cancer Institute, National Institute of Neurological Diseases and Stroke and the National Institute of Arthritis and Metabolic Disorders.

> **While the committee recognizes there may be a need for reorganization due to budgetary restrictions, it is concerned that such reorganization will be at the expense of research that is vital to the present and future health of aging Americans.**

A VACANCY IN THE COMMUNITY HEALTH SERVICE DIVISION

In 1968, the Senate Committee on Aging reported on the establishment of a new Community Health Service within the Public Health Service. At that time, Dr. John Cashman, Director of CHS, informed the committee that a position had been established for a Coordinator of Aging in the newly formed Division. The Coordinator would, in the words of Dr. Cashman: [65]

> * * * coordinate, stimulate and provide a focal point for diverse Public Health Service efforts and resources in health services for the aged * * *

One year later—there is still no Coordinator of Aging in the Community Health Service Division.

A recent letter from the Director of the Division of Health Care Services [66] gave this rationale for the delay:

> An internal community health service task force has been reviewing activities (including health of aging) in relation

[65] P. 33 in "Developments in Aging 1968."
[66] In a letter to Senator Harrison A. Williams, from Jerry A. Solon, Ph. D., Director, Division of Health Care Services, Public Health Service, Department of HEW, March 23, 1970.

> to organization of the several divisions in Community Health Service. Division of Health Resources programs are, in some ways, more directly related to the aged than those in Division of Health Care Services, since Division of Health Resources is concerned specifically with home health agencies and nursing homes which serve a high percentage of the aging population. Evidence at this point in time indicates that health of the aging activities, portions of which currently involve both Divisions, may more appropriately be focused within the Division of Health Resources.

In view of this information, it is hoped that a way can be found to fill the position of Coordinator of Aging—in either the Community Health Service Division or the Division of Health Resources. Considering recent developments—the need is great.*

*An appointment was made in April 1970.

CHAPTER III

NUTRITION AND THE ELDERLY

Major attention was directed to nutrition of the elderly during 1969 at a White House conference and by two Senate committees.

What emerged was an often startling portrait of the older American as a nutritional loser: victim of mingled problems caused by low income, living patterns, lack of mobility, loneliness, ailments, and—to an appalling degree—ignorance about food needs.

From the White House conference came recommendations that should receive widespread attention. From the committee hearings came clear indications that additional congressional attention is warranted.

I. PROBLEMS THAT DEEPEN EACH OTHER

> These 20 million Americans form the most uniformly malnourished segment of our population.

The words are from Senator George McGovern's opening statement at a hearing by his Select Committee on Nutrition and Human Needs.[1]

And the 20 million Americans to whom he refers are those of age 65 and over.

Senator McGovern identified poverty as a major cause of nutritional problems among the elderly.

The first witness, Senator Harrison A. Williams, told of the consequences, the "impossible choices" that had to be made every day even by many elderly who are not technically below official poverty levels:

> Shall they purchase prescription drugs or shall they buy food for the table?
>
> Shall they try to pay the tax bill on the home they have owned for decades, or shall they sell the home to have more money for food?
>
> But if they do sell the house, where can they move? What community in this Nation of ours has a good selection of apartments at reasonable rentals for the elderly?
>
> And for those who live alone, another question arises:
>
> How can I keep making meals for myself when I don't have the money—and why should I bother; there is no one left to prepare meals for or eat with me? [2]

[1] "Nutrition and the Aged," Washington, D.C., Sept. 9, 10, and 11, 1969, p. 5227. The McGovern hearings on the elderly were conducted with the cooperation of the Senate Special Committee on Aging at the suggestion of the special committee chairman, Senator Harrison A. Williams.

[2] In testimony at hearing cited in footnote 1, p. 5230.

Senator Williams, chairman of the Senate Special Committee on Aging, cited committee hearings and surveys showing that nutritional difficulties among the elderly are caused and deepened by other problems which take on both similarities and differences in the urban and rural regions in this land of widespread abundance.

A. The Elderly in Urban Centers

Poor nutrition among many elderly city dwellers is primarily attributable to a level of income that would be considered low by any standards.

Approximately 20 percent of the elderly residing in poverty neighborhoods in Washington, D.C., for instance have no income whatsoever. An additional 24 percent have incomes under $1,000 a year.

Mrs. Anne B. Turpeau, associate director of the Washington Urban League, provided examples of what it means for an elderly person to exist below minimum subsistence levels in this urban area: [3]

> Mrs. W. lives in a public housing unit for the eldery and pays $50 for rent. Her Social Security check is $52. Out of the remaining $2, she spends 25 cents to buy a money order to send in her rental payment. Her daughter gives her a contribution so that she can receive $18 worth of food stamps * * *
>
> * * * * *
>
> Mrs. H. is 75 years old. She receives $51 a month for Social Security. She refuses to apply for old-age assistance supplemental benefits because she has been told she must surrender her insurance policy. She pays $32.50 for a room in an apartment and shares one-half the cost of gas and electricity. What money is left over she uses to buy food. Her other needs, including supplemental food, are met by the person with whom she rooms.

Other factors: [4]

—Recent studies indicate that the elderly may be afraid to go into the street in central city metropolitan areas. In one such study: [5] Of a sample of 137 aged individuals, each had been mugged at least once. As a result shopping is infrequent.

—Public transportation is often too expensive for low-income elderly in urban centers and in suburban areas, it is often nonexistent or sporadic. Many older persons cannot carry heavy packages back to their homes and therefore, purchase less than is needed for a balanced diet. The elderly may prefer to shop in neighborhood markets (those which still exist) and small food stores tend to be more expensive than supermarkets. Thus, an already tight food budget is stretched even tighter. This "preference" may actually be a necessity when, as is often the case, the neighborhood market is the only one accessible.

—The changing face of urban America may present special problems to the elderly. It is not unusual to see neighborhood popula-

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[3] In testimony at hearing cited in footnote 1, p. 5235.
[4] In testimony at hearings cited in footnote 1.
[5] From testimony of Dr. Douglas Holmes, director of the Center for Community Research in New York at hearings cited in footnote 1.

tions change from year to year, and entire urban areas are often razed to make way for urban renewal. The elderly are therefore left with the prospect of shopping in unfamiliar neighborhoods.
—Large numbers of indigent older persons may be hidden from society. Many do not receive welfare benefits or any other form of social service because they may not know such benefits exist, or they may be fearful and ashamed to apply for benefits.

Recent research findings illustrate the depth of this problem:

> Among 452 participants in a nutrition project for the aged [located in New York City], social isolation has been a major problem in over 85 percent of the cases. This isolation often leads to inadequate nutrition—there is no one to cook for, to care for.
>
> An intensive door-to-door search for isolated aged, in an area already screened by agencies using more traditional recruitment methods, showed that there were about three "hidden" aged for every person who had become known to existing social/recreational agencies.[6]

B. The Rural Elderly

In rural America, remoteness is often a way of life. In such areas, food stores, health clinics and other social/recreational services may be located many miles from an individual's home.

One witness provided an eloquent example of what this can mean to an older person living alone:[7]

> Many of the participants in my program live off the main roads and up the hollows of their counties. For example, we have a participant who must walk one-and-one-half miles out of a hollow to the main road and then must hitchhike a ride 38 miles to the [nutrition] center.
>
> * * * * *
>
> The small rural stores that are within walking distance no longer exist and it is many miles to the nearest store which is often understocked and high in prices. In order to get from their homes to the county seat or the largest town within the county they have to hire someone to transport them or in some counties where taxis are available they have to pay on the average of $5 per trip. Since * * * income for our area is low, transportation is held at a minimum because of its high cost. Coupled with * * * transportation and isolation problems, perpetuated by the low income, is the lack of services available within the area.
>
> There is one hospital within the six-county area and the majority of doctors are within this town. Some of the counties have one or two doctors for the total population. There are many services available to the elderly that they are not aware of and could not utilize if they were made aware of them without some assistance. The lifetime habit of fending

[6] In testimony cited in footnote 4 at hearings cited in footnote 1, p. 5304.
[7] In testimony of Mrs. Regina Fannin, Project Director, Country Gathering Program, title IV Nutrition Demonstration Project for the Rural Elderly in Six Northeastern Kentucky Counties, at hearing cited in footnote 1, p. 5313–14.

for themselves is deeply ingrained in the culture of mountainous people.

Senator Frank Church described a possible solution to these problems—now being carried out in his predominantly rural State of Idaho:[8]

Almost 2 years ago, the Western Idaho Community Action Program, Inc., headquartered in Emmett, Idaho, began a food service program to the elderly which they called "Pot Luck Dinners" in which two hot meals a week were served at a central dining area. At first, it was simply a question of going out and finding the elderly persons in need of help and bringing them to the center for a meal. It was found that the participants seldom went anyplace, had few friends, and such low incomes that they bought little food or clothing. The change wrought by bringing these people together for two or three hot meals a week and showing them a little kindness and attention, has been most rewarding. For example, one of the first participants was an elderly widower, we'll call Mr. A., who was found digging roots to cook for his dinner. No one knows how long he had lived in his little shack alone but he was extremely undernourished. He drank no milk, ate no meat, and his diet seemed to consist of the roots and weeds he would dig up and cook, and what pitiful vegetables grew in his makeshift garden. At the first Pot Luck Dinner Mr. A. came dressed in rags and he obviously had not bathed in quite some time. He did not speak to the other participants, just ate his meal and waited to be taken home. The second week found Mr. A. cleaned up somewhat, and beginning to talk with his dinner companions. The other participants, 25 men and women, were in much the same condition as Mr. A. and had the same reactions. Within a month's time, the participants had begun to dress up for their dinners, chat and visit with their newfound friends and, now, just short of 2 years later, the group has had three weddings, plan social events and dances for themselves, and Mr. A. has become an active member of the senior citizen's board of the Western Idaho Community Action Program.

A few months ago, the program was fortunate enough to be awarded an Administration on Aging Title IV grant to expand their program, and there are now Pot Luck Dinner programs in four different counties in Western Idaho, and hot meals are served every day in the local community action centers. Senior Citizen volunteers have been recruited to act as the transportation committee, who supply the participants with round trips to and from the centers, visits to doctors and hospitals, and help with shopping and recreational activities. Ten Senior Citizens are employed by the program, who are paid to cook, clean, and provide out-of-reach services by actually going out and finding elderly "isolates" and presenting the program to them. The program also provides education to the participants in meal preparation and marketing

[8] P. 5244 in testimony at hearing cited in footnote 1.

and provides home delivered meals to those older community residents who are homebound.

C. Problems Not Limited to Poverty Areas

As was pointed out in a recently published research monograph entitled "Nutrition and Aging, A Monograph for Practitioner,"[9] there are specific problems which affect the diets of all older persons, including:

Loss of teeth and ill-fitting dentures, age-related loss of the senses of smell and taste, and physical ailments which may contribute to loss of motivation to prepare or shop for food.

In addition, the food habits of older persons represent a wide range of cultural and social experiences acquired over their individual lifetimes. These habits do not necessarily change as people grow old and the result may be seen in the seemingly "robust" or overweight older person who is actually malnourished. This occurs among the low-income elderly, whose diet may consist of inexpensive foods that are high in calories, such as rolls, bread, noodles and cereal; as well as among the more affluent elderly, who may nibble on "snacks" between meals.[10]

Available research on nutritional habits and problems of the elderly tends to confirm conclusions gathered in the Gerontological Society report, but—as AoA Commissioner Martin made clear in the following summary—much more is needed:

> The results of the 1965 U.S. Department of Agriculture survey of food consumption of households in the United States showed that about one-fifth of the diets provided far below the recommended dietary allowance for one or more nutrients. The results of this survey broken down by age groups indicated that women 65 and over and men 75 years and over, more often than those younger, had diets short in several essential nutrients.
>
> A limited number of case studies by both academic and government experts confirm the inadequancy of nutrient intake of significant percentages of older people.
>
> * * * a study at the University of Nebraska in 1961 showed that, in general, the diets of 32 active healthy women, aged 65–85, provided only two-thirds of the recommended dietary allowances. Iron, calcium, and vitamin A were consumed at less than satisfactory levels in many of the diets.
>
> A food consumption survey by the U.S. Department of Agriculture of older households in Rochester, N.Y., was conducted in 1957. Those sampled were Social Security beneficiaries who maintained their own households and ate most meals at home. The survey indicated that about one-fourth of the households had food that furnished far less than the recommended allowances of one or more nutrients. Shortages of calcium and ascorbic acid were the most frequent.

[9] "Nutrition and Aging, A Monograph for Practitioners" by Sandra C. Howell, M.P.H., and Martin B. Loeb, Ph.D., published by the Gerontological Society, Autumn 1969, p. 17.

[10] Miss Jennie Wilmot, member, Legislative Council, American Association of Retired Persons, National Retired Teachers Association, in testimony at hearings cited in footnote 1, page 5275.

In a survey in Iowa of 695 persons, 65 years of age and over, only one person in 20 was choosing a nutritionally desirable diet.

Another survey was made in Iowa of the food intakes of a group of women representing an area probability sample of all women 30 years of age and over in the State at the time of the survey (1959). The study disclosed that the diets of many women over 65 were deficient in one or more nutrients. This study also pointed out that changes in food habits of the elderly are related not only to physiological factors but also to psychological and emotional reactions to changes occurring in their lives.[11]

A new national nutrition survey now underway—should be used to document and dramatize food needs and problems of the elderly. Every effort should be made by the Administration on Aging—and by other appropriate Federal agencies—to get the facts to both the old and the young.

II. THE SPECIAL PROBLEM OF SERVICES

Even if every aged or aging person in this Nation had full and accurate knowledge about nutritional needs in later years of life, a critical question would yet remain:

How can nutritious meals reach the many isolated (geographically or emotionally), and economically hard-hit older persons in our cities and rural areas?

Another, related question is: How can meal service programs be used not only to provide food, but also to help meet other social needs?

Fortunately, at least partial answers to these questions are emerging from pilot programs—limited in number and precariously financed, to be sure—funded through the Older Americans Act.

The nutrition projects, funded under title IV, include: Hot meals provided for a nominal fee at a central dining room, such as churches, local schools, recreation centers, homes for the aged, and social halls in public housing. Most projects also include recreational activities and transportation. Health (medical and dental) services are provided in some cases. Meals are planned to meet at least one-third of the daily recommended dietary allowances, but menus differ from community to community to serve a variety of socioeconomic and ethnic groups. All of the projects employ elderly participants and utilize many older volunteers (who are also participants in the programs).

Two key components in all projects are: group meals served in a social setting so the elderly may eat in company with others and participate in social activities, and nutrition education and food purchasing information.

Twenty-three such projects have been in operation for more than a year in 17 States and the District of Columbia. Approximately 18,000 meals are served a week to older persons ranging in age from 55 to 87 years and with incomes of $700 to $5,000 a year. A majority have incomes of less than $1,000 a year.

[11] P. 5288 in testimony at hearing cited in footnote 1.

According to the Administration on Aging:

> Experience to date demonstrates conclusively, that an effective program to combat the nutrition problems of the aged must be comprehensive and involve the provisions of meals in a group setting which fosters social interaction and facilitates the delivery of other services which bear directly on adequate nutrition.[12]

Service for shutins.—Under title III the Administration on Aging has also aided 27 State agencies on aging in the delivery of meals at least twice a week to elderly shutins.[13] These meals are invaluable to the health and well-being of the elderly recipients, not only from the standpoint of good nutrition but because in many cases, the person who delivers the meal may be the only visitor the older individual has to look forward to. This program, too, has been hampered by a low level of funding. AoA Commissioner Martin, has observed:

> We believe that high cost is the major reason that so few of the 1,000 community projects supported under title III are devoted to meal delivery. State agencies have naturally been reluctant to commit the small annual allotments available to them to such expensive projects which are capable of reaching only a fraction of the State's elderly population.[14]

Another witness, however, said that food service programs are by nature deficit operations, and that they merit wide support:

> * * * experience has shown that programs for the aged are deficit operations. This is particularly true in such as nutrition programs, in which there are considerable costs associated with the delivery of services. Despite any efforts to develop local, private support for nutrition programs, it appears most doubtful that such programs can be maintained by most agencies, without major public support. Objective research data validates the utility of such programs; yet their continuation is unlikely within the budgetary frameworks of most private agencies.[15]

PILOT PROGRAMS FACE TERMINATION

All of the nutrition projects administered by the Administration on Aging are demonstrating that something can be done to improve the nutrition and general well-being of the Nation's elderly. It should be remembered, however, that these are pilot projects serving a limited number of elderly persons for a limited time.

When such projects terminate—as they must—the disappointment and confusion experienced by the participants can be devastating.

Life history of a project.—Senior Centers of Dade County, Fla., operated a title IV nutrition project for the elderly from September 1966 until August 1969. This program served 500 hot, nutritious meals 5 days a week, at the six Dade County Senior Centers, along with a number of home-delivered meals.

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[12] From "An Overview of the AoA Research and Demonstration Projects" paper presented at the White House Conference on Food, Nutrition and Health, December 1969.
[13] For a description of title III meal delivery programs, see appendix 1, item 1, p. 172. Administration on Aging Report.
[14] P. 5290, hearing cited in footnote 1.
[15] P. 5305 in testimony by Dr. Douglas Holmes, at hearing cited in footnote 1.

When the Federal funds ran out, the project director applied to the county commissioners for additional funding to keep the program going. The need for such a service was well known in the community, which includes a large elderly population. Thus, while awaiting the decision from the county, the program continued—due to generous private donations—on a week-to-week basis. It was cut to only one senior center. Finally, the center's application for additional local funding was turned down in November of 1969 and the program terminated after utilizing the remaining donated funds in December. With the termination of this program—the only one of its kind in the entire Dade County area—the project director said:

> The present lack of funds * * * has dramatically and adversely affected the morale of the senior citizens of Dade County. It has reinforced the elderly's belief that they are truly the "forgotten ones" in today's youth oriented society.
> Without this low cost meal, many elderly in Dade County will lack the necessary nutrition to maintain independent living, and their health will be adversely affected.[16]

Faced by similar terminations elsewhere in the Nation, Commissioner Martin called at the hearing for "the Nation to work out arrangements whereby ambulatory older persons who wish to do so can come together for meals in a group setting and shutins can receive home delivered meals." [17] He agreed with others who have observed that such programs not only assure delivery of proper nutrients, but "will also solve problems of loneliness and isolation."

Lessons learned from the AoA nutrition projects are too important to be overlooked. Additional efforts should be made by the AoA—working in conjunction with State and local government, as well as private agencies, to establish permanent arrangements for meal service programs as an important part of community service programs for the elderly.

III. FEDERAL FOOD ASSISTANCE PROGRAMS

The Committee on Aging, in preparation for the "Nutrition and the Aged" hearings, sent questionnaires to every Commissioner on Aging in the Nation, as well as to Directors of the Title IV Nutrition Projects, in an attempt to accumulate factual data and to add to general knowledge of nutritional problems of the elderly. Among the findings:

A. The Food Stamp Program

—Many older people do not become poor until old age, and so the application to a local welfare agency for food stamps is regarded as demeaning. Many do not apply.

—Those who have been poor all their lives are often reluctant to pay out the necessary amount of money from their welfare grants

[16] In Memorandum from Senior Centers of Dade County Inc., to Florida Bureau on Aging, Jan. 5, 1970.

[17] P. 5291 in testimony by John B. Martin, Commissioner of Aging at hearing cited in footnote 1.

that is necessary to purchase food stamps each month. After such purchases, many are left with no cash.

—The chronically ill elderly may require special diets. The special dietary foods they need are costly. Even with food stamps, they forego such foods at the expense of their health.

—Lack of transportation presents an almost impossible obstacle to the purchase of food stamps by the elderly. Many cannot get to the welfare office to apply, nor can they travel to the banks to pick up the stamps. If they do reach the bank, many of the "older" more feeble aged cannot bear the long waits to receive their stamps, cannot get to the markets to purchase food, and ultimately, cannot carry heavy packages to their homes.

—Large numbers of older persons take their meals outside of their living quarters, including those who live alone in rooms where they cannot prepare meals, or in large residential hotels. For these people, food stamps are useless.

B. The Commodities Program

Even if elderly recipients can travel the distances usually required to get to distribution centers, they are often unable to carry the heavy, bulky commodities home with them.

—The types of surplus foods available are often unappetizing to the elderly and in some parts of the country the foods are unfamiliar to the people receiving them.

—Items such as flour, wheat and dried milk have a tendency to spoil (once opened) in certain climates. Therefore, much food is wasted. Moreover, these foods come in such large packages that many elderly have no place to store them.

—Older individuals are likely to have dental problems and cannot chew many of the "hard" fruits and vegetables necessary to a balanced diet. The "soft" foods available on the commodity program, such as corn meal, bread and other starches, may be filling but lack the nutrients necessary to good health.

Witnesses appearing at the "Nutrition and the Aged" hearings expressed concern with the food stamp and commodities programs:

> The donated foods program of the U.S. Department of Agriculture has failed to recognize the needs of older people. The selection of food is not always appropriate to the nutritional needs of the elderly and does not take consideration of their physical limitations. The packages of food are enormous. The distribution points in New York City are far apart and the method of distribution is crude and callous.
>
> Our neighborhood depot is covered by a 59-block area and services 500 to 600 people a day. If one is lucky, he can get through the line in 2 or 3 hours, if not he must wait the whole day out in the hot sun, the rain and the snow. A quick survey of older people in line revealed that many lived in furnished rooms or hotels without adequate storage facilities and most had to literally drag the food home because they had no money for cab fare.
>
> The donated foods program could be a source of help to the older person if the program's administrators are willing to

take a hard look at the kinds of foods and the methods of distribution. We urge smaller food packages for the elderly family, a more effective method of distribution and most of all, a more realistic understanding of the needs of the older population served.[18]

* * * * *

From the many requests we have had from the older persons, requesting assistance in obtaining food stamps or commodities it appears that the programs are not reaching many of the most needy—those unable to travel the distances involved to get to the distribution centers—misunderstanding concerning eligibility and certification and the unnecessarily long and embarrassing process. In the counties that have the food stamp program many cannot participate because of the outlay of cash on a specific day along with the transportation problems. These people must continue to purchase from a fixed income while the prices of their needed services increase; thus, making it more imperative that they receive assistance with food.[19]

Obviously, the two programs must undergo extensive changes and improvements before they can reach all older persons who require assistance—and provide them with an adequate, nutritious diet. Here again, education seems to be the keynote.

It should be remembered, however as one witness noted:

We know that elderly people tend to have reduced motivation to learn new food habits and rarely apply to themselves what they read, even when they read. And yet professionals—doctors, nurses, and dietitians—persist in handing out written pamphlets on diet (as an aside, between 50 and 70 percent of diabetics do not even follow their written dietary prescriptions). Money is spent to produce and distribute dietary information without the least bit of evaluation of the effectiveness of such materials or of the time spent by professionals teaching in a home or in a group situation.

As a case in point, this "Food Guide for Older Folks," produced by the U.S. Department of Agriculture, has never been evaluated. As far as I know, it is used openly and freely just to be handed to older people. I am quite sure it is irrelevant to them, if it is even read.[20]

C. Actions Taken by Congress

On September 24, 1969, the Senate passed and sent to the House, S. 2547—"A Bill to Amend the Food Stamp Act of 1964." [21]

[18] P. 5344 in testimony by Patricia Carter, Hudson Guild, New York City, at hearing cited in footnote 1.
[19] P. 5316 in testimony by Mrs. Regina Fannin, Project Director, country gathering program, northeastern Kentucky, at hearing cited in footnote 1.
[20] P. 5301 in testimony by Mrs. Sandra Howell, project director, Gerontological Society, at hearing cited in footnote 1.
[21] At year's end, the bill was under study by the House Agriculture Committee, and no date had been set for clearance.

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Provisions Which Affect the Elderly.—The bill would:

—Permit the purchase of products for personal clealiness and home sanitation as well as food.

—Adjust the price of stamps so that no family would be required to spend more than 25 percent of its income for food stamps.

—Permit continuation of commodity distribution program in counties transferring to food stamp program, until the latter program is in full operation.

—Authorize elderly persons to exchange food stamps for meals prepared and served by nonprofit organizations if: they do not have cooking facilities or reasonable access to such facilities, or if they are homebound, feeble, physically handicapped or otherwise disabled so that they cannot prepare meals themselves.

—Provide that nutritional counseling be offered to food stamp recipients at schools, approved retail stores, in their homes or at other appropriate and convenient places.

—Provide that any individual applying for food stamps shall be certified for eligibility solely by execution of an affidavit, in such form as the Secretary of Agriculture may prescribe.

—Require that issuance of food stamps take place no less than once a week.

—Authorize State agencies administering the program (unless otherwise provided by law) to allow any individual participating in the program to have the charges for coupon allotments deducted from any grant or payment received under any federally aided public assistance program and have the allotment distributed with such grant for payment.

IV. THE WHITE HOUSE CONFERENCE ON FOOD, NUTRITION AND HEALTH

The conference, which was held December 2–4, 1969, was attended by 3,000 participants from all walks of life. Along with the "experts" were the poor and the hungry.

One of the liveliest panels at the conference was devoted to "The Aging." Along with progressive and far-reaching recommendations, the panel put forth a demand for immediate action:

> The present crisis among the aged demands immediate national action to relieve poverty, hunger, malnutrition, and poor health.[22]

Among the 10 major recommendations [23] made by the panel were several worthy of widespread attention in aging and related fields:

—Development of a national system of food delivery, by which supplying a substantial proportion of nutrient requirements may be distributed to the elderly through restaurants, institutions, and private homes.

—Social Security minimum payments be raised from $55 to $120 monthly within the next 2 years, taking an additional 5 million

[22] P. 62, report, "White House Conference on Food, Nutrition, and Health," Dec. 24, 1969.

[23] See app. 7, Item 2, p. 398 for detailed list of recommendations.

persons out of poverty and hunger. And, that Social Security beneficiaries receive income in an amount at least of a level on parity with any implemented system of guaranteed annual income.
—That the U.S. Government develop guidelines for a nutrition education program aimed at the elderly, also emphasizing physical activity and social interaction.
—The establishment of a national code of health, nutrition, and personnel standards, for those persons and agencies providing residential or home health care to any number of elderly individuals.
—All housing programs for the elderly no matter how financed or sponsored, include meal service with proper nutrition.
—The U.S. Department of Transportation, in conjunction with the Department of Health, Education, and Welfare, its Administration on Aging and the Department of Housing and Urban Development, should study methods of providing necessary transportation for the elderly (and other disadvantaged groups) who are not within reach of, or are unable to use, normal transportation.

V. OTHER CONSUMER PROBLEMS OF THE ELDERLY

The Senate Committee on Aging Subcommittee on Consumer Interests of the Elderly conducted a hearing in 1969 [24] to study major issues facing the elderly consumer. In order to fulfill its role in the committee's yearlong study of "The Economics of Aging: Toward a Full Share in Abundance," much of the information sought was based on a fundamental question, posed by Senator Frank Church: [25]

> What are the consumer needs of the elderly and the relationship of those needs to retirement income? [26]

Considering the following issues brought out at earlier hearings [27] this question has special relevance:
—The retirement income problem for today's elderly is serious and has grown worse over the years; the median income of the elderly is less than half that of younger people.
—Today's workers—those middle aged and younger—will also have serious retirement income problems unless major, comprehensive action is taken on several fronts.
—Poverty afflicts one out of three elderly Americans today.

A. What the Latest "Moderate" Budgets Show

The major findings of the U.S. Bureau of Labor Statistics' "Retired Couple's Budget for a Moderate Living Standard, Autumn 1966" (issued in autumn 1968) was that a self-supporting, retired couple in U.S. urban areas required an annual expenditure of about $3,869 to

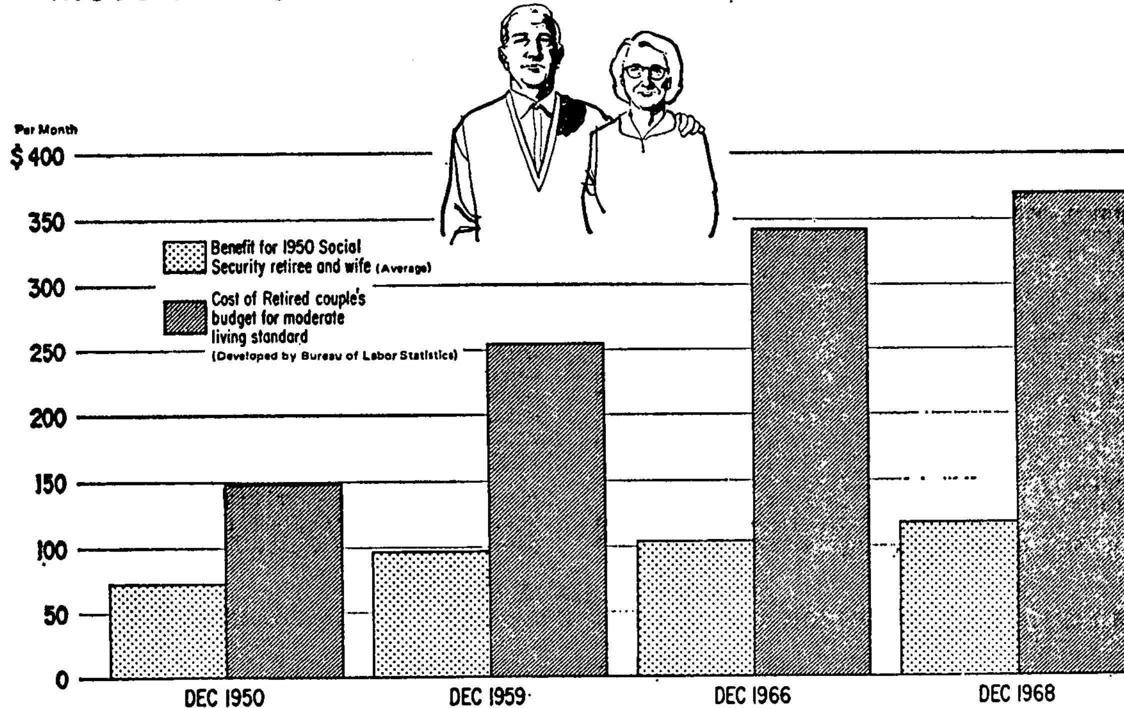
[24] "Economics of Aging: Toward a Full Share in Abundance", Part II, "Consumer Aspects", Ann Arbor, Mich., June 1969.
[25] Chairman of the U.S. Senate Special Committee on Aging Subcommittee on Consumer Interests of the Elderly.
[26] P. 334, hearing cited in footnote 24.
[27] In testimony (and working paper) by members of special task force at hearings on "Economics of Aging: Toward a Full Share in Abundance," Washington, D.C., Apr. 29–30, 1969. See chapter I of this report.

live comfortably, but not luxuriously. For a single retired person, an estimated $2,000 would be needed.[28]

The task force working paper on "The Economics of Aging: Toward a Full Share in Abundance," pointed out, however, that there is a rising gap between Social Security benefits and what is considered a "moderate" standard of living for retired couples (see chart p. 57).

[28] According to Mrs. Helen H. Lamale, Chief, Division of Living Condition Studies, Bureau of Labor Statistics, U.S. Department of Labor, the cost estimates of the retired couple's budget are for an urban family of two persons—a husband, age 65 or over, and his wife, who are assumed to be self-supporting and living independently of any other family group. The budget also specifies that both husband and wife are in reasonably good health for their age and are able to take care of themselves, and that each is covered by hospital and medical insurance under the Federal Medicare program. Two-thirds of the retired couples are homeowners, living in houses which are mortgage free. The couple has average inventories of clothing, house furnishings, major durables, and other equipment. The costs for a single retired person are 55 percent of those for a retired couple, or approximately $2,000 at the moderate U.S. urban average in autumn 1966. See pp. 373–374, hearing cited in footnote 24.

A RISING GAP - *SOCIAL SECURITY BENEFIT AND MODERATE STANDARD OF LIVING FOR RETIRED COUPLES*



Statistical basis discussed on following page

CHART A: A RISING GAP—SOCIAL SECURITY BENEFIT AND MODERATE STANDARD OF LIVING FOR RETIRED COUPLES

SOURCE OF DATA: "OASDHI Benefits, Prices, and Wages: Effect of 1967 Benefit Increase," by Daniel N. Price, *Social Security Bulletin*, December 1968, page 32.

TECHNICAL NOTE: The Retired Couple's Budget for a Moderate Living Standard, developed by the Bureau of Labor Statistics, is intended to represent a measure of what retired couples themselves consider an appropriate level of living. It provides for the maintenance of health and social well-being, and participation in community activities. The retired couple is defined as a husband age 65 or older and his wife, self-supporting, living independently in an urban area, and enjoying fairly good health.

The cost of this monthly budget for couples living in rented dwellings in 18 cities was: $149 in December 1950; $255 in December 1959; and $344 in December 1966; (the 1966 budget study was the first in the series to include data for homeowners and comparison with earlier studies is therefore limited to renters). Of the increase in costs between 1950 and 1966, about half has been attributed by the BLS to higher standards of living and half to advances in prices for the goods and services in the budget. Adjustment of the 1966 figure by the increase in the Consumer Price Index would bring the cost to $370 in December 1968.

The worker who retired late in 1950 received a social security benefit that averaged $49.50; addition of 50 percent for a wife would raise this average to about $75, or half the cost of the elderly couple's budget at that time. Legislative increases would have raised this benefit to $98 by December 1959 and to $104 by December 1966. The increase resulting from the 1967 Social Security Amendments brought the benefit to $118, somewhat less than one-third of the cost of the budget for a moderate standard of living. (Had the average benefit for a couple been used—rather than 150 percent of the average payable to all retired workers—the dollar figures would have been slightly higher for each year. But the widening gap between the benefit and the budget cost would have been the same.)

THE FINDINGS: The average social security benefit payable to an elderly couple who retired in December 1950—even though it has been adjusted over the years—would now purchase a significantly smaller fraction of the Retired Couple's Budget for a Moderate Standard of Living than at the time of retirement. (See discussion, pp. 13–14.)

Senator Frank Church also noted that:

> * * * a $3,869 income is far out-of-reach for most persons past age 65 in the United States today."[29]

Earlier BLS "moderate" budgets were limited to very large metropolitan areas and included only rental housing costs. The revised budget has been expanded to include 39 metropolitan areas, four regional classes of nonmetropolitan areas, as well as the average for urban United States. In addition, the budget includes costs for maintaining mortgage-free homes, along with rental housing costs. One of the important remaining gaps, however, is that there is no similar information for rural retired couples.[30]

According to the BLS, the "moderate" budget is a research tool—a benchmark measure of how much it would cost to maintain a moderate standard of living in urban places—not a spending plan for an average retired couple.[31]

Sidney Margolius, columnist and author on consumer subjects, criticized the BLS budget for many reasons, all of them related to unrealistic assumptions. He gave these examples:

> The Bureau estimated only about 60 percent of retired people who had cars, on the basis of a 7-year-old car, were allowed only $45 a month to own and operate it. The Bureau explained that they made this lower allotment because a car that old is usually not repaired but traded in.
>
> * * * * *
>
> * * * based on the data from AAA and the Bureau of Public Roads, is that the total cost of owning and operating a 7-year-old car is about $65 to $70 a month, including depreciation and repairs.
>
> * * * * *
>
> Another thing I am concerned about is the paidup home with no mortgage allowance taken as the basis for housing costs for a homeowning family. I am not sure this is entirely realistic these days when mortgages may run as high as 35 and 40 years. That means a retired man who bought his first house after age 35, assuming at least a 30-year mortgage, will find his housing expense is underestimated. The budget data is based on the assumption that 85 percent of the retired couples live in homes on which the mortgage has been paid up.
>
> This data is based on the 1961 survey and I just wondered if we need a little more investigation there to make sure that we aren't underestimating.
>
> * * * * *
>
> By now, of course, the medical allotment is completely out of date. The fee for part B of Medicare alone has increased 33⅓ percent and probably will be going up some more. The medical allotment, while it may be based on actual practice at the time of the expenditure survey, would not provide for really adequate care and annual checkups.

[29] P. 335, hearing cited in footnote 20.
[30] P. 372, hearing cited in footnote 24.
[31] P. 372, hearing cited in footnote 24.

> I think the allotment for annual checkup allowed one-sixth of one for the couple each year. One-sixth of one for both, that means each one of the older people could get one checkup of this type every 12 years.[32]

In assessing the revised "moderate" budget, this committee observed [33] that the budget:

> * * * still leaves unanswered many urgent questions about appropriate standards to use in assessing the adequacy of income of various groups in the aged population.

In response to this and numerous other requests for more varied standards for evaluating needs of retired couples, a preliminary report on the first "Three Budgets for a Retired Couple for Spring 1967",[34] was issued in the autumn of 1969. (See app. 7, pp. 395–397.)

Major findings.—In spring 1967 a retired couple needed $2,671 to live at the lower budget level, $3,857 was required to live at the intermediate or "moderate" level, and it cost $6,039 to live at the highest level (see chart below).[35]

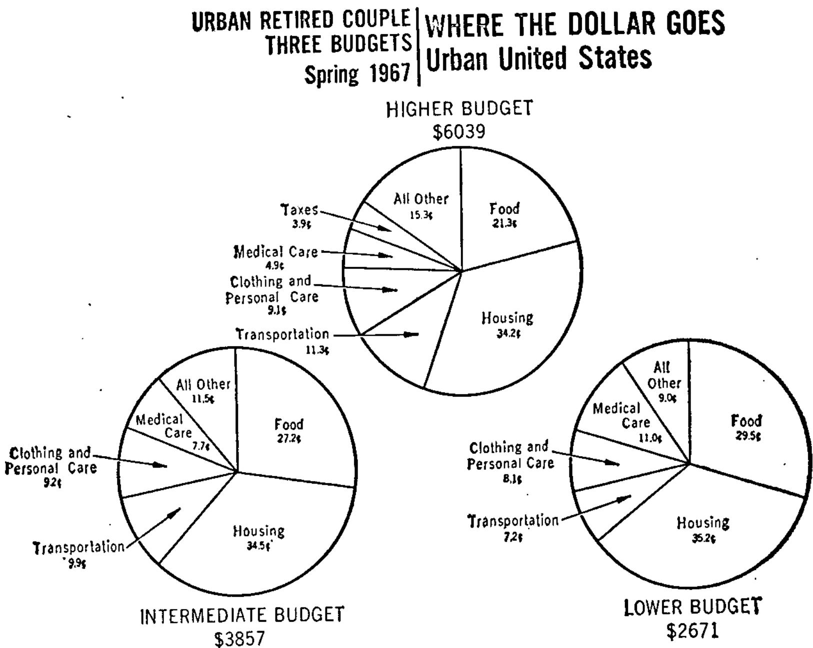


EXHIBIT 4

According to the BLS preliminary report:

> The budgets have been developed to meet the needs of public assistance agencies, voluntary social and welfare agencies,

[32] Pp. 381–382, hearing cited in footnote 24.
[33] See "Developments in Aging 1968" Chapter III, p. 35.
[34] Completed report on "Three Budgets for a Retired Couple in Urban Areas of the United States," BLS Bulletin 1570–6 went to press as of this writing.
[35] See app. 7, pp. 395–397.

> business, labor unions, and individuals concerned with retirement planning.[36]

There are still unanswered questions in the BLS budgets.

For example, the intermediate or "moderate" budget is lower in spring 1967 than it was for autumn 1966, even though the latter budget is considered unrealistic for most older persons in the Nation—as observed earlier in this chapter by Senator Church and others.

Indeed, it has been found that all three spring 1967 budgets are out of reach for a large percentage of older couples. Mr. Herman Brotman, Chief, Reports and Analysis Division, Administration on Aging, has estimated that:

> Of all retired couples, as many as 36 percent cannot afford even the "Lower" BLS budget; 56 percent cannot afford the "Intermediate" BLS budget; and 75 percent cannot afford the "Higher" budget.

The BLS informed the committee that the factors which reduced the "intermediate" budget (from autumn 1966 to spring 1967) were revisions [37] in recreation and transportation expenses, and the elimination of cigarettes.

It would seem that eliminating actual expenditures, such as cigarettes, is an unrealistic method of evaluating a retired couple's budget. Although such items may not be considered "necessary" to a retired couple's well-being, many still purchase and use these items. A witness at the Ann Arbor hearing—although he spoke before publication of the three budgets—expressed relevant criticisms of the BLS budgets in general: [38]

> * * * let us examine the basic concept of the family budgets, which BLS originally set up. BLS wrote in 1947 when they started defining a budget: "When it is said that the budget recommended is intended to cover the necessary minimum 'necessary' is to be given the common interpretation as including what will meet the conventional and social as well as biological needs. It represents what men commonly expect to enjoy, feel that they have lost status and are experiencing privation if they cannot enjoy, and what they insist upon having."
>
> Examination of expenditures in relation to incomes is the only basis that we have for estimating, or defining need. If you spent all your money, then obviously you thought that you needed those goods and services on which you spent the money.

The BLS is expected to publish the spring 1969 budgets for retired couples in 1970. Thereafter, estimates will be published each spring periodically.[39]

It should be noted, however, that:

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[36] See app. 7, p. 379.
[37] The revisions appear in detail in the forthcoming BLS Bulletin 1570-6.
[38] P. 387 in testimony by Abram J. Jaffe, professor of economics, Bureau of Applied Social Research, Columbia University, at hearing cited in footnote 24.
[39] P. 374, hearing cited in footnote 24.
[36] See app. 7, p. 379.

> Rising prices between spring 1967 and spring 1969 have added about 9 percent to the cost of goods and services required to sustain retired couples.[40]

In view of these rising costs, a retired couple would require more than the $4,100 estimated by one witness[41] to live moderately but comfortably in 1969.

Another witness in Ann Arbor,[42] in fact, recommended:

> The amount of $4,300 or $4,400 (in 1969 prices), which is the BLS moderate-living-standard budget which permits expenditures on virtually all components except income tax, should be, I recommend, the very minimum which any family with the head retired should have.
>
> I say minimum income—that would be pension income plus earned income, or any other source of income. The total amount of money that they should have, should be not less than $4,300 or $4,400 (in 1969 prices).

Clearly, the budgets should receive continued attention—especially in the area of miscellaneous consumer items. These items, such as cigarettes and recreation should go hand-in-hand with housing, food, transportation, and medical care—in order to effectively determine the actual standard of living for elderly couples.

B. Other Points From Ann Arbor Hearing

Almost every problem facing the elderly in the marketplace today is directly related to inadequate income—as was poignantly summarized by an elderly retiree:[43]

> Sickness in the last 5 years, after retirement, a heart attack, a stroke, loss of hearing in one ear, for myself, and I am deprived of my hearing aid here today because when it stops hearing, I stop hearing.
>
> I had to send it in to have it fixed up. I got a letter back Saturday and they said it will cost you $57.50 to have it reconditioned. So that is out of my budget.
>
> My wife had a heart attack and arthritis and two major operations last year and two, so far this year, in 1969 and the loss of the sight of one eye. She has had in our married life, which was 50 years last March 11, between 25 and 30 operations. She is right now, this minute, in the osteopathic hospital in Jackson waiting for another operation, possibly tomorrow.
>
> Yes, we have both Blue Cross and Blue Shield insurance and Medicare. We have paid out an awful lot of money for it. Expenses for the month, from the doctors, office calls, for two of us, was $6 to $9, and this is one point that I would like to bring out, is prescriptions from doctors visits, new medicines, they are going to try this, "We are going to try that, here is a prescription, go to the drugstore and have it filled."

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[40] In U.S. Department of Labor, BLS Bulletin 10–746, "Three Budgets for a Retired Couple for Spring 1967."

[41] Pp. 374–5, hearing cited in footnote 20.

[42] Pp. 386–87, hearing cited in footnote 24.

[43] Pp. 369–70 in testimony by Mr. Herbert Taylor, panel, "Older Consumers Speak" at hearing cited in footnote 24.

> From one to three prescriptions and that is twice a month—not every visit—costs us from $3 to $22 and that is not covered by Medicare.
>
> An unexpected expense was repairs on a 1961 car. We had our anniversary party and our children gave us this party. Instead of giving us a lot of things that we couldn't use, they had a money tree for us. We got $222 on this money tree. I didn't know that within a month or 6 weeks afterward that the automatic transmission was going to have to be overhauled in my car. What is more useless than a car setting in a yard with a transmission out? You can't get a price on it on a trade-in. They just won't give it to you.
>
> The next thing I got on my list here is living costs: Food, we hunt up the cheapest and the best markets for food. And we stock up those that we can for a month and try to make them last until our next check comes.
>
> *   *   *   *   *
>
> Then we have rent, heat, light, garbage service, all kinds of necessary household articles, and time does not permit me to name them all. You all know what they are.
>
> Yearly expenses. I have 10 grandchildren and four great-grandchildren; a son, a wife, a daughter, and a husband, and they have a habit of having a birthday every year. They have just got that habit and you can't get anything for 98 cents anymore.
>
> Sometimes we can make things at home. But not always. That includes then all gifts and holidays.
>
> Entertainment, yes; I got a 17-year-old TV, on the dial where you dial your channel, I finally get it, and I put a piece of tissue paper or something up in there to hold it there until the program is over. I can't afford to have it fixed.
>
> * * * we go fishing around Jackson and we have a boat and a small motor and a homemade trailer. We are satisfied with just that.

This elderly consumer is more well-off than many. He and his wife still own a car—albeit an old one in constant need of repair.

For the elderly consumer who must depend upon public transportation, the act of getting to and from the marketplace can impose intolerable burdens. Once he reaches the marketplace, he often finds it indifferent to his needs. For example, the Project Director of a consumer education center for the elderly in New York City [44] approached three major department stores to assist in a fashion show of appropriate clothing for older women. She was unsuccessful because the stores had no desire to be thought of as an "old people's market."

It has been said that older people don't need as much clothing because they don't go out as much as younger persons. The fallacy in this assumption was discussed by Commissioner on Aging, John B. Martin:

> For the kind of life we hope to provide for our present older people, ourselves, and our children in their future later

[44] P. 358 in testimony by John B. Martin, Commissioner of Aging, in discussion of Hudson-Guild-Fulton Center, at hearing cited in footnote 24.

years, we certainly do not want a lessening of clothing expenditures because they "do not go out."

That is certainly the wrong direction to travel in. We think older people should be active, participating, traveling, attending the theater, concerts. Just when they have more free time, withdrawal because of the cost of participation is cruel and inhuman punishment.

Actually some older people may need more of certain kinds of clothing—or more expensive models—for example, shoes, because of foot troubles.[45]

The elderly consumer also experiences great difficulty in obtaining assistance from providers of services, such as repairmen, banks, and legal firms. These essential services are not always reliable—they are confusing to many older persons—and they are almost always costly.[46]

Mrs. Virginia H. Knauer, Special Assistant to the President for Consumer Affairs, cited some additional difficulties which plague the older consumer:

* * * for the older person, particularly those I would term the "old elderly," there are some additional consumer problems. This group may be much less physically mobile, so they cannot shop around as easily to compare products and prices in order to get the best buy, if indeed they can go to shop at all. They may be residents of the inner city ghetto areas where availability of merchandise, price differentiation, and quality limit their choice. Hence, they may pay more, and for lower quality. Their anxiety, fear, and pride may make them hesitate to ask questions in the stores, or to admit they have made a mistake in time to correct it. They may not hear clearly, may not realize they do not hear well, or may be too proud to ask the clerk to repeat. Their vision may be somewhat dim, so that reading the fine print is difficult. But pride may prompt them to indicate they have read it. They may not have had an adequate educational background. Living alone, and perhaps not wishing to be a burden on children or friends, they may hesitate to seek advice. And they may not know where or whom to consult for legal advice, or perhaps they are unable to afford a lawyer.

For these reasons, the older person is often the special target of the practitioner of fraud. Retirement land deals, promises of medical "cures," devices or gadgets which may seem at the time worth a chance, make-money-at-home schemes, and home repair and improvement deals which play on the older person's community pride and his efforts to maintain his own home as long as he is able—all these and more—often constitute traps for an older consumer. Losses cut deep into limited incomes, and too often there is little hope of recovery of the loss. And in the case of a fraudulent health scheme, even worse than the financial loss is the delay in seeking legitimate medical care.[47]

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[45] P. 355 in testimony by John B. Martin, at hearing cited in footnote 24.
[46] Pp. 355–6 in testimony by John B. Martin at hearing cited in footnote 24.
[47] P. 345 in testimony at hearing cited in footnote 20.

C. Consumer Protection and Education

At hearing after hearing during 1969, the Committee on Aging heard testimony from elderly citizens themselves which indicates that many manage extremely well on their limited incomes. They search the marketplace for inexpensive items, comparing prices and workmanship, and they are often quick to spot a "phoney" or fraudulent scheme. It should be recognized, however, that the committee heard from those elders who are actively involved with life—helping others less fortunate than themselves. The people they helped were often too old, too feeble, too lonely and too poor, to "manage".

As was pointed out by Mrs. Knauer—it is the marketplace itself, and the consumer protection, information and education systems that need changing. She observed that the Federal Government can and should play a large part in bringing about these changes:

> Our goal is to help, yet enable the elderly citizen to retain his pride and self-respect. We must recognize his competence in judgment, but at the same time make more information and counseling available. We must make certain that the information is clear and to the point, available in Spanish or other languages, and is widely disseminated. * * * Wider exploration of the use of television and movies is needed. We must develop new means of getting our material into the homes of the elderly, especially with regard to matters of particular concern to the older American—for example, information about hearing problems and the purchase of hearing aids.
>
> But not all of the older consumer's problems can be resolved by informing and educating him as an individual. It is also our priority that he be provided with more effective means to make himself heard, and to obtain redress for his grievances. We have made progress, but the aggrieved and the defrauded still have problems. It should be possible for the consumer to get satisfaction without being out of pocket, and to receive reimbursement for losses sustained. Too often a $50 loss can only be recouped through a $150 lawyer's fee. Voluntary arbitration at the community level should be encouraged. Greater use of class suits would help to alleviate crowded court dockets and would enable the consumer on a fixed and inadequate income to obtain redress for his grievances without expending large amounts of money. More information regarding the use of small claims courts would also be most useful in achieving this goal.[48]

The Administration on Aging [49] is actively engaged in projects to educate and protect the elderly consumer. Education is included—as was mentioned earlier—in all the title IV demonstration nutrition projects, and is available in the title III Senior Center programs. Programs which specifically focus on consumer education are Project Moneywise Senior and the Hudson-Guild-Fulton Center Project:[50]

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[48] P. 346, hearing cited in footnote 24.
[49] P. 358 in testimony by John B. Martin at hearing cited in footnote 24.
[50] For detailed description of the two projects see pp. 358 and 412–13, hearing cited in footnote 24. Further information on the Hudson-Guild-Fulton Center Project can be found in "Designs for Action for Older Americans", AoA publication.

"The Consumer Guide for Older People"—developed by the AoA in cooperation with the President's Committee on Consumer Interests and the Food and Drug Administration in 1968—is testimony to the fact that older consumers are vitally interested in educating themselves. During 1969, the Administration on Aging printed and distributed 1 million copies. In addition, 250,000 copies were distributed by the Government Printing Office in 1969.

The U.S. Office of Education, Department of HEW, conducted a number of programs to assist the elderly consumer during 1969,[51] including: Consumer education for the elderly through telecasts and counseling services; and retirement counseling, educational programs and discussion groups.

It is unfortunate that plans for a nationwide survey of consumer education programs, announced by the Office of Education late in 1968 [52] were not developed in 1969. This survey could have proved invaluable in assessing consumer education needs and developing programs to meet those needs.

All of the older consumer's problems cannot be resolved by education—he needs protection and legal assistance as well.

The Office of Economic Opportunity has continued in 1969 to assist the older consumer through its legal research and services for the elderly demonstration program, sponsored by the National Council of Senior Citizens.[53]

The report from the U.S. Postal Inspector for 1969 [54] confirms the extent of the need for legal protection. Some examples of effective prosecution:

—An advertised treatment for diabetes called for complete withdrawal from insulin and ingestion of white table sugar to replace the medication. Medical authorities stated that a diabetic following this treatment would do so at grave peril to his health.

—An entrepreneur in California, whose name has been a household word since 1934 to hundreds of thousands of the ailing, the elderly and food faddists throughout the Nation, maintained advertisements for various products on 50–60 radio stations at a cost that sometimes reached $30,000 a month. Commercial pitches were often mingled with religious sermons and inspirational organ music. Some products which cost as little as 50 cents to produce were sold for $10.

—A brokerage sold promissory notes offering—falsely—a return of from 40 percent to 100 percent. The public loss was approximately $4 million.

D. The Need for Research

> Who is the older consumer and what are his consumer needs? * * * How can the facts [we do have] work toward the consumer good of older people and toward a profit for business? [55]

[51] See app. 1, p. 264.
[52] See "Developments in Aging 1968" chapter III, p. 45.
[53] See app. 1, p. 255.
[54] See app. 1, p. 208.
[55] P. 378 in testimony by Patricia Carter, project director, Hudson-Guild-Fulton Center at hearing cited in footnote 24.

The Administration on Aging programs and other Federal programs are providing answers to some of these questions. But more comprehensive data is needed. For example, the food industry has recently shown a heightened interest in the elderly—as was pointed out in an article by Dr. Alfred A. Messer in 1969.[56] Some of the new food products include eggs with reduced cholesterol, a low-acid orange juice, and pureed meats, vegetables and stews that are flavored to adult tastes. Most of the products are still in the development stage, but little research has been done to determine if the elderly consumer will actually purchase such foods—and indeed, to find out if he needs special foods. Another article, for example, states that older persons would be better off purchasing a variety of ordinary foods, since their normal dietary requirements are essentially the same as those for younger persons.[57]

Thus, it is clear that not only is more comprehensive data needed: there is also a need for distributing the information already available—to the consumer—to industry—and to providers of services.

It is only through a coordinated system of protection, education and assistance that the elderly consumer will be assured of a voice in the marketplace—and the ready availability of the goods and services he desperately needs.

[56] "New Products Help Elderly" by Dr. Alfred A. Messer, The Hackensack New Jersey Record, December 17, 1969.
[57] In Medical World News, February 1970, "On Diets for the Aged," cited study by Mrs. Neil Solomon and Nathan W. Shock.

CHAPTER IV

HOUSING: ADDITIONAL TOOLS AND MOUNTING PROBLEMS

Building upon the solid achievements of the Housing and Development Act of 1968, the Congress added innovations of special interest to the elderly during the past year and insisted upon maintaining a program especially useful to nonprofit sponsors of housing for the elderly. But low levels of funding caused severe problems for the elderly who so often find that rising property taxes make homeownership a heavy burden beyond their capacity to support. And yet, alternative rental housing is often either nonexistent or beyond their financial reach.

I. HOUSING PERSPECTIVE FOR 1969: GRIM

> The current mortgage credit situation is almost a depression and I predict that the home mortgage market will get even tighter.—Preston Martin, Chairman of the Federal Loan Bank Board, as quoted in the Wall Street Journal December 29, 1969.

In 1969, skyrocketing construction costs, rapidly rising property taxes, and the highest interest rates in 100 years precluded millions of Americans, both old and young, from a basic goal—a decent home in a suitable living environment.

The laudable goal of the 1968 Housing Act—calling for the production of 26 million units in 10 years—appeared to become unreachable as new housing starts in 1969 dropped to 1.1 million down from 1.5 million starts in 1968. Twenty million Americans still live in substandard housing.

Senator Charles Goodell (R-N.Y.) was moved to comment:

> These grim facts mean that we have failed. Government housing programs, although well intentioned and ambitious, have not met the needs in our urban areas.
>
> The prime reason for our failure to met the housing goals has been inadequate funding.[1]

Representatives of labor and management joined Senator Goodell in his indictment of inadequate funding by the Federal Government and were quick to add that increasing labor and construction costs also had their inhibiting effect on the housing market.

Many congressional leaders like Congressman Wright Patman advanced other arguments:

> Mr. Speaker, certain members of the banking fraternity and the administration have taken to publicly whimpering

[1] Congressional Record, Nov. 6, 1969, p. S 13850.

> that the rising cost of labor and materials are driving the price of housing beyond the reach of the Nation's low- and moderate-income families. They wring their hands, chant the national housing goals and declare that the goals cannot be attained. If they would stop listening to their mutual lament long enough to study the figures they would be forced to admit that the cost of money is the reason our national housing goals are not being achieved.[2]

From December 1968 through December 1969 Americans watched unhappily while banks raised their prime interest rates six times. At the same time banks and savings and loan institutions were faced wth wholesale withdrawals as investors bought higher yielding corporate and Treasury bonds and commercial paper.

Savings and loan institutions—which provide about 60-percent of residential mortgage loans—were especially hard hit. In order to maintain deposits the Beverly Hills Federal Savings and Loan Association has resorted to a novel incentive. The firm pays 5-percent interest on passbook accounts, the same as other similar institutions in California, but it also donates an additional 1 percent to whatever religious or charitable organization the saver designates.[3]

The response of the Federal Government to stop the drying up of funds available for mortgages was to raise the interest rate ceiling on mortgages insured by the Federal Housing Administration or guaranteed by the Veterans' Administration to an unprecedented rate of 8½ percent. This new 8½-percent ceiling, one full percentage point above the 7½-percent rate that had been in effect since January 24, 1969, was the largest increase ever and was higher than the legal maximum interest rate of some 21 States.

In practical terms, the new ceiling effective January 5, 1970, will add $6,210 to the cost of buying a $25,000 home with a 30-year mortgage after that date.[4]

The housing situation in 1969 was summed up by Leroy Pope:

> A generation ago finding a place to live was the least of the average American's worries. Today it is likely to be his largest headache.[5]

II. HOMEOWNERSHIP PROBLEMS

On July 31 and August 1 the Subcommittee on Housing for the Elderly of the U.S. Senate Special Committee on Aging conducted hearings on "Homeownership Aspects of the Economics of Aging" as part of a larger study which began earlier in the year when a task force commissioned for the full committee submitted its working paper on "The Economics of Aging: Toward a Full Share in Abundance."

The task force was emphatic in its recommendation that further study be given to the question of maintaining homeownership in later years indicating:

1. For most of the elderly, the home is the only major asset. In fact, two out of three own their own homes, and 80 percent of

[2] Congressional Record, Oct. 29, 1969, "Pricing Housing Out-of-Sight", p. E 9113.
[3] George Grimsrud, Wall Street Journal, Dec. 29, 1969, p. 1.
[4] Philadelphia Inquirer, Dec. 31, 1969, p. 1.
[5] Washington, D.C., the Evening Star, Jan. 19, 1970.

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them are free of mortgages. Half have an equity of $25,000 or more in their homes, yet many are house-poor because of limited retirement incomes.

2. Rising property taxes and other costs, unfortunately, are making it increasingly difficult for the elderly to hang on to their homes.

Testifying at the hearing, Richard Coffee, State Senator from New Jersey, put this issue into perspective:

> As in most of our populous States, the base of local government financing in New Jersey is the real property tax. Accordingly, as the services of the government increase, so does the burden on the property owner. This hits hardest at our older residents because of their lack of sufficient income, and many of them are facing financial problems which have reached crisis proportions.[6]

3. For those who wish to sell their homes and live in smaller quarters, there may be difficulties, particularly for those living alone. This problem is severe for widows and single women who are troubled by:

(*a*) The unavailability of alternative quarters at reasonable prices and suitable location. Significantly, the rental market vacancy rate has dropped sharply from 7.5 percent in 1965 to 5 percent in the third quarter of 1969. In the Northeast where the rate was already tight showing a vacancy rate of 5 percent in 1965, current statistics show only 2.8 percent of units vacant.

(*b*) The possible liability of offering for sale a structure which may be old in a neighborhood which is not attractive to new buyers.

PROPOSED SOLUTIONS

Former Secretary of Health, Education, and Welfare, Wilbur J. Cohen, recommended:

> * * * elimination of the State and local property tax on homes and the closing of loopholes in the Federal and State personal and corporate income tax and an increase in the yields of the inheritance and gift taxes. * * *[7]

He noted that there was a trend in State Legislatures exempting all or part of the value of the homestead of a senior citizen from local property taxes:

> While I was Secretary I endorsed and supported this trend (and) this legislation in my opinion, has not solely been to give a tax advantage to senior citizens. It is a recognition of the fact that many low income persons among our aged live on fixed incomes. There are somewhere near 5 million aged in the poverty group and some 2 million more who are near the poverty group.[8]

[6] Hearing on "Homeownership Aspects of the Economics of Aging," by the Subcommittee on Housing for the Elderly, Special Committee on Aging, Washington, D.C., July 31, Aug. 1, 1969, p. 763.

[7] See pp. 749–750, hearing cited in footnote 6.

[8] See p. 748, hearing cited in footnote 6.

The former Secretary also recommended a U.S. Government corporation that could buy, sell, rent, and renovate residential property for senior citizens:

> The corporation could purchase the home of an aged person who was ill and pay the aged person a monthly annuity which might enable him to meet extraordinary medical or nursing home costs.
>
> Or the corporation could pay for remodeling the large home of an aged person and make it possible for one or more additional aged persons to live there, thus making it financially feasible for all the aged to have a comfortable residence at a reasonable rental.
>
> Older people, he said, fear losing their homes: "They have anxieties about financial transactions. They fear being defrauded. They are sometimes hard of hearing, or senile, and cannot understand the complexities without adequate help."
>
> All of these considerations make it desirable to have a friendly and reliable organization for older people which could help them with their housing needs.[9]

ROLE OF AID TO EDUCATION

Dean Cohen also described "an adverse impact on our educational system" caused by "conflict or controversy between the interests and needs of older persons and younger persons." He described the tendency of many older persons to vote down bond issues for elementary and secondary education. But, by increasing the Federal share of the costs of education, property taxes could be reduced while school needs could be met. Mr. Cohen said:

> We need vastly increased funds for education in this country, * * * local bodies cannot finance this adequately through the proper action. I believe we must increase Federal and State funds for this purpose and reduce the relative impact of local residential property taxes on educational and public services purposes. I believe we should also include in appropriate Federal legislation an incentive to reduce or repeal residential property taxes which would have a tremendous impact and advantage not only to senior citizens but to our educational systems.
>
> This incentive should be included in an appropriate bill providing Federal aid for elementary and secondary education or for other essential public services.
>
> One way it could be done, and this is merely illustrative, is to earmark a given sum for education such as $400 million—roughly $2 per capita—and allot this amount in relation to State and local tax effort, exclusive of residential property taxes, thus giving an incentive to State and local taxation from nonproperty tax sources. I believe we should do something along these lines before Congress adopts any general shared revenue legislation on a noncategorical basis. I believe

[9] Wilbur Cohen's proposal as reported and summarized by Theodor Schuchat, retirement editor, North American Newspaper Alliance, September 1969.

this has a much higher priority than any of the proposals I have seen for shared revenue.[10]

HOMEOWNER ANNUITY

Professor Yung-Ping Chen of the University of California at Los Angeles had a somewhat similar proposal with far-reaching implications. Under his proposal retirees could "sell" their houses for a lifetime annuity income and still have the use of their own homes for the remainder of their lifetime.

Professor Chen has described his home sale and annuity purchase plan in these terms:

> An older homeowner, assured of lifetime tenure in the house, would create an irrevocable escrow to convey the property title to a financial intermediary—possibly an insurance company or a pension fund—at the death of the owner or spouse, if later, in exchange for a monthly annuity income, which I call a housing annuity.
>
> The amount of the annuity would be based on the appraised value of the property, the amount of home equity, the life expectancy, and the generally expected rate of price inflation.
>
> If the owner wanted to change his residence later, he would have the option of selling his house to a third party and paying back the annuity payments plus interest or the option of conveying title to the financial intermediary and thus receiving additional annuity payments.
>
> The problem of property value changes would be solved by a variable annuity arrangement or a renegotiation clause for adjusting annuity payments. If the FHA, for example, could guarantee the property's value over its economic life in return for an appropriate insurance premium, the homeowner-annuitant would not face the prospect of reduced annuity payments.*

Commenting on the Chen plan, a retirement editor later wrote:**

> Today, according to Professor Chen, a $10,000 annuity bought at age 65 would assure a retiree and his wife of between $53 and $60 per month of income for life. Under his plan, a home worth $10,000 would bring the same couple only half as much, he estimates, but they would also continue living in their home for life.
>
> The Chen plan poses some problems, as its author admitted to the Senators. It would not permit a couple to will their home to their children. On the other hand, swapping the home for an annuity would be entirely voluntary.
>
> He believes that enabling retirees to derive current income from their homes is a better way of helping them than granting property tax reductions to elderly homeowners, as many counties and States do now.

[10] See p. 749 hearing cited in footnote 6.
*See p. 828, hearings cited in footnote 6.
**Article by Mr. Schuchat cited in footnote 9.

"Although tax reductions result in increased income," he contended, "the increase is usually rather small. By contrast, my proposal would bring forth larger increases in income."

At least one major insurance company has formed a group of experts to study the possibilities of the Chen plan with its author.[11]

Mrs. Marie C. McGuire, Special Assistant for Problems of the Elderly and Handicapped of the Department of Housing and Urban Development, in testimony before the subcommittee gave her thoughts as to what should be the government's policy with regard to homeownership by senior citizens:

> In brief, we want to help older people to remain independent as long as feasible, which is their own primary objective. At the same time, we hope to expand their effective range of housing choices and at rates they can reasonably afford.[11a]

III. EXISTING PROGRAMS

A. The Reorganization of HUD and a Program Status Report

On November 7, 1969, Secretary George Romney announced plans for a major revamping of the Department of Housing and Urban Development. Policy goals were described as greater efficiency, responsiveness and service. The Secretary also announced the policy of finding ways to entice large numbers of white middle class suburbanites back into the central city and to make it possible for many poor inner city residents to move out.

The effect of this reorganization on the elderly cannot be measured as of yet but it is significant that the Federal Housing Administration has given greater decisionmaking power to FHA's 75 district insuring offices. Whereas Washington and the regional offices held tight rein on the purse strings in allocating the $25 million available in 1968 under the section 235 interest subsidy program, the 75 FHA insuring offices are now given complete authority to allocate the $45 million available in supplemental funds which became available in July 1969.

The support of HUD for housing programs for the elderly continued at a constant level through 1969. From the inception of this program in 1956 until the present, the cumulative number of dwellings under the several senior citizens programs rose to nearly 326,000. These dwellings are estimated to serve approximately 408,000 senior citizens.[12]

Low-rent public housing continued to be the largest program, accounting for a total of 233,878 units through September 30, 1969. This compares with a total of 183,154 units at the end of 1968.

The FHA section 202 direct loan program under FHA at the end of the third quarter of 1969 accounted for 45,687 units as compared with the 1968 figure of 42, 652 units.[13]

The new FHA section 236 program authorized under the 1968 Housing Act accounted for 3,269 units through the third quarter of 1969.

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[11] Cited in foootnote 9.
[11a] Testimony at hearing cited in footnote 6, p. 758.
[12] See app. 1, p. 210, for report from HUD including tables showing State-by-State project grants.
[13] Substantial discussion of the 202 program is found in pt. IV of this chapter dealing with the 1969 Housing Act.

The FHA section 231 mortgage insurance program which incorporated the old section 207 accounted for a total of 43,115 units in 1968 but there were no new starts under this program in 1969.

B. Appropriations for HUD in Fiscal Year 1970

The independent offices appropriation bill which contains the allocations for the Department of Housing and Urban Development passed the Congress on November 18, 1969. The total appropriation for the Department was $1,869 billion which was down from the appropriation of $2.155 billion for fiscal year 1969. Significantly, the programs of special interest to the elderly with the notable exception of the section 202 direct loan program all received an increased level of support.

The Congress appropriated $90 million for the homeownership assistance under section 235, which is an increase of $20 million over the fiscal year 1969 appropriation of $70 million.

The interest subsidy section providing rental housing assistance under section 236 received an $85 million appropriation, a gain of $15 million over the $70 million appropriated last year.

The appropriation for the rent supplement program was raised $20 million over last year to a total of $50 million for fiscal year 1970.

There was no request in the budget for an appropriation for the section 202 direct loan program and accordingly the entire $25 million appropriation for fiscal year 1969 was deleted.[14]

C. Operation Breakthrough

The Proxmire amendment to the Housing and Urban Development Act of 1968 made possible a significant program entitled "Operation Breakthrough." Senator Proxmire described this program as follows:

> I proposed an amendment that HUD construct 1,000 units each of at least five different housing prototypes over a 5-year period—or a total of 25,000 units—to test whether new housing construction techniques could bring substantial reductions in housing construction costs. The amendment was agreed to, and the funding for the units was provided in the bill.
>
> My proposal was based on a unanimous recommendation of the Douglas commission, officially called the National Commission on Urban Problems, which had both done detailed work on housing needs and which in its hearings and studies had been dismayed at the lack of housing production and the absence generally of modern techniques and mass production methods in housing.[15]

During 1969 there were 621 entries from which 20 shall be selected. These winners of the national competition will be given the opportunity of building prototype housing on sites in Memphis, Indianapolis, Jersey City, St. Louis, Sacramento, Houston, Seattle, Macon (Georgia), Wilmington (Delaware), and Kalamazoo (Michigan). Mr. Harold B. Finger, Assistant Secretary for Research and Technology in

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[14] Source of appropriation statistics, Congressional Record, Nov. 18, 1969, S14576.
[15] Congressional Record, Dec. 17, 1969, S17068.

HUD, indicated that "quite a few" of the experiments planned by "Breakthrough" will be complete in 1970.[16]

A substantial roadblock in the way of "Operation Breakthrough" was removed on November 7, 1969, when three labor unions, the carpenters, electricians, and plumbers signed a contract with a New York manufacturer of module homes. The agreement marks the first time that the three unions have concurred in the construction of prefabricated homes.

Although pleased with this progress, Senator Proxmire said:

> The real test will be when we actually get volume production of decent housing in a suitable environment at reduced costs.[17]

IV. CONGRESSIONAL ACTION AND THE 1969 HOUSING BILL

A. The 1969 Housing Act

On December 12, Congress cleared the housing bill of 1969 for the President's signature. The bill which was subsequently signed into law on December 24, 1969, authorizes $4.8 billion for Housing and Urban Development funds through fiscal year 1971. This new housing bill primarily extended existing programs with a few notable exceptions to be discussed below.

The bill contained a number of provisions aimed at increasing housing for low-income persons. The bill increased the fiscal 1971 and 1972 contract authority for the section 235 homeownership and section 236 rental assistance programs; it raised room cost limitations for public housing projects; limited rent paid to 25 percent of tenant's income in public housing projects and increased direct loan authority under section 202 which provides loans to nonprofit sponsors providing homes for the elderly.

1. The new act meets a major criticism of the past, that urban renewal meant freeways or a shopping center but little in the way of housing for the poor by requiring that for every apartment razed as part of an urban renewal project, a new low-income unit would have to be built in the city or county involved.
2. In adopting the amendment proposed by Senator Edward Brooke, the Congress limited rents fixed by public housing agencies to no more than 25 percent of the tenant's income. Very low-income tenants may be charged less if the Secretary of HUD determines that paying 25 percent of their income would reduce their welfare assistance. The bill authorized $75 million annually in public housing subsidies which are made available through the basic annual contributions contract, rather than through a grant requiring a special appropriation. It is also notable that Congress has made a significant effort towards paying part of operating costs for public housing projects. Previously, operating and maintenance cost were handled entirely out of rents resulting in severe financial hardships for many housing units.

[16] Washington Daily News, Jan. 16, 1970, p. 26.
[17] Congressional Record, Dec. 17, 1969, p. S17068.

3. In terms of the general housing picture, construction cost limits per room are raised from $2,400 to $2,800 for public housing and from $3,150 to $4,200 for public housing projects in high-cost areas.

4. The downpayment required on FHA-insured homes valued at $25,000 was lowered from 20 to 10 percent.

5. The bill increased the maximum amount per mortgage of mobile home court projects from $500,000 to $1,000,000. It also authorizes FHA financing of mobile homes up to a maximum of $10,000 with repayment over 12 years. Senator William Proxmire underlined the importance of this provision pointing out the estimated number of 400,000 mobile homes were built in 1969.[18]

6. The Congress authorized $300 million for the urban mass transportation program in fiscal year 1971.

7. Extended to October 1, 1970, the authority of the Secretary of HUD to set maximum interest rates on FHA and Veterans' Administration mortgage loans.

8. The Congress added a new section of direct importance to the elderly by expanding the FHA section 232 nursing home program to include intermediate care facilities. This new program is congressional recognition of the existence of a vacuum in the continuum of housing programs for the elderly. Government policy had provided substantial assistance in the way of dwellings for the well elderly who were capable of independent living and on the opposite extreme for those elderly who are ill through assistance to nursing homes. The adoption of the Montoya amendment taken in conjunction with the 1967 amendment to the Social Security Act introduced by Senator Jack Miller, makes possible for public assistance recipients vendor payments to intermediate care facilities and will result in the filling of this vacuum. Personal care services will be provided for those people who cannot live independently and yet do not need skilled nursing home care.

The need for intermediate care facilities was highlighted in "Harvest Years" by James Frush, Jr., vice president and director of research, of Retirement Residence, Inc.:

> One study on the ambulatory aged shows that 15 percent can't clean house; 16 percent can't shop; 12 percent can't prepare meals. Not too long ago, the National Conference on Aging stated that of aged persons not in hospitals or nursing homes, 26 percent have one chronic medical condition, 20 percent have two, 31 percent have three or more, 43 percent have a chronic limitation of mobility or activity.[19]

B. The Status of the FHA Section 202 Program

The FHA section 202 program provides direct loans at 3 percent interest to nonprofit sponsors providing homes for the elderly. Under this program it is possible to borrow directly from the Government 100 percent of the cost of any project.

According to Senator Frank E. Moss, chairman of the Subcommittee on Housing for the Elderly:

[18] Congressional Record, Dec. 12, 1969, p. S16552.
[19] "Harvest Years," December 1969, p. 9.

> The 202 program had been one of the most effective and efficient of our housing programs. Nonprofit sponsors had learned the procedures and had begun to develop a sizable volume of projects until the program was harshly interrupted by a HUD policy which in effect required conversion of all 202 projects to FHA section 236 financing upon completion. This abrupt termination was a result of a misunderstanding of the 1968 Housing Legislation which authorized section 202 sponsors to convert to section 236 on a voluntary not a mandatory basis.[20]

The action of HUD in deleting the section 202 program was in keeping with the administration's announced policy against direct loans by the Government.

Under the reorganization of HUD by Secretary Romney, all requests for Federal assistance for housing for the elderly were channeled under section 236 which is an interest subsidy section requiring a sponsor to shop for financing on the marketplace in competition with other borrowers.

Mr. Richard Fullerton, housing consultant of the American Institute of Housing Consultants, Inc., in a March 3, 1969, letter to Senator Frank E. Moss forcefully pointed out the difference between section 202 and section 236 financing:

> 202 is accepted on the local scene in many ways:
>
> 1. Local taxes are waived or abated. 236 will be fully taxed, raising rents about $30.
> 2. Local zoning is adjusted to serve. The project by its very nature will be subject to all the parking and other zoning requirements of commercial apartments.
> 3. Even the utility companies' "single metering" for a greater savings to the tenant. 236 projects will require a separate meter for every apartment, everyone will pay more.
>
> 202 is a program guided and controlled by the sponsoring church or charitable organization.
>
> 236 is a builder's and broker's dream whereby they take great profits out and leave the church to manage a costly and awkward mortgage and the Government to foot the bill.
>
> 202 has its own architectural criteria which realistically fit the needs of the elderly.
>
> 236 is subject to all of the FHA minimum property standards.
>
> 202 provides benefits for the tenant, the needy.
>
> 236 provides huge benefits for the opportunists, the greedy.
>
> The intent of Congress was and is that section 202 should continue to function while section 236 is being tested.

Mr. Fullerton had further comments in testimony before the Senate Subcommittee on Housing and Urban Affairs of the Committee on Banking and Currency in hearings on July 25, 1969:

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[20] Speech before the American Association of Homes for the Aging, St. Louis, Mo., Nov. 17, 1969.

> Surely, the awful differences have shown up sufficiently in stark outline. * * * The net result is that an apartment complex worth $2,807,000 cost the tenant $24.81 more per month (under sec. 236) and cost the Government $5,397,910 more over the mortgage. The information section of HUD has done a marvelous job to make the public believe that the new way is cheaper than the old. The increase in the subsidy alone comes to exactly twice the whole cost of the entire project. The Government can do three 202 projects for the price of one 236.
>
> Cannot we together face the fact that under the frugal and careful direct loan program the modest subsidy is in behalf of the elderly tenant while in section 236 the subsidy is 3½ times as much and is obviously in behalf of the moneylenders. Actually, the lenders could not perpetrate this until they convinced the public that the interest subsidy gimmick makes the deal "private." Nothing could be further from the truth. It is public money going to the lenders in huge amounts instead of public money going to the elderly in small amounts.
>
> But the insult added to injury is this: The old folks and the poor people both are used as pawns. Their scant dignity is sacrificed to those who have money to lend. They submit to a pauper's oath to be eligible to live in a subsidized apartment while the lenders are encouraged to pose as compassionate patriots by accepting great largess from the public purse.[21]

In reaction against the deletion of the section 202 direct-loan program, the Senate Banking and Currency Committee and its counterpart in the House made known in the strongest possible language their congressional intent that the program be continued.

The housing bill of 1969 accordingly contains an authorization of $150 million effective December 24, 1969, the day that President Nixon signed the bill, for the continuation of the 202 direct loan program. But an authorization is not an appropriation.

> **Significantly, as was pointed out earlier in this chapter, no funds were requested by the administration for 202 and the Appropriations Committees of the Congress accordingly deleted even the diminutive $25 million appropriation that 202 had received in fiscal year 1969.**

Even if the Appropriations Committees should make funds available for section 202 there is no guarantee that this would bring about the program's restoration in the face of administration hostility to direct loan by the Government even where granted to deserving nonprofit sponsors who endeavor to build badly needed housing for the elderly.

[21] HUD legislation of 1969 hearings by the Subcommittee on HUD, Banking and Currency Committee, U.S. Senate, July 25, 1969, p. 427.

C. The Uniform Relocation Assistance and Land Acquisition Policies Act of 1969

Passage in the Senate on October 27, 1969, of Senate bill 1, the Uniform Relocation [22] Assistance and Land Acquisition Policies Act is considered of significant import to the poor and the elderly. The purpose of this bill was spelled out by its sponsor, Senator Edmund S. Muskie:

> Mr. President, the Uniform Relocation Assistance and Land Acquisition Policies Act of 1969, will establish a uniform policy with respect to relocation assistance and land acquisition involving Federal and federally assisted programs.
>
> This is as high priority a measure as stands before the Senate. There are more than 50 Federal programs which result in the condemning of land and quite literally, the bulldozing of hundreds of thousands of people from their homes and businesses annually. Many of these people are low-income families. Many are the elderly. Here, the record is clear. Nearly all federally assisted programs have differing, if not conflicting, provisions for helping those displaced.
>
> The primary objective of S. 1 is to establish a uniform policy among Federal agencies, and State and local recipients of Federal funds in their dealing with property owners and others displaced by Federal or federally aided land acquisitions.
>
> Specifically, S. 1, does this in two ways: First, it provides for relocation payments, advisory assistance, assurance of available relocation housing, and economic adjustments and other assistance to owners, tenants and others displaced; and second, it establishes policies to guide all Federal and federally assisted agencies in negotiations with owners for the acquisition of real property for public use.[23]

The Senate-passed bill was referred to the Public Works Committee of the House which scheduled hearings for February 1970. The outlook is considered good for its passage by the House.

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[22] Subcommittee on Involuntary Relocation of the Elderly:
Part 1. Washington, D.C., Oct. 22, 1962.
Part 2. Newark, N.J., Oct. 26, 1962.
Part 3. Camden, N.J., Oct. 29, 1962.
Part 4. Portland, Oreg., Dec. 3, 1962.
Part 5. Los Angeles, Calif., Dec. 5, 1962.
Part 6. San Francisco, Calif., Dec. 7, 1962.

[23] Congressional Record, Oct. 27, 1969, p. S13278.

CHAPTER V

TRENDS IN LONG-TERM CARE

Medicaid and Medicare costs continued to rise to unanticipated heights during 1969, deepening a climate of urgency about high Federal outlays for care provided in nursing homes and other long-term care institutions. That sense of urgency was sometimes expressed in terms of alarm—as at hearings before congressional committees—and also in projections of future developments for which preparations must be made.

The past year saw worsening of personnel shortages, widespread complaints about retroactive denial of benefits under Medicare; and charges of "cheating" or undue costs under federally assisted programs.

In 1969 the number of licensed nursing home beds reached well over 1 million; many "chain" operations flourished and a growth rate of 300 beds a day continued through 1968 and 1969. If the average size of a nursing home is 42 beds, then statistically seven nursing homes were built every day last year.

But—according to the American Nursing Home Association—the period of greatest growth lies just ahead: At the present rate, nursing homes will pass the 2 million-bed mark by 1975.

I. THE NURSING HOME "INDUSTRY"

Twenty years ago, nursing homes had 1.2 percent of the U.S. health dollar. That share rose to 4 percent by last year, when expenditures reached more than $2.5 billion, or 400 times the 1960 total. Close to 1 million Americans are in nursing homes.

Women outnumber men by 2 to 1; 1 out of 3 patients is past age 85; and 88 percent are past age 65. The average age: 81. The average stay: more than a year. Monthly charges range from $245 to more than $1,000 a month.

Federal expenditures.—Two out of every three dollars that go to nursing homes are from public coffers, and the greatest share comes from Medicare and Medicaid.

Approximately one-fifth of all nursing homes—4,800 or thereabouts—were certified for reimbursement under Medicare at the end of 1968. There were close to 1 million Medicare admissions that year, for a total Federal share of $500 million. Roughly the same amount was expended in 1969.

Under Medicaid, $1.1 billion was spent in 1968, and outlays increased to $1.3 billion in 1969.

II. "CHEATING" AND OTHER CAUSES FOR CONCERN

> When on January 1, 1967, Medicare's extended care program went into effect—suddenly there sprang up beautiful modern buildings surrounded by lovely grounds. What we did not realize was that many of them lacked a "heart"—good nursing home care.—Marie Villing, R.N. with 25 years experience in the field, from an unpublished manuscript entitled, "Which Home has the Heart."

Since the Federal Government is the major supporter of the nursing home industry, any change in policy will have a far-reaching effect on the industry. In 1969 the new administration did institute changes which restricted access to Federal money for both users (patients) and providers (nursing home operators).

Senator Russell B. Long, chairman of the Finance Committee of the Senate chose July 1, 1969, the third anniversary of the Medicare program, to launch a series of hearings on Medicare and Medicaid. He said:

> * * * They've done a lot of good for a lot of people and can continue to serve the national interest in the future * * *. We want the care to be high quality. But, we think it should be provided on a basis that is efficient and economical, not on a basis that is wasteful and extravagant.
>
> * * * However, during the past year we have progressively stepped up our scrutiny of the Medicare and Medicaid programs. Today, we are quite capable of identifying and pinpointing major areas of concern—including widespread abuse, and fraud, as well as lax administration. It almost appears as if everyone involved in Medicare wants to make that extra buck at the expense of the taxpayer and the millions of older people in Medicare.[1]

The Finance Committee's hearing report asserted that Medicare and Medicaid are in serious financial trouble. As primary evidence of this they point to the fact that the projected estimates for the year 1970 are much too low. Initial estimates offered at the enactment of the programs in 1965, have been exceeded on the average by 50 percent according to the committee. In the specific case of nursing homes under Medicare (extended care facilities) the projected estimate will have been exceeded 10 times over.

The estimates for nursing homes under Medicare were spelled out in terms of 1965 projections for the year 1967. It was estimated that the average daily charge of a nursing home would be $11 and that average utilization would be one-sixth of a day per beneficiary or a total cost of $1.80 per beneficiary per year. The actual cost of a day in a nursing home in 1967 was $18 and the length of stay was an average of one full day. By this calculation the total cost to the program, $18 per beneficiary per year, was 10 times the original estimates.

To the Finance Committee, reasons for the increase in cost were easily discernible. First it was said that Medicare and Medicaid programs were both cause and victim of the inflated medical costs. Blame was fixed on a lack of an effective control mechanism to deal with over-

[1] Hearing before Senate Finance Committee, July 1, 1969, "Medicare and Medicaid," p. 1.

utilization and abuses of the program on the part of recipients and providers. General inflation and administrative laxity were the other reasons cited.

Among the abuses cited by the committee were widespread "kickbacks" to doctors, druggists, and other suppliers and of conflicts of interest such as physicians sitting on the utilization review committee of a hospital or nursing home in which they had a vested financial interest. Mention was made of "gang visits." A physician, for example, would visit a nursing home and "see" 30 or 40 patients within a couple of hours and charge Medicare $400 or $10 a visit per person.

The committee attacked the Social Security Administration as not being concerned with the quality of care or with holding down costs. Unfortunately, the Finance Committees' revelations were used in justification of increased taxes, deductibles and premiums paid by seniors and in support of cutting back the availability of services. These trends in 1969 can be measured with the following examples:

1. In September 1969 the President submitted to Congress a proposal calling for an additional $136 billion in Medicare payroll taxes over the next 25 years. The proposal supplements taxes already scheduled under the Social Security Act. Some $131 billion represents the amount by which Medicare's expenditures are expected to exceed its anticipated income with the additional $5 billion as a safety factor. The purpose of these additional taxes is to prevent the projected 1973 exhaustion of the hospital insurance trust fund.

2. The first $40 of hospital cost was deductible, that is to say payable by the patient, when the Medicare program took effect in July of 1966. By January 1, 1969, the deductible had been raised to $44. Effective January 1, 1970, the deductible was raised to $52 with the promise of a projected jump to $84 by 1974.

3. The part B portion of Medicare which goes to pay doctors' bills had required the initial payment of a $3 premium when Medicare began. The $3 premium was matched with Federal funds in equal amount. The premium had been raised to $4 where it remained until December of 1969 when it was increased 32 percent to $5.30 a month effective July 1970. The increase will raise $600 million annually with the Government providing $300 and the remaining $300 being made up by the Nation's 20 million elderly.

4. The Finance Committee attacked the cost-plus formula for reimbursement which was said to be inherently inefficient. Effective July 1, 1969, the date of the hearing, the 2-percent bonus above actual cost for hospitals and nursing homes was eliminated. Senator Long made the announcement in his opening statement and claimed that the measure will save the taxpayers $100 million in fiscal year 1970. Significantly, Commissioner Robert Ball indicated that the 2 percent—1½ percent in case of proprietary institutions—allowance in addition to accounted-for costs was not a bonus, but represented a finding that some costs were present that were not otherwise expected to be specifically provided for in the costs accounted for and apportioned to Medicare:

> But, I would not agree that the 2 percent was over and beyond cost. It was over and beyond defined and accounted for cost.[2]

[2] Testimony cited in footnote 1, p. 96.

5. In the Finance Committee report there was much discussion of the abuses that are possible in the manipulation of the depreciation allowance. The administration obliged early in 1970 by knocking out all accelerated depreciation for hospitals and nursing homes receiving Medicare funds, and required the use of the lowest of three possible computations for the depreciation basis.

6. The abuses of physical therapy disclosed, included an instance of a nursing home with 81 patients who received a total of 2,309 chargeable treatments at $9 each for a total of $20,781.

"That meant that the daily average of 136 units of therapy was rendered every day except Sunday," said Senator John J. Williams of Delaware. The result was the Bureau of Health Insurance intermediary letter No. 173 which has the unhappy effect of relegating almost full responsibility for physical therapy to the nursing staff. Dr. Michael B. Miller, medical director of the White Plains Center for Nursing Care, commented:

> There is one more bombshell that came in this week. That is ECF No. 173 related to physical therapy services. If you will look under section B, Restorative Nursing Care, it says: Restorative nursing care would include such measures as maintaining good body alinement and proper positioning of bedfast patients, keeping patients active and out of bed in accordance with physicians' orders, and developing patients' independence in activities of daily living by teaching self-care, transfer and ambulation activities. In addition, nursing personnel should assist patients in adjusting to their disabilities, in practicing the use of prosthetic devices, and in carrying out prescribed physical therapy exercises between visits of the physical therapist.
>
> We have just knocked out professional physical therapy. What the fiscal intermediary and the Social Security Administration are now saying is that physical therapy should now be carried out by a nursing staff already overloaded but it is untrained in physical therapy. Guess who is going to do this kind of physical therapy—the RN. The LPN is scarcely as oriented. Your nursing aide is going to be doing this.
>
> Who are the nursing aides? Please believe me we are devoted to them, we appreciate their willingness to help old sick people. Usually nurses aides are working people one step above literacy—well intentioned but untrained and uninformed people. We want to put into their hands the most sophisticated, the most sensitive treatment programs for the aged that took 20 years for rehabilitation medicine to establish in one fell swoop. We will have nurses aides training patients in prosthetic uses. Something must be seriously wrong.[3]

7. There was also discussion of some nursing home administrators receiving salaries up to $75,000. The response in early 1970

[3] Hearings, "Trends in Long-Term Care," pt. III, Hartford, Conn., Jan. 15, 1970; not in print at time of publication.

was an order to the intermediary by the Social Security Administration to review salaries paid to nursing home operators and to their staffs. Like most SSA requests, this action was retroactive to 1967. (The letter referred to above is classified as secret and is not available to nursing home people or to the public generally.)

8. Other issues that received attention were methods to freeze physicians fees; i.e., ceilings on certain medical charges; the possible exclusion of "bad performers," providers who did not make "proper" use of the system; and alternatives to the present cost reimbursement formula. No action has been taken on these proposals but logic suggests that these further changes may also be instituted.

9. The basic attack of Medicaid was that it was much more expensive than anticipated, that Medicaid standards allow lower quality of care than Medicare and that in spite of the 57-percent increase in Medicaid outlays in 1967–68, there has only been a 19-percent increase in the people served in the same 2 years. Early in 1970 the administration announced a cutback in Medicaid funds indicating that Federal funds were no longer to be available for patients who were custodial. Custodial patients, it was said, are the responsibility of the States. This announcement fell upon a backdrop of facts indicating that Medicaid payments in most States are inadequate. For example, the rate in California is $14 a day which—as Miss Gladys Strauss, a nursing home administrator and member of Mayor Alioto's Technical Advisory Council on Aging, points out—works out to 58⅓ cents an hour over a 24-hour period.

"For this amount you are supposed to provide 24-hour nursing care, feeding, laundry, housing, food, therapists, gowns, wheelchairs, walkers and, ah, yes, tender loving care as well,"[4] she added.

In defense, the Social and Rehabilitative Services responded to the Finance Committee's report with a statement presenting information "to place in perspective preliminary findings by the committee staff which in many instances are based on a relatively small number of cases of abuse, generally identified by the Social Security Administration and reported to the Senate Finance Committee for its information."[5]

Miss Charlene Birkins, director of the Colorado State Department of Welfare and a member of National Advisory Council on Nursing Home Administration commented:

> I spent one solid day and a half after the releases came out from Washington concerning this study where one physician got $326,000 in Colorado. This turned out not only to be the wrong provider code number that was released, but this $326,000 went to a hospital where it covered physicians' service for about 127 doctors. I call for more accuracy and less

[4] "Trends in Long-Term Care" pt. V, a hearing held in San Francisco, Calif., on Feb. 12, 1970; not in print at time of publication.

[5] A more complete response, "Department of Health, Education, and Welfare comments on the Senate Finance Committee Recommendations for Changes in Medicare and Medicaid," was issued on Feb. 26, 1970. This document noted several important areas of agreement on which the Department had already initiated action but it also challenged several staff recommendations.

sensationalism out of reports coming from Washington generally.[6]

III. THE STRUGGLE FOR HIGHER STANDARDS

A. Licensing the Administrator

Senator Edward M. Kennedy introduced an amendment to the Social Security Act that became law in 1967 requiring the licensing of nursing home administrators.

> * * * the operator or administrator of a nursing home is the key person in assuring that the care received by nursing home patients is of a very high quality.

said Senator Kennedy in support of his amendment.[7]

The amendment set up the National Advisory Council on Nursing Home Administration under the Department of Health, Education, and Welfare to advise the Secretary of Health, Education, and Welfare and the States with regard to implementation. The committee's report under chairman Dr. Harold Baumgarten was completed in July 1969 and released to the States early in 1970.

Under the provisions of the amendment States are required to license administrators of all nursing homes whether or not they provide care to Medicaid patients. Beyond setting standards, issuing licenses, States must measure compliance, investigate, and act on complaints. The States are allowed to waive, temporarily, certain standards for individuals who meet the requirements of good character and suitability and have been employed as nursing home administrators for a calendar year before the licensing program takes effect. The price to the State for use of the waiver provision is that such State must set up training courses to help individuals so licensed to qualify for full licensure by July 1, 1972. Federal funds will be available to pay up to 75 percent of the approved training program.

The American Nursing Home Association has welcomed the Kennedy amendment as a step toward "professionalization."

B. Implementing the Moss Amendment

The 1967 amendment to the Social Security Act which bears the name of its sponsor, Senator Frank E. Moss, was one of the most potentially constructive and far-reaching acts of legislation to affect the nursing home industry. His amendment to Title XIX (Medicaid) had the intent of raising standards of care in nursing homes. The amendment calls for the States to set up medical review teams which would inspect skilled nursing homes on a regular basis and evaluate the medical care provided in terms of adequacy for patient needs. This part of the amendment has not been implemented by the Department of Health, Education, and Welfare. Some of the other provisions such as recordkeeping arrangements, ownership disclosure, nursing home-hospital arrangements, meal planning and supervision, State licensure of nursing homes, and compliance of Medicaid homes with the

[6] Hearings, "Trends in Long-Term Care," pt. VI, Salt Lake City, Utah, Feb. 13, 1970; not in print at time of publication.
[7] See *Developments in Aging, 1967*, p. 87.

Life Safety Code of the National Fire Protection Association have fared somewhat better.

The year 1969 marked the first time that States were asked to send in their records to Health, Education, and Welfare as provided for by the provision under the Moss amendment requiring that people with a 10 percent or greater interest in a nursing home make such disclosure to the State. In June of 1969, the Secretary of Health, Education, and Welfare, Robert Finch published in the Federal Register the interim standards for skilled nursing homes purportedly in implementation of the Moss amendment.

On July 30, 1969, Senator Moss called for a hearing on the so-called interim standards which he said were "directly antithetical to Congressional intent."[8] Appearing at the hearing were members of all interested and affected professional groups and speaking for the administration was Thomas Laughlin, Acting Commissioner, Medical Services Administration, Social and Rehabilitative Service.

The focus of the hearing was the requirement for nursing supervision during the afternoon and evening shifts (4 p.m. until 8 a.m.) in skilled nursing homes. The interim regulations provide that until July 1, 1970, practical nurses, licensed by waiver may be in charge on shifts other than the day shift which must have registered nurses in charge.

Speaking for the American Nursing Association was Mary E. Shaughnessy, associate professor, Department of Graduate Studies, Duke University School of Nursing, and a member of the ANA Commission on Nursing Services. Miss Shaughnessy said, in part:

> The proposed interim regulations issued in the Federal Register on June 24, 1969, concerning Standards for Skilled Nursing Homes ignore the need for adequately prepared personnel and propose to pay from taxpayer funds for care that cannot be forthcoming * * *.
>
> One of the reasons given for the lowered standards is the shortage of qualified nurses. The availability of qualified personnel should not be the factor which determines the standards for an establishment. Rather, the standards should be set according to the services that are to be provided.[9]

"The interim standards," commented Senator Moss,[10] "have the effect of lowering standards below their former level."

> We are left, therefore, with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes "properly supervised nursing services" on the afternoon and night shifts. It is the duty of Congress and of the Department of Health, Education, and Welfare to see to it that these patients who must use nursing homes receive the quality of care being purchased.[11]

The response of the Department of Health, Education, and Welfare was to turn the issue over to the Task Force on Skilled Nursing Home

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[8] Speech before American Association of Homes for Aging, Nov. 17, 1969, St. Louis, Mo.
[9] Hearings, "Trends in Long-Term Care, pt. I, July 30, 1969; pp. 68, 69.
[10] Speech cited in footnote 8.
[11] For more detail on the battle over standards for skilled nursing homes in implementation of the Moss Amendment, see December 1969 *Hospital Practice*, by Mal Schecter, in appendix 6, p. 375.

Care established under the Medical Services Administration, Social and Rehabilitation Service. The first report of the Task Force was not acceptable to all the members and was redrafted. This revised draft was presented to Secretary Finch in November of 1969. As of this writing, the contents have not been officially made public. But in his speech before the American Association of Homes for the Aging on November 17, 1969, Senator Moss indicated that contents of the report of the Task Force "were encouraging" and that reportedly, the SRS Task Force had recommended a strict interpretation of the Moss amendment limiting supervision on other than the day shifts to registered or licensed practical nurses and setting forth ratios of staff to patients and supervision to staff.

> We must be ever vigilant to insure the highest standard of care for those who unfortunately must spend long periods of time in our nursing facilities,

commented Senator Moss.[12]

IV. MEDICARE REVISITED

Part II of this chapter delineates in some detail the changes that have occurred in the Medicare program in 1969. It is suggested that part of the reason for these changes was the hearings and report of the Senate Finance Committee. It is suggested that the changes reflect the thinking of a new administration with different thinking on where health falls in terms of priorities. A further reason is, of course, the active participation in the Medicare program by our 20 million elderly, by providers and those offering ancillary services.

The Medicare nursing home program took effect in January 1967 and in that year the Government paid out $250 million under the program. The estimate for the first year cost of this extended care program was $25 to $50 million dollars. The huge increase over the estimates was due to rapid certification of nursing homes and conditions of certification that were "lower than had been anticipated." [13]

In 1968 the Federal payment to nursing homes under Medicare went up to $500 million and the new administration was determined to cut costs and increase efficiencies in 1969.

In easy stages the Social Security Administration directed the intermediaries to start pulling in on the reins. Up until these directives in early 1969 the primary function of the intermediary was as a conduit for funds. There were little if any eligibility requirements to get nursing home extended care other than preadmission for 3 days to a hospital.

One of the first directives decided that Medicare would not pay for patients who were merely custodial. Even if they needed the extension of the kind of care that they were receiving in the hospital they would not be compensable unless they had rehabilitative potential. All terminal patients were excluded at once with great savings to the Government.

The next major step was the controversial Intermediary Letter No. 371 which decreed that beyond having rehabilitative potential patients

[12] Speech cited in footnote 8.
[13] Robert Myers, Chief Actuary of the Social Security Administration, Aug. 4, 1969, memorandum to the Senate Finance Committee.

were only compensable if they fell within the narrow category of skilled nursing care and covered care was defined within the letter. From a medical or clinical point of view the definitions of skilled nursing home care are artificial if not nonsensical, according to Dr. Michael B. Miller, who cited a few examples:

1. Feeding a patient is an unskilled service under current regulations and is not compensable, and yet a common problem among nursing home residents is loss of weight. Many patients lose up to 50 percent of their body weight during their stay in a home.

> We don't know how to feed patients today because nobody has ever studied it. I have noticed that some nurses can feed certain patients but not others. I'd like to know why.[14]

2. Giving drugs currently is a skilled service unless given by mouth. According to Dr. Miller this is nonsensical because a great many patients who are emotionally sick or with organic brain damage should not be entrusted to take the medication themselves, which is what happens today. Further science has been working these many years for an alternative to the needle and with success it suddenly becomes an unskilled service.

> It is just as easy to give an overdose of drugs by mouth as it is by injection.[15]

3. The insertion of catheters is a covered so-called skilled service but the care and treatment of the patient from then on is currently classified as an unskilled service.

> The use of catheter is fraught with dangers because there is no way that it can be accomplished without putting infection in the body. Just raise the receptacle of the incatheter up to bed level and I will guarantee you the patient will have fever and chills within 36 hours. Mishandling in the slightest degree can lead to death and yet this is not classified as a skilled service.[16]

With these new directives the function of the intermediary changed to making decisions as to whether individuals were compensable, if they and the nursing home meet eligibility requirements, and if the written forms were filled out in good order.

Mention has been made of Intermediary Letter No. 173 which relegates physical therapy to nurses, orderlies and aides by a more than generous definition of restorative nursing care. In effect, the new requirements simply expand the function and the responsibility of nurses to include what used to be acknowledged physical therapy functions.

The effect of the new directives issued since January 1969 has been sharply restrictive cutting down on utilization of nursing homes. Neither physicians nor operators could guarantee payment by Medicare. For this reason and because of retroactive denials and the obligation to pay back payments received from Medicare on the basis of some future determination of past cost allowances, more than 500 nursing

[14] Hearing cited in footnote 3.
[15] Hearing cited in footnote 3.
[16] Hearing cited in footnote 3.

homes have dropped out of the Medicare program according to an Associated Press survey.

In the face of resistance of nursing home operators to receive Medicare patients, it is reported that physicians have had little choice but to retain patients in the hospital at three times the cost of nursing home care. Paradoxically, the Medicare machinery seems willing to pay hospital costs for patients who could be served just as well at one-third the price in a nursing home. In the effort to cut back on the number of days spent in the extended care facilities, the Social Security Administration has significantly increased the burdens on the hospital. Especially is this significant when it is remembered that payments to ECF's nursing homes under Medicare represent only 5 to 10 percent of total Medicare funds going to hospitals. Commissioner Robert Ball before the Finance Committee put it this way:

> Take all the ECF's, it is only about 5 percent of the cost of part A and in the hospital area, which is the expensive part * * * [17]

It is worth restating that the reasons announced for the changes were that Medicare and the nursing home program in particular had become more expensive than had been anticipated, and that there was a need for greater efficiency and economy. A freeze on Medicare nursing home admissions in and of itself is regrettable from the point of view of a patient in need of services.

If changes must be made because of financial limitations these new restrictions should properly operate prospectively. When changes are instituted retroactively, to the date the program became effective, then there are serious questions of equity and due process.

An example will serve to make the point more graphically. Hypothetically, a nursing home operator who incurred $5,000 in costs for a patient over 1967 and 1968 and has a claim pending in 1969 because the patient has been discharged or has died. Under the regulations announced in 1969 it could be decided that, for example, the patient was merely custodial, without rehabilitative potential. Accordingly, the claim pending would be denied retroactively to January 1, 1967, the date the extended care-nursing home program became effective. The $5,000 incurred in costs would have to be charged off as a loss because regulations prohibit soliciting among the relatives of a patient for payment. Even worse if the claim had been processed in 1967 or 1968 and the administrator had received a check, it could be decided under the 1969 regulations that the payment was made in error in light of these same 1969 regulations. The operator would then be faced with paying back in 1969 funds he had received from Medicare in 1968 or 1969.

The gravest injustice is the new regulation formulated in late 1969 requiring the intermediary to review wages for all employees and particularly salaries paid to administrators retroactive to January 1, 1967. The administrative guidelines for implementation of this new regulation are labeled classified information and are not available for public scrutiny. Certainly any employee in any occupation would be taken aback at the prospect of having his wages reviewed for the last 3 years and being faced with the possibility of paying back any amount which is now decided (using newly issued criteria) to have been excessive.

[17] Testimony cited in footnote 1, p. 116.

If Medicare is a contract between the Government and the elderly, it is a one-sided contract which the Government can alter at will. The only decision the recipient has is whether or not to participate. If he does participate he is constantly faced with higher deductibles for part A and with higher premiums for part B. The operator furnishing services may be in even a more tenuous position since there is no guarantee that he will be reimbursed for services rendered. In the face of retroactive denials and the obligation to pay back sums which upon review are decided to have been improvidently granted, it is small wonder that nursing home personnel say with Lee Dalebout, executive director of the Utah Nursing Home Association, that they are both glad and sorry for their experience with Medicare.

> We are glad that we have survived it (Medicare) thus far and sorry that we ever heard of it.[18]

V. HEARINGS: TRENDS IN LONG-TERM CARE

In December of 1969, subcommittee chairman, Senator Frank E. Moss announced hearings on "Trends in Long-Term Care" to be conducted in 1970.[19]

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

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

Senator Moss made clear his intent to emphasize the positive with these hearings:

> Inevitably we must deal with problems and unfortunately we sometimes give the impression that there is nothing positive in the nursing home industry. Nothing could be farther from the truth. We seek examples of America's finest nursing homes that can be used as models for the future.[20]

[18] Testimony at hearing cited in footnote 6.
[19] Hearings were held for several cities, including St. Petersburg, Fla., Jan. 9, 1970, pt. 2; Hartford, Conn., Jan. 15, 1970, pt. 3; Washington, D.C., Feb. 9–10, 1970, pt. 4; San Francisco, Calif., Feb. 12, 1970, pt. 5; and Salt Lake City, Utah, Feb. 13, 1970. A report based on these hearings is expected in 1970.
[20] Dec. 29, 1969, press release for St. Petersburg hearing.

CHAPTER VI

TRANSPORTATION AND THE ELDERLY

Aged Americans—whether they live in crowded city neighborhoods or deep in remote rural areas—are encountering transportation problems which apparently are worsening, despite growing Federal concern about public transit needs.[1]

Evidence for that conclusion was offered in 1969 at hearings by the Senate Committee on Aging and its subcommittees. It mattered little what the subject of the hearing was: transportation inadequacy was mentioned again and again as a complicating factor in other problems affecting the elderly.

Fortunately, both the U.S. Administration on Aging and the Department of Transportation have recognized that the problem exists, and have taken promising first steps toward action.

I. THE PROBLEM: "FORCED IMMOBILITY"

> It has been said that the United States is the only country in the world that consults its teenagers on world affairs and tells its older people to go out and play.
>
> Even if the older citizen accepted this admonition, he cannot afford the expense of getting to the playground.[2]

So said the director of a municipal office on aging recently in a New Jersey city which has seen the number of persons past age 65 increase from 14,000 to 18,000 in less than 10 years.

This increase in the population of elderly individuals is typical of such increases in other urban centers. As has been made clear at hearings on the usefulness of the model cities program to the elderly (see ch. 8), older Americans have disproportionately high numbers in the central city.

Describing the "forced immobility" of the elderly in such areas the director gave this description of transportation difficulties encountered in her community:[3]

> 1. Cost—which limits mobility for those on limited fixed income. This relates to employment for those who need a little extra work to supplement Social Security payments, participation in education, recreation and social events, visiting fam-

[1] Until the 1960's, the Federal interest in urban mass transit needs was not recognized in legislation. But beginning with a $25 million grant and loan program authorized under Housing Act of 1961, the program was expanded with the Urban Mass Transportation Act of 1964 and extended in 1966 and 1968. Establishment of a mass transit fund was proposed in 1969 by Senator Harrison Williams in S. 1032 and a later administration proposal (S. 2821).

[2] From statement by Miss Constance Midkiff, executive director, Paterson, N.J., Office on Aging, at information session on "Transportation Aspects of the Economics of Aging," Dec. 6, 1969, in Paterson.

[3] As cited by Senator Harrison A. Williams in Congressional Record, Dec. 19, 1969, p. E10790.

ily, friends, clinics, physicians, hospitals, shopping, etc. We have proposed reduced fares during the nonrush hours which we believe would create greater movement and increase business as well as relieve some of the isolation existing among older people. Even with permissive legislation now in existence, we have been unsuccessful in our efforts to reduce cost.

2. Schedules—during weekdays and Sundays long waits are necessary involving time and exposure especially dangerous to health in bad weather.

Many people are deprived of work and opportunity to worship in their own churches because they have no way to get there.

3. Routing—involving two fares are an extra drain on the pocket book and limit older people to their own living areas or neighborhood.

4. Lack of safety in the loading and unloading zones is often reported. Many complain of the difficulty of getting on and off buses. The handicapped are virtually isolated because of this problem.

What is true in this city is true in other metropolitan areas. Mass transit systems, so often described as the only rational answer to heavy automobile traffic during commuter peak hours, are faced by financial problems and dwindling ridership. Those that are solvent, or even profitmaking, may find it increasingly costly to provide service during nonrush hours.

Rural residents also face difficulties. As they grow older, they may find that automobile travel is too expensive or too risky. Whatever bus or other public transportation in earlier days may have existed is likely to have deteriorated or disappeared as the general population in many such regions dwindles while the percentage of elderly rises. (See Chapter VII, Older Americans in Rural Areas.)

Practical difficulties of many kinds arise, as indicated in this excerpt from testimony by the State Health Commissioner of Maine: [4]

> We have no public transportation system in the State of Maine that is worth a "hoot." For all practical purposes, we have no public transportation system.
>
> This leaves us with private transportation of one kind or another, like automobiles.
>
> Now, elderly people in general, at least of the kind we are speaking of with these kinds of problems, are not likely to have either the money or the abilities to provide their own transportation. There are community groups of one kind or another that on a voluntary basis have organized transportation services, but I think this is not a very dependable type of a system, and certainly it is not universally available.
>
> What I am saying, I guess, is that in the long run somebody is going to have to put money into the transportation system, because without being able to bring the patient and the necessary resource together, then obviously the resource is not of very much value.

[4] Dean H. Fisher, M.D. Commissioner of the Maine State Department of Health and Welfare, p. 571, "Health Aspects of the Economics of Aging," July 17, 1969.

I think to some extent we may even be talking ultimately of assisting elderly people to relocate so that the transportation and mobility problem no longer exist.

Question: Would it be possible that this kind of relocation would actually reduce Government expenditures?

Dr. FISHER. I think it would. One of the things I am talking about is adequate housing. There are a great many elderly people living in rural areas, not by choice, but by necessity. They may perhaps have some old ties to a given community, but in general they may well be living here simply because this is the only kind of shelter that they can afford.

WHAT PROJECT FIND REVEALED

Analysis of 44,000 questionnaires returned under Project FIND[5] revealed many major transportation problems in urban, rural, and mixed settings. In fact, project directors concluded:

> The frequency of transportation difficulties expressed as a major problem of the elderly poor was probably one of the most surprising findings of Project FIND. In some target areas, transportation appears, indeed, to be a major problem since not only food, but health and medical care, church attendance, cultural activities, and recreation and social contacts depend upon adequate transportation facilities.

Other findings from FIND:

—Overall, about one-third of the poor respondents reported having transportation difficulties; about one-fifth of the near poor so reported. Of these, 41 percent of the poor and 30 percent of the near poor said that they had difficulties with transportation often or very often; 23 percent of the poor and 19 percent of the near poor had trouble occasionally. Thus, only about 37 percent of the poor and about one-half of the near poor who reported having transportation difficulties find these problems not to be major.

—The reasons given for lack of transportation are usually "cannot afford transportation" (91 percent of those lacking transportation often or very often), and "public transportation is not very good" (67 percent of those lacking transportation often or very often).

—Amount of income appears to be very important in the degree of difficulty experienced. Very small amounts of income added to that of persons living at the poverty line appear to result in considerable alleviation of transportation problems. Indeed, the most striking aspect of the table which follows is the substantial improvements in transportation which are indicated just at the point of the poverty line. Thus, fewer couples with incomes of $2,000–$2,499 than those with incomes of $1,500–$1,999 report difficulties often or very often. This is even more striking in the case of single persons reporting difficulties often or very often at the $1,500–$1,999 level as compared to the $1,000–$1,499 level. Sim-

[5] Project FIND was conducted by the National Council on the Aging "to give a national picture of the elderly poor" and to provide services for them in the following communities: lower West Side in Manhattan, Phillipsburg, N.J., Warren, Pa., Washington, D.C., Huntington, W. Va., St. Petersburg, Fla., Pontiac, Mich., Hammond, Ind., Alexandria, La., Milan, Mo., Muskogee, Okla., and Watsonville, Calif. Jan. 16, 1970. Facts about transportation are summarized from "The Golden Years * * * a Tarnished Myth," a report prepared by the Council for O.E.O.

ilarly, the percent of those reporting difficulties rarely rises appreciably for either couples or individuals with incomes over the poverty line.

Income in relation to frequency of transportation problems—Percentage distribution for individuals and couples

Income	Often and very often		Occasionally		Seldom or never	
	Couples	Individuals	Couples	Individuals	Couples	Individuals
0 to $499	37	49	21	21	41	31
$500 to $999	38	45	21	23	40	33
$1,000 to $1,499	38	45	22	23	40	31
$1,500 to $1,999	35	31	18	21	47	47
$2,000 to $2,499	29		19		52	
$2,500 to $2,999	24		14		62	

The meaning of such statistics is made clear in these excerpts from field reports:

Transportation services designed specifically for the aging are grossly limited. One of the most often provided services of the FIND aides was in transporting elderly persons to services or transporting services to them. Other than public buses, the fare for which will soon be raised from 20 to 25 cents, the only stable and substantial transportation service is from private taxis. The American Red Cross provides this service on a limited basis, if a volunteer is available. The service of the Red Cross is geared toward transportation during disasters and for welfare recipients through appropriate referrals when the welfare recipients are in need of transportation to medical clinics, private physicians, or medical facilities. They can generally accommodate only 5 persons per day.

In one sparsely populated rural area where the local community action agency secured some Government surplus vehicles, transportation or escort services to doctors, banks, stores, etc., was the one direct service most frequently given, with 3,560 such trips recorded during the project's duration.

In another area a team captain in a summary report to the project director wrote:

It appears that a lack of transportation is in the single most important item that affects the older group. Lack of transportation keeps them from shopping centers so they could take advantage of lower prices. They have to buy from neighborhood stores and drug stores which charge more for their products and thereby the small amounts of their incomes cannot be stretched to a full advantage.

Lack of transportation also keeps them from going to city and county health clinics for doctor and medications at a reduced cost.

A large proportion of the people who need surplus commodities are unable to receive them because they cannot get back and forth to the distribution points.

II. "MOBILITY IS THE GOAL": ACTIONS TAKEN

Under mass transit legislation [6] cleared by the Senate Committee on Banking and Currency late in 1969, State and local governments stand to receive substantial assistance for the rescue or development of much-needed transportation systems.

To older Americans—as well as to the younger commuter who faces the weekday likelihood of rush-hour traffic jams—broadened Federal action of this kind offers the prospect of greater mobility and less dependence upon automobiles.

In addition, less far-reaching, but significant, pilot programs are demonstrating that other actions can be taken to solve problems directly related to transportation needs of the elderly.

A. Reduced Fares During Nonrush Hours

At least 34 reduced-fare plans for the elderly were in operation by the end of 1969 in cities of widely varying sizes.[7]

Advocates of such programs argued that (1) although the elderly depend upon public transportation to a very large degree, fare increases are putting such transportation out of their reach, (2) most travel needs of the elderly can be met during nonrush hours, when buses and other travel vehicles have relatively few passengers, and (3) by increasing ridership during those hours, transportation systems might even increase profits.

Off-hour reduced fares have won enthusiastic acceptance. For example:

1. San Francisco.—Any person past age 65 can present their Medicare cards in any bus (or cable) and pay only a nickel for his ride. The San Francisco Office on Aging reports that the reduced fares, as well as low-cost meals now available in two restaurant chains, are bringing more older persons to downtown senior centers, where attendance has increased by 30 to 50 percent.
2. New York City.—Subway and bus service are available for 10 cents between 10 a.m. and 4 p.m. and from 7 p.m. to midnight Monday through Friday and all day on weekends and holidays. More than 500,000 New Yorkers have registered for the half-fare passes, and registration is continuing at municipal offices and at 250 selected neighborhood banks and savings and loan offices.[8]
3. Chicago.—A reduction in fares went into effect on April 20. Elderly individuals pay 20 cents for a 40-cent ride.

[6] Differences in the Williams (see footnote 1) and administration bills were ironed out in a bill (S. 3154) which would commit $10 billion over 12 years. Senator Williams said his bill could also "provide the means for municipalities and private bus companies to enter into a partnership relationship to keep transit running and—more important—to improve transit and make it more attractive and convenient in the suburbs as well as in the central city * * * the emphasis is on innovation. For the elderly and everyone else, this bill should be used to develop transit facilities that grow and change as cities and suburbs grow and change."

At year's end, action had not been taken in the House, but extensive hearings were planned by the Subcommittee on Housing, Banking and Currency Committee.

[7] In California, Gardena, Los Angeles, Oakland, San Diego, San Francisco, Santa Barbara; in Connecticut, Hartford, Meriden, New Haven, Stamford; in Illinois, Chicago; in Iowa, Cedar Rapids, Davenport, Des Moines; in Massachusetts, Boston, Worcester; in Michigan, Ann Arbor, Detroit, Flint, Grand Rapids; in New Mexico, Albuquerque; in New York, Binghamton, New York City, North Merrick; in Ohio, Cleveland, Euclid, Lorain, Maple Heights, Toledo; in Pennsylvania, Philadelphia, Pittsburgh; in Utah, Salt Lake City; and in Washington, Seattle, Tacoma.

[8] Responding to a letter from Rhode Island Gov. Frank Licht on June 18, Secretary Finch made these comments: About title III (see app. 1, Report of Administration on Aging for full description).

AoA Research.—Health, Education, and Welfare Secretary Robert Finch has taken the position that funds available under title III of the Older Americans Act may not be used to help pay for reduced fare programs.[9] On April 23, however, the Administration on Aging and the Department of Transportation announced a jointly funded study of the effect of reduced transit fares on the mobility of older people and on the finances of transit companies involved.

The target area for this $60,000 study is Chicago. In addition to providing information useful nationally on methods of measuring ridership and reduced fare costs, the study will also provide local information on mobility patterns of the elderly in differing neighborhoods.

New York City ridership patterns also came under AoA study. On July 30, $53,367 was earmarked for evaluation of the social and economic effects of reduced fare programs on transit authority revenues. The research is intended "to assist in providing definitive answers" needed to "determine the direction of program policy developments in AoA's title III program and in grant programs of other departments, particularly in regard to the need and feasibility of national transit fare subsidies."

B. Experiments in Providing Service

The Administration on Aging reports [10] that more than 300 projects under title III had a transportation component during fiscal 1969. For the most part, such components met specialized needs, such as bus travel needed by volunteers in Project SERVE of Staten Island.[11] In a few cases, however, the AoA funds were used to provide low-cost transportation designed to help them participate more fully in services and programs.

For example:

Prince Georges County, Md.—Six 60-passenger buses were obtained from the Board of Education at $250. Five of the buses will be used to provide transportation to and from Senior Citizen Clubs, Senior Activity Centers, and other designations. The fare is to be 35 cents. Retired schoolbus drivers will be employed. Service will be provided Monday through Saturday, with some Sunday use planned.

Emmett, Idaho.—A project called "Senior Citizens A-Go-Go" has become part of the life in a six-county region of western Idaho. A Government surplus bus and a used schoolbus, purchased with project funds, are used to provide "field trips to interesting places," as well as transportation to attend group social activity exchanges with other community senior citizen centers.[12]

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[9] See app. 1, report by Administration on Aging, for full descriptions of title III. Responding to a letter from Rhode Island Gov. Frank Licht on June 18, 1969, Secretary Finch said:

> I have given careful consideration to your letter of February 5, concerning a possible grant under title III of the Older Americans Act to the Rhode Island Transit Authority of funds for reimbursement of losses thought to result from the operation of a reduced fare plan for older persons.
>
> After a review of the provisions of the act, I am obliged to advise that while it is intended to increase community services to older people, I do not believe Congress intended to provide broad subsidy programs such as would be involved in a general subsidy to local transit systems for providing reduced fares for older people. One indication of this is the fact that all funds now available under title III would be totally absorbed by this program alone if extended to other States.

[10] See app. 1 for AoA report on all title III projects.

[11] See "Developments in Aging, 1968" p. 73, for additional information on SERVE.

[12] The project is described in some detail in testimony taken by the Senate Special Committee on Aging at a hearing on "Older Americans in Rural Areas," Emmett, Idaho, Feb. 24, 1970, Senator Frank Church presiding.

Chicago, Ill.—The YMCA Senior Citizens Mobile Service concluded a 3-year AoA-funded demonstration period with a strong recommendation that the service be continued. In its final report, submitted in December the YMCA of metropolitan Chicago said the project had taken shape to test the hypothesis that "many senior citizens experience loneliness from needless isolation, frustration from hunger and pain simply because of immobility." Not agile enough to take public transportation and too often unable to afford private transportation, hundreds of older people give up in frustration and make no effort to benefit from health services and social activities offered them by public and private welfare agencies.

The Mobile Service enabled 1,606 different individuals to travel to local health centers, welfare agencies, shopping tours, social outings, and other activities. A total of 30,403 trips were made by the two seven-passenger vans which were used. Sponsors said that the demonstration project "has validated" the hypothesis described above and has "pointed up a serious need for a coordinated system of transportation, to effect a more efficient delivery of services to the elderly."

More AoA Research.—Several research projects, now underway, should yield facts that will help in future public policy decisions on transportation meant to serve the elderly. Among these studies:

—Fisk University, in a project jointly funded by AoA and the Department of Housing and Urban Development, will attempt to determine whether older people's life styles and mobility habits have a direct influence on their use of transportation resources. The study site is Nashville, Tenn.

—A study by the Langley Porter Neuropsychiatric Institute will seek to identify the major factors that determine the transportation habits, preferences, needs, and problems of older people in urban settings. Data will be collected in San Antonio, Tex., and in San Francisco.

C. The "Dial-A-Bus" Concept

Within the Department of Transportation, considerable attention has been given within the past year to a transportation innovation most commonly called "Dial-A-Bus." Such interest is centered largely in work underway at Massachusetts Institute of Technology, where the concept is now in advanced developmental stages.

Briefly, the system would be used in this way: a person in need of transportation phones in his present location and destination, a computer gives almost instantaneous routing directions by radio to the bus driver (the "bus" might actually be a large taxi-like vehicle) closest to the caller, and the driver picks up the passenger within a few minutes after the call.

The potential importance of this breakthrough in mass transit technology was described to Senator Harrison Williams recently:

> What Dial-A-Bus can do is to combine the convenience of a taxi at substantially reduced rates—perhaps in the area of 50 to 60 cents a ride.
>
> If successful, it would solve a host of problems currently plaguing transportation planners.

> First, it could provide a viable public transportation system in low- and medium-density suburban areas which cannot now be economically served by fixed bus routes.
>
> Second, it would solve the dilemma resulting from the fact that the great majority of transportation trips are either crosstown or are trips to widely dispersed destinations rather than in radial patterns to the central city.
>
> Third, it is particularly adaptable to the special needs of the elderly, the poor, and the handicapped. The physical stress of walking to a bus stop in bad weather, of waiting out of doors, ascending high steps, et cetera, are impediments to working out bus solutions for transportation problems of the elderly and the handicapped.[13]

D. New Focus on Travel Barriers

Advancing years may not necessarily cause individual older Americans to regard themselves as handicapped in any way. They may feel just as fit as ever; they may have no fear at the many rigors—high steps in buses, fast-moving escalators at subway stations, unsheltered bus stops, lurching vehicles, etc.—that public transportation can impose upon them.

But it has become increasingly clear that such hardships can, and do, discourage many elderly persons from using transit systems that may be their only hope for mobility.

It is also clear that they are not alone. A significant report issued during 1969 gave this appraisal of the problem:

> Every person in the United States, at some point in his lifetime, will be handicapped.
>
> Although he may not be one of the Nation's over 8 million people who in 1985 will be limited in mobility as a result of a long-term medical condition or impairment, he will most certainly be handicapped as a result of age, unusual size or weight, fatigue, a broken limb, pregnancy, or just parcels and packages.
>
> Although the handicaps suffered by most people will be no more serious than an encounter with mass transportation while carrying an armload of bulky groceries, a heavy briefcase, or a child, the public's willingness to use mass transportation on a regular basis is undoubtedly influenced by such trying experiences.
>
> Clearly, many of the design and operating changes which might be made to a transportation system for accommodating the chronically handicapped would also *improve the quality of transportation for the rest of the population.*[14] [Emphasis added.]

Americans classified in the report as "chronically handicapped" have one or more long-term diseases, and there are more than 6 million of them in the United States. The study, however, said that 5.6 million are potential riders of public transportation:

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[13] In a letter, Jan. 17, 1970, from Ronald Berman, Assistant Commissioner of Public Transportation, State of New Jersey Department of Transportation.

[14] "Travel Barriers: Transportation Needs of the Handicapped," p. 11, prepared for the Department of Transportation by Abt Associates, Inc., August 1969.

> In addition, the population over 65 is continually increasing, so that there are now more than 18 million citizens who may have difficulty using available transportation.
>
> A significant proportion of the aging and handicapped population are denied equal opportunities to work, shop, and participate in social activities as a result of inaccessible low-cost transportation.[15]

Authors of the report concluded that "economically viable," specialized transportation systems could be designed and put into use for the elderly and the handicapped in cities with populations of 100,000 or more. Transportation Secretary John Volpe, discussing the report in a speech on November 20 [16] commented:

> One of the major obstacles to making transportation more accessible to the handicapped has been a general lack of knowledge about what modifications the handicapped require. This report should stimulate designers, planners, and operators to come up with better systems.
>
> Making transportation systems more accessible will not only provide the handicapped with equal access to employment, education, health, and recreational opportunities, but will improve the quality of transportation for all travelers.

How can "accessibility" be increased? Among the suggestions offered in the survey: [17]

> *Sheltered benches.*—For example, sheltered benches, with firm armrests to help the infirm get up and down, with infrared heating units in the roofs above them would alleviate considerable hardship. One city recently made this improvement—but, typical of the thoughtlessness which is the nub of the entire environmental barriers problem, placed them on the street edge of the sidewalk, assuring that those who use them on a rainy day will be well splashed by passing traffic.
>
> *Subway gates.*—Turnpike travel has proved that subway turnstiles are unnecessary and obsolete. The same type of automatic devices that make it possible to pay fare on a toll road without leaving one's car could be readily adapted to replace the inconvenient turnstiles that subways now use.
>
> *No-step buses.*—No insoluble engineering problem requires that passengers must ride on top of the bus machinery rather than under it, but, as one designer commented, the basic blueprints for building buses haven't been changed in more than 40 years. If redesigned, a bus could pull level with the street curb and wheelchair users, along with everyone else, could get to a seat without encountering any steps. Although buses seem to be immortal—over half the transit buses now in use in the United States are 14 years old or older—they probably are not, and if all replacements were step free, the problem would gradually disappear. For more immediate relief, it is possible to install hydraulic lifts.

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[15] Cited in footnote 14, p. 2.

[16] In Columbus, Ohio, November 20, for speech in conjunction with the 50th Anniversary of the funding of the National Easter Seal Society.

[17] As Abstracted and discussed by "The Goal is: Mobility. Background Information on Environmental Barriers and Transportation," prepared by Ruth Lauder for the National Citizens Conference on Rehabilitation of the Disabled and Disadvantaged, 1969. Distributed by the Social and Rehabilitation Service, HEW.

Well-spaced poles.—Overcrowding of cars during rush hours may be inevitable, but better spacing of poles would mitigate the problem for rush hour standees and help the disabled and infirm at all hours. Instead of placing poles in the center of aisles, they could be placed beside every other seat. This would give standees more places to hold to, leave aisles open for wheelchairs, and give the infirm the support they need for getting up and down from their seats.

Computerized speeds.—Some of the newer transportation systems are finding it practical to control takeoff and stopping speeds automatically so that, by gradual acceleration and deceleration, there is no jolting and passengers can walk safely to their seats. Cheaper and more practical for many systems would be operator training which stressed consideration for all passengers and allowance of sufficient time for the aged and disabled to be seated before the vehicle moves. Frequent inspection would help to assure that this training was put into practice.

Collecting fares.—In many countries, two employees work on each bus, one of whom collects fares from passengers after they are seated and helps passengers who need assistance in getting on and off. An alternative to this increased manpower is a ticket box at each stop where passengers, by taking the precaution of having the right change on hand, can get their tickets before they board. Obviously, such boxes would need to be low enough for children and wheelchair users to reach.

One-way doors.—While it is difficult to control incoming and outgoing traffic, particularly in rush hours, more doors, especially in subway cars, would help. Buses sometimes control the problem by not opening the entrance doors until all passengers have left the exit door.

A background paper prepared for a conference later in the year asked, however, whether improvements in transportation systems will be designed to benefit the disabled, and it gave this answer: [18]

At present, the signs are not promising. Among communities that have begun to reform their mass transportation systems, only one thus far reflects a genuine effort to enable everyone to use its facilities—the Bay Area Rapid Transit which serves the San Francisco area. Minneapolis and St. Paul are beginning to add accessibility features and in Washington, D.C., concerned citizens, armed with a mandate from Congress, are carrying on a determined battle to have their new subway system barrier free. A few other communities have added, or are planning some features that will make transportation somewhat more feasible for some disabled.[19]

Transportation problems among older Americans have reached the critical stage in many metropolitan and rural regions of the United States. Federal agencies have made a beginning in identifying problems, initiating research, and conducting pilot programs to test systems and con-

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[18] P. 22 of report cited in footnote 14.

[19] A bibliographic list, "Transportation for the Handicapped," was issued by the Department of Transportation in November 1969. Among the references are several directly related to older Americans.

cepts. The overall problem, however, is so serious that the following additional actions should be taken:

—Technical assistance should be provided by appropriate Federal agencies to acquaint municipal governing bodies and private transportation managers with facts about transit barriers, special needs of the elderly and the handicapped, and new transportation concepts which would benefit, not only the elderly, but all persons who use public transportation.

—The Urban Mass Transit Administration should submit to the Congress its recommendations for removing travel barriers and using existing and potential mass transit legislation to promote worthwhile social purposes, including those discussed in this chapter.

—Provision should be made in planning the 1971 White House Conference on Aging for a preliminary report on transportation, to be prepared by a panel capable of giving adequate attention to sociological, technical, and psychological aspects of the subject. Every attempt should be made to show the relationship of transportation to service programs, existing or contemplated, for older Americans.[20]

[20] An encouraging and potentially significant development in interdepartmental cooperation was scheduled for May 25, 1970. The Administration on Aging, Urban Mass Transit Administration of the Department of Transportation, and the Department of Housing and Urban Development were to sponsor a workshop on the subject of "Transportation and Aging."

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CHAPTER VII

OLDER AMERICANS IN RURAL AREAS

Many urban neighborhoods have rising numbers of elderly residents (see Chapter VIII, model cities) largely because many younger persons have moved to the suburbs. In rural America, too, the proportion of aged persons is very high. Here again, younger families have moved away—often in search of jobs, sometimes simply for a change.

The Senate Committee on Aging in 1969 began a study [1] of the rural elders, partially to determine what special problems they might have, and also to explore the part that the elderly can play in retaining or restoring the rural way of life while meeting new challenge.

I. THE SCOPE OF THE STUDY

Senator Vance Hartke, who suggested that the committee study be made, gave this description of its objectives in his opening statement:

> Our fundamental purposes, here and elsewhere, are the following:
> —To explore unique problems encountered by those elderly who live in rural areas, including economic or other pressures that may cause withdrawal from such areas.
> —To determine whether Federal programs and services intended to serve older Americans are as effective as they should be in rural areas.
> —To gather information that will supplement another Committee study, "The Economics of Aging: Toward a Full Share in Abundance." Thus far, relatively little testimony in hearings on that subject has been taken on the rural elderly.
> —To seek recommendations for Federal action.[2]

He also discussed the committee's working definition of a "rural area:"

> I am well aware that there are many other issues, such as this very basic question: just what is a rural area? There is much discussion of this point, and at present the Bureau of the Census seems to be leaning toward a division into "metropolitan" and "nonmetropolitan" areas, with subdivisions within

[1] Older Americans in Rural Areas:
Part 1. Des Moines, Iowa, Sept. 8, 1969.
Part 2. Majestic-Freeburn, Ky., Sept. 12, 1969.
Part 3. Flemming, Ky., Sept. 12, 1969.
Part 4. New Albany, Ind., Sept. 16, 1969.
Part 5. Greenwood, Miss., Oct. 9, 1969.
Part 6. Little Rock, Ark., Oct. 10, 1969.
Part 7. Emmett, Idaho, Feb. 24, 1970.
Part 8. Boise, Idaho, Feb. 24, 1970.

[2] Hearing cited in footnote 1, pt. 1, not printed at time of publication.

each. Undoubtedly, we will hear more on that subject from witnesses here and elsewhere.

For our purposes here today, I think we can safely say that a rural area is not necessarily in a farming belt, nor is it necessarily a town which has a specified population, such as 2,500 or under. Instead, I think we can say that a rural area is one in which:

1. Population is sparse, and small concentrations of population are few and far between;
2. Delivery of services—including transportation or health care—is rendered more difficult by wide dispersal of population and limited sources of funding;
3. And where the countryside is not given over primarily for industrial purposes.[3]

II. EMERGING ISSUES

Rural America defies generalizations, just as the rest of the Nation does. But in its study thus far, the committee has encountered major issues which will be further discussed at future hearings:

1. *Generally lower retirement income.*—Earnings during the work lifetimes of many rural elderly have been lower than in urban areas. Social Security coverage is generally lower, and poverty is widespread. In addition, there is strong reluctance to apply for Old Age Assistance, or "welfare."
2. *Rising percentages of elderly.*—As mentioned earlier, many rural areas have a much higher proportion of elderly than is the national norm of about 10 percent. The exodus of youth is caused in some States by the impact of "corporate farming" and other changes in agriculture. In eastern Kentucky, the conversion of the coal mining industry to widespread mechanization has reduced employment available for young men.

Documentation of the rise in rural Iowa was provided by Woodrow Morris, Director of the Institute of Gerontology at the University of Iowa. Describing a "senescity index"[4] developed to measure the relative numbers of elderly and younger residents of a community, Dr. Morris said:

> Currently, according to the estimates of the U.S. Bureau of the Census, Iowa has over 25 percent more than its pro rata share of the Nation's elders. Furthermore, as noted earlier, the Iowans in this age group are unevenly distributed both geographically by counties and by urban-rural residence throughout the State. For example, over half of our elder citizens reside in rural areas.
>
> The 18 most populous counties in Iowa contain 48 percent of the State's population; but these counties have only about 40 percent of the senior citizens of the State. In other words, they are running about 10 percent under their proportionate share.

[3] Hearing cited in footnote 2.

[4] Asked for the meaning of this term, Dr. Morris said, " 'Senescity' as a word is designed to mean those population structures or characteristics of an area which point to the relative balance or imbalance of the older population in that particular area. * * * It is based on the word senescence, which refers to the period of life which is generally referred to as the period of later years or the aging period," hearing cited in footnote 2.

By way of contrast, there are 12 counties with 16 percent or more of their population in the upper age category (three of these are: Taylor, 18.6; Wayne, 19.1; and Appanoose, 19.3); 16 other counties had between 14 and 16 percent of their population over 65 years of age. All of these are small, rural counties mainly located in the southern portion of the State. The 12 counties with the highest percentages of the aged have far more than their quota of the elderly.

Outmigration is selective on the basis of age and sex for many reasons. The selective feature of migration affects natural increase because it produces an unbalanced age structure. Since young adults have the most children, an area which has a deficit of young people will experience a lower birth rate, thus compounding the outmigration effect and resulting eventually in an even more rapid decline in the population. Since there are so many characteristics to keep in mind it would be useful if the net effects of the aging trends in an area could be expressed in a single figure showing whether the relative shifting in the population is toward or away from increasing aging.[5]

Isolation and "invisibility".—Many rural problems are worsened simply because relatively few persons are aware of them. Harold Wright, president of the Indiana Farmers Union emphatically made that point:

> I might add that I believe the real tragedy in rural Indiana and rural America today is the fact that our poverty in these areas has been so well hidden. By saying this, I don't mean to imply that this has been done on purpose. This has just come about by letting things take their natural course.
>
> I would like to point out that in our urban areas, our low-income people are situated primarily in one particular place. I think this has come about because our more affluent people have moved out of the central cities into suburbia and have left the low-income people in the inner city. But in rural America our low-income people are dispersed. You have to look a lot harder to find a low-income person in rural Indiana than you would in urban Indiana.[6]

Inadequate local base for services.—Small communities and sparsely populated counties often lack resources with which health care facilities, service programs, and institutions can be maintained. Even relatively modest matching funds for Federal help sometimes cannot be met, in areas where they may be needed most.

Housing as a major problem.—Many elderly individuals and couples are living in homes built decades ago for the "family farm." As the family farm declined, so did the structure in which the family lived. Much testimony has been taken about the limitations of assistance available by the Farm Home Administration. Rehabilitation also has received attention. In eastern Kentucky, where many of the houses were built for coal-miners communities, a unique home repair project uses resources available through programs of the Federal Department

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[5] Hearing cited in footnote 2.
[6] Testimony at hearing cited in footnote 1, pt. 4, not printed at time of publication.

of Agriculture, Department of Health, Education, and Welfare, and the Kentucky Department of Economic Security.

Mrs. Pat Gish, director of the Eastern Kentucky Housing Corp., described the program:

> The home repair program has provided a variety of changes in the homes of the families involved. It has repaired leaky roofs, built ramps for persons confined to wheelchairs, installed pitcher pumps at sinks so water no longer has to be carried in from the outside, rebuilt porches and railings to make them safer, widened doorways so wheelchairs can get through them, replaced rotting floors, sealed cracks and installed insulation, underpinned houses, replaced dangerous wiring, replaced falling or steep steps, installed new window glass, repaired chimneys and flues, rebuilt privies, installed light switches and sinks at levels where wheelchair patients can reach them, and painted inside and outside where necessary.
>
> So far the program has completed repairs on a total of 500 homes.[7]

Innovative programs are at work.—As the eastern Kentucky home repair project demonstrates, Federal resources can be put to good use when they result from down-to-earth planning at the local level. The committee has also received testimony on an Arkansas mobile health unit (formerly a schoolbus), transportation and nutritional services for the elderly of western Idaho, and other federally supported projects which, in one way or another, are providing much-needed services. In addition, several are providing employment.

Perhaps the most dramatic and effective example is Green Thumb. (See ch. IX for details.) The elderly participants, many of them well over 70 and even 80, are working on park development projects and beautification of highways and historical sites. In Indiana and Arkansas, the Green Thumb workers are working on projects of direct importance to the tourism industry.

Additional study will be given by the Committee on Aging to the elderly in rural areas of this Nation. Hearings thus far indicate that this subject should also receive intensive attention at the White House Conference on Aging in 1971 and in preliminary State conferences.

[7] Testimony at hearing cited in footnote 1, pt. 3, not printed at time of publication.

CHAPTER VIII

MODEL CITIES: PROMISE AND SOME PROGRESS

"All commitments are firm and will be honored."

That assurance was given by George Romney, Secretary of Housing and Urban Development, in October when widespread concern was expressed about reports of cutbacks in the model cities program.

One reason for the alarm was that the reports had been preceded by a long period during which the model cities program had been subjected to searching evaluation within HUD and by President Nixon's Council on Urban Affairs.

Secretary Romney's pledge [1] to meet commitments are of special concern to municipal, State, and Federal officials who work on programs serving older Americans. It has been recognized from the very beginning of that program that the elderly could be among its major beneficiaries.

President Johnson, in his 1967 message on "Aid for the Aged," directed HUD "to make certain that the model cities program give special attention to the needs of older people in poor housing and decaying neighborhoods." [2] The Administration on Aging was soon at work [3] in reviewing all model cities applications for components needed to serve the elderly, and AoA developed a close working relationship with HUD.

There were sound reasons for such interest and early action:

—Some 33 percent of all Americans age 65 or over live in central cities.

—Of that number, 27 percent are living in poverty.

—Badly-needed services for the elderly are, in most cities, unavailable or unaccessible to those who need them most. To many gerontologists, the model cities program appears to offer the hope and the means for developing rational and effective service systems.

The Senate Committee on Aging, at hearings [4] over a 12-month period, has heard from witnesses both in Washington and in the field. A final report will be issued later in the year, but the following summary can be given of major points made in testimony during 1969.

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[1] For statement by Secretary Romney on model cities policies, see app. 8, p. 402.

[2] P. 9, 90th Cong., 1st Session, House Doc. No. 40.

[3] See testimony by William D. Bechill, Commissioner of the Administration on Aging at hearing on "Usefulness of the Model Cities Program to the Elderly," pt. 1, pp. 33–40, U.S. Senate Special Committee on Aging, July 23, 1968, Washington, D.C.

[4] Usefulness of the model cities program to the elderly:
- Part 1. Washington, D.C., July 23, 1968.
- Part 2. Seattle, Wash., Oct. 14, 1968.
- Part 3. Ogden, Utah, Oct. 24, 1968.
- Part 4. Syracuse, N.Y., Dec. 9, 1968.
- Part 5. Atlanta, Ga., Dec. 11, 1968.
- Part 6. Boston, Mass., July 11, 1969.
- Part 7. Washington, D.C. Oct. 14, 15, 1969

I. HUD-AoA AGREEMENTS AND ACTIONS

At the end of 1969, $310.9 million [5] in funding for the model cities program had been obligated for 58 cities.[6]

Despite its heavy emphasis upon housing needs within target neighborhoods, the model cities program is meant to serve several major purposes simultaneously. As one HUD statement describes it: [7]

> The model cities program is a comprehensive attack on the social, economic, and physical problems of selected blighted areas. It does not stop with a "Job" solution, or a "housing" solution, or a "transportation" solution. Rather, it relates all of these needs to a comprehensive plan to upgrade the life of a neighborhood. For the low income aging persons in the model neighborhood, this approach is most vital. Their problems are so often multiple and interrelated. The need for health services is often vitally linked to inadequate transportation facilities to bring the person to treatment centers. Inadequate housing often contributes to the health problems of the elderly. The lack of job and recreational opportunities often contributes to the deteriorating health problems of the aging. In short, the comprehensive nature of the model cities approach can meet the most constant and justified criticisms of public and private services to the elderly—fragmentation, isolation, and intermittent attention.

Clearly, no single Federal agency or department can meet all such objectives. The model cities program is producing new mechanisms for interdepartmental cooperation.

A. HUD and the Model Cities Administration

HUD Assistant Secretary Floyd H. Hyde [8] informed the Committee on Aging that the model cities staff has been able to identify more than 50 components in the first 30 cities funded which directly or indirectly will benefit the aging. These programs deal with such matters as health, employment, transportation, housing, leisure time, consumers, homemaking, and coordination of services.

Assistant Secretary Hyde said, however, that HUD is not convinced that these programs adequately interrelate need and solution.

"Too often," he said, "the components in some of the older model cities tend to be isolated projects meeting one or more pressing needs of the aging within the neighborhood. *In almost no city has the program indicated a systematic examination of across-the-board needs of*

[5] An authorization of $1 billion was provided for the model cities program for fiscal year 1970 under the Housing and Urban Development Act of 1968. A budget request of $750 million was made by the Johnson administration, but was reduced to $675 million by the Nixon administration. An appropriation of $575 million was provided for the program for fiscal 1970.

Funding for model cities projects under the 1969 Housing Act (Public Law 91–152) included an authorization of additional $600 million, to be added to a carryover of $712.5 million, for a total authorization of more than $1.3 billion for fiscal 1971. The funding request for fiscal 1971 is $575 million, the same amount appropriated for fiscal 1970.

[6] For additional information, see app. 1, pp. 219 (HUD Report on Model Cities program) and app. 8, p. 403 for Model Cities guidelines discussed by Secretary Romney.

[7] See app. 1, p. 219.

[8] Statement of Floyd H. Hyde (HUD Assistant Secretary for Model Cities and Government Relations) was given at the October 14,15, 1969, hearing cited in footnote 4, pt. 7, not printed at time of publication. Because of his illness, the statement was read by Robert H. Baida, Deputy for Model Cities and Governmental Relations, HUD.

the elderly and a long-term plan to meet these needs." [Emphasis added.] [9]

Mr. Hyde, discussing his working arrangement with the Administration on Aging, said that these "concrete results" had been achieved:

—Statewide meetings of city demonstration agencies and older persons organizations and agencies were to be conducted in Connecticut, Michigan, Pennsylvania, Georgia, New Jersey, and California under the sponsorship of AoA and the Model Cities Administration at the Federal and regional levels and under the sponsorship of the State agencies on aging and the model cities at the State level.

—In cooperation with AoA, the school for social work at the University of Syracuse and the City Demonstration Agency of Seattle was to conduct a national model cities program development conference in December. (Some 10 to 15 model cities sent representatives to the conference, which was to be used as a training vehicle for model cities regional staff.)

—The University of Syracuse School of Social Work is developing program guidelines for model cities.

—Some $200,000 was "tentatively allocated" in the model cities program for technical assistance in the field of aging for fiscal 1970. "This marks for us a major emphasis program in the current fiscal year," said Mr. Hyde.

—Finally, "we are planning to utilize on an increased basis the services of the regional HUD social service advisors who are now fully acquainted with the needs of the elderly, through their work within the senior housing program, together with the work of our own model cities regional social service advisors, Mrs. McGuire's (Marie McGuire, Special Assistant for Problems of the Elderly) staff * * *" [10]

Cutbacks "more apparent than real".—Senator Frank E. Moss, concerned about press reports [11] that a 42 percent, $215 million reduction would be made during the fiscal year, said that such actions could well shake the confidence of municipal officials and private citizens involved in model cities planning. He received the following reply from Robert H. Baida,[12] HUD Deputy Assistant Secretary for Model Cities and Governmental Relations:

> I believe that the cut is really more apparent than real. I can state positively that it does not result in either reducing the scope or the pace of the program, that the allocations that have been made to individual cities will remain at their present level, and that we will fund the second round cities at the expected level.
>
> This was made clear to us at the time that the reduction and estimates of expenditures were made, that we were not asked and we were specifically told not to slow down the pace or reduce the rate of obligations. So we do intend to continue with the program at the present pace.
>
> Now with respect to the charge that there has been a slowdown and stretchout of the program itself, I think that the

[9] Testimony, hearing cited in footnote 8.
[10] Testimony, hearing cited in footnote 8.
[11] New York Times, October 10, 1969.
[12] At hearing cited in footnote 8.

administration must take a certain responsibility for the length of time it took in reviewing the model cities program, in determining what its posture with respect to the program would be.

Now with the exception of this review process and the time that it took, there has been no change or slowdown in the process. We are trying to process our cities as fast as we can. We are concerned, however, that good management requires the review process that we are going through and in some cases the revisions that such a review requires of cities prior to approval of a program.

We intend to exercise this kind of management, but we also assure you that it will not be exercised in a manner which is deliberately designed to slow down the program.[13]

B. AoA Concern Over "Visibility" of Elderly

AoA Commissioner John B. Martin[14] told the committee that the Administration on Aging—in addition to its joint projects with HUD—also has established a task force "to engage in continuous evaluation and the impact of the (model cities) program to follow its developments.

He also described "three levels of activity" to which he gave attention after he became Commissioner:

> When I first became Commissioner on Aging, I gave immediate attention to the relationship between the Administration on Aging and the model cities programs that were going on in the various States, and it was apparent that there were three levels of activity to which we ought to pay attention. The first was that visibility had to be gained for the aging in model cities planning. This was difficult to do because, as I said before, most of these planning committees are made up of younger people and older people are less likely to be vocal, less likely to speak up and less aggressive in putting their needs forward. But we have achieved this in some measure and hope to achieve greater visibility for them.
>
> Second, technical assistance has to be provided in planning after aging is accepted as a critical community issue. This means that good planning advice as to what must be available does make a good comprehensive program for the aging.
>
> Third, a comprehensive network of community services for the aging must be achieved through assuring that all relevant projects initiated in a model city have an aging component.
>
> In the past, the review of project proposals was the principal role performed in the Administration on Aging, here in Washington, and in the regional office and State units on aging. Recently this role has changed to one of stimulating and meeting the city requests for technical assistance in planning and program development for older persons. For instance, we have urged the universities funded under AoA's title V program to make their knowledge available to model

[13] Testimony, hearing cited in footnote 8.
[14] At Oct. 14 hearing cited in footnote 8.

> cities planners and to their faculty and students in the program. We are also developing ways to assure that the research and demonstration findings of the Administration on Aging title IV program are made immediately available to appropriate persons engaged in the model cities planning.
>
> The assignment of students in our title V training projects to work in model cities programs has been a helpful thing which we have done for both these mid-career students and the city Demonstration Agencies.[15]

Mr. Martin also said that AoA had urged State agencies on aging to work in cooperation with model cities programs:

> Some 50 percent of the State agencies are participating in some phase of the planning or review of model cities plans, which ranges from consultation to participation on a task force charged with writing the plan's section on services for the aging.[16]

He also noted that the AoA title III program has some 114 projects related to model cities activities.

Commissioner Martin, too, discussed funding:

> The critical issue now is funding. Proposals in hand and anticipated for fiscal 1970 already total far more than is available. Priority in the allotment of funds from all resources must include older persons programs.
>
> The Department of Health, Education, and Welfare and the Administration on Aging are giving indepth attention to the entire issue of financing model cities activities. Joint efforts and agreements have been initiated in the past few months with other Federal agencies and I have high hopes for our initial efforts with the voluntary organizations and agencies.[17]

II. "VULNERABILITY" AND OTHER CONCERNS

Dozens of witnesses have appeared before the Senate Committee on Aging in its study of the model cities program. A report, soon to be issued by the committee, will discuss major issues and make recommendations. For this brief summary, it suffices to list a few items of major concern.

1. "Vulnerability" of the elderly.—Despite assurances and conferences, there is still good reason to fear that officials at the local level may tend to put a very low priority on planning and action for the elderly.

Neal S. Bellos, assistant professor at the School of Social Work of the University of Syracuse, referred to this danger:

> This is a special type of vulnerability above and beyond those brought by the aging process itself with illness, low inability of low influence and, for want of a better term, lack of consideration. Whereas our Nation has addressed itself to the problems of its people, the aging have been inadequately rep-

[15] Testimony, hearing cited in footnote 8.
[16] Testimony, hearing cited in footnote 8.
[17] Testimony, hearing cited in footnote 8.

resented in decisionmaking and find themselves on the lower rung of human priorities.[18]

2. Representation of the elderly.—Closely related to Professor Bellos' concern about overall vulnerability of the elderly is the matter of adequate consultation with the elderly during the planning and action phases of the model cities program. One example of direct communication with the elderly was provided at a hearing in Boston,[19] where a "council of elders" has become the official agency for older persons program in one target area. The council, which had been incorporated even before the model cities program came into being, places heavy emphasis upon consultation with individuals in their home neighborhoods.

The importance of the concept was described by Leonard Weiner, executive director, Age Center of New England:

> The age center supports and endorses the Boston model city elderly program because the Council of Elders, Inc., is the embodiment of this perception of elders and provides the avenue for full participation of elders in community events and decisions which affect them.
>
> The council, in fact, takes this a step further by providing the mechanism whereby elders can themselves initiate events and programs. This concept—actualized in and by the council of elders—is perhaps the most radical conceptual innovation in American social gerontology in the last 50 years.
>
> There is a rather interesting or possibly distressing implication alined with this conceptual innovation and that is the subtle demand for coordinating existing gerontological resources and the various services these agencies offer around this representative body of consumers. This will prove a remarkably effective operational test of the actual value of the various services we offer, for, with the council of elders, the consumer has finally attained a means of communication and reaction.
>
> The conceptual structure of the council is such that the representatives of the elders in the model city should have realistic control not only of the programs designed in collaboration with this body but also to employ whatever expertise it sees as pertinent to solution of its contemporary problems.
>
> In essence, if the council calls upon the age center and we do not provide the product we have promised, we will not be used again. I believe this is a healthy development. What better realistic assessment can be made of agency programs than by the consumers of agency services?
>
> In its very existence, the council of elders suggests a direct reversal of the stereotypic image of the elder in our society. In our study of retirement and its effect upon the relative independence of the individual we have discovered that retirement per se is perhaps less important a dynamic than is the total fabric of existence for a given individual.[20]

[18] Testimony, hearing cited in footnote 8.
[19] At hearing cited in footnote 4, pt. 6, not printed at time of publication.
[20] P. 554, hearing cited in footnote 4, pt. 6.

3. Uncertainities about funding.—Many witnesses have told the committee that leaders in their communities made major efforts to rouse community support and interest in the model cities program. They are afraid, however, that this interest and level of support will falter and perhaps fade away if funding is late in coming. In Boston, for example—despite the headstart provided by the council of elders—many months of delay caused great concern and even hostility to the program.[21]

Additional attention will be given by this committee in the near future to the usefulness of the model cities program to the elderly. For this interim summary, it is enough to say that—

(1) The new administration has taken steps which indicate an awareness of the need for the program to serve the elderly and

(2) Additional attention must be paid, however, to unique problems and opportunities that exist among this "vulnerable" group.

[21] Testimony by Jack Leff, hearing in Washington, Oct. 14, 1969 as cited in footnote 8.

CHAPTER IX

OLDER WORKERS, EARLY RETIREMENT, AND SERVICE OPPORTUNITIES

Older workers are dropping out of the labor force in alarming numbers, too often unwillingly.

Consequently, they endanger their own retirement security, help to worsen an unfavorable, national "dependency ratio" of nonworkers to workers, and intensify inflationary pressures by cutting the supply of capable employees.

These conclusions were presented to the Senate Special Committee on Aging in a study [1] which provided fresh new perspective on a perplexing question worthy of national attention:

> What does a nation—and its people—lose when ablebodied men and women find themselves in "retirement" when they would much prefer employment instead?

By raising that question, the paper also called attention to a major deficiency in Federal manpower policy. As two prominent committee members [2] expressed it:

> The report forcefully makes the point that the United States does not yet have a clearcut, effective policy for utilization of Americans now regarded as "older workers" * * *.

On the contrary, they added:

> Both Government and private industry seem instead to regard earlier and earlier retirement—in some cases it is actually enforced unemployment—as inevitable and perhaps desirable.

I. WHY OLDER WORKERS HAVE PROBLEMS

If current labor force participation trends continue, 1 out of every 6 men in the 55 to 64 age category will no longer be in the work force by the time he reaches his 64th birthday. Ten years ago this ratio was only 1 out of 8.

Seen over a two-decade span, a startlingly large number of middle-aged and older men have withdrawn from the labor force. In 1949 there were 821,000 men 55 to 64 who were not in the labor force, compared with 1,406,000 in 1969—approximately a 75-percent increase. For men aged 65 and older, the "dropout" rate was even more substantial, increasing from 2,773,000 in 1949 to 5,821,000 in 1969.

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[1] "Employment Aspects of the Economics of Aging" Working Paper prepared by Sheppard, Harold L. Ph. D.; Sprague, Norman; Withers, Irma R.; December 1969. Much of the material in this chapter is drawn from that report.

[2] Senators Harrison Williams and Jennings Randolph in foreword to report cited in footnote 1.

A. The Critical Period: 45 to 55

Various indices suggest that the critical period concerning employment for adult men occurs during their late forties and early fifties, when "aging" makes it difficult or impossible to find employment. For instance, in 8 out of 11 years beginning in 1947, the unemployment rates for men 45 to 54 had risen after they were 10 years older (55 to 64).

	Unemployment rates of men aged 45 to 54 in:[3]—										
	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957
Percent unemployed in given year	2. 6	2. 5	4. 3	4. 0	2. 4	2. 2	2. 3	4. 3	3. 2	3. 0	3. 3
Percent unemployed 10 years later	3. 5	5. 5	4. 5	4. 6	5. 7	4. 6	4. 3	3. 9	3. 3	2. 6	2. 4

[3] P. 12, report cited in footnote 1, "Employment Aspects" Working Paper.

For this age group several discernible employment trends become evident:

—Labor force participation declines.
—Unemployment begins to rise.
—Duration of unemployment increases.
—Poverty increases.

Another study of nonparticipants in the labor force strongly suggests that many older persons are unemployed for reasons other than health problems. For instance, the following table illustrates that among men who wished to be employed but who were not looking for a job, 46 percent of those in the 55 to 59 age bracket and 37 percent of those 60 to 64 were not ill or disabled.

Reasons for not looking for work among men not in labor force who wanted a regular job Sept. 1966, by age

Reasons	20 to 24	25 to 54	55 to 59	60 to 64	65+
Percent:					
Ill health, disabled	9	53	54	63	36
In school	54	10			
Miscellaneous, personal	23	9	18	5	15
Expect to be working		7			
Believe it impossible to find work	14	21	28	32	49
(a) No other reason	14	16	18	32	40
(b) Also ill		5	10		9
Number (in thousands)	122	376	61	105	305

Source: Robert L. Stein, "Nonparticipation in the Labor Force," *Monthly Labor Review*, July 1967.

In addition, this study reveals that about 30 percent of all those wanting a job but unemployed because they believed it impossible to find one, felt that employers thought that they were too old. More-

over, the table also shows a direct relationship between age and the belief that it is impossible to find employment.

IDLENESS: A CAUSE OF ILLNESS?

Ill health is the explanation most frequently given for not working, whether accurate or not. However, there is a growing body of knowledge which suggests that a major reason for the health problems exhibited by unemployed older individuals is related to damaging employment experiences in previous years.

For example, Dr. Sidney Cobb, of the Institute for Social Research of the University of Michigan, has been examining the impact of the closing of a Detroit plant in 1963 on the physical and mental health of the workers. He has concluded from this study and earlier experiences that losing a job can exacerbate diseases and even produce new illnesses. Out of 54 men laid off in Detroit, he identified eight cases of arthritis, six cases of severe depression requiring medical help, three instances of ulcers, five of hypertension requiring hospitalization, two of high blood pressure, and one of alcoholism as directly traceable to the plant closedown and its aftermath.

B. Long Periods of Unemployment

Once an older worker is unemployed, he is likely to be off the job for comparatively long periods. For example, the proportion of long-term unemployment [4] for men 45 and older increased from 31.5 percent in 1961 to 49.2 percent in 1967, although the employment situation improved markedly during this period.

Another illustration of the greater long-term unemployment risk among older workers can be seen from the following table:

Percent of unemployed out of work for 15 or more weeks, by age and sex, 1957, 1961, 1966, and 1968

	Age					U.S. unemployment rate for 16+ labor force
	14 to 19	20 to 24	25 to 44	45 to 64	65+	
Males:						
1957	13	15	19	28	39	4. 1
1961	22	31	35	41	47	6. 4
1966	12	14	22	31	37	3. 2
1968	8	10	18	26	34	2. 9
Females:						
1957	11	13	18	23	21	4. 7
1961	16	25	29	34	41	7. 2
1966	11	10	17	22	34	4. 8
1968	10	11	15	18	25	4. 8

Source: Based on table A-18, Manpower Report of the President, 1969.

It is also significant to note that in each of the 4 selected years, the proportion of the long-term unemployed increased with age in practically every instance.

[4] Long-term unemployment refers to those unemployed for 15 weeks or longer.

C. Industrial Employment Patterns [5]

Industrial employment patterns have also had an impact on earlier retirement. In declining industries, such as agriculture, mining, and railroads, older workers have constituted a disproportionately high percentage of the employees. In growth industries their percentage is disproportionately small. When older workers are displaced from their jobs because of automation, plant shutdowns, and other reasons, they frequently lack the education or training to move into the expanding industries. Furthermore, only a small percentage of the Nation's manpower training and retraining efforts have focused upon people 45 and older, although they comprise a disproportionately large percentage of the long-term unemployed. For example, only about 11 percent of all training under the Manpower Development and Training Act has been directed at persons 45 and older. In addition, the training allowance under the MDTA is also quite low, roughly equivalent to the allowance for unemployment insurance.

Frequently an individual will accept a lower paying job that may not provide long-term employment opportunities, rather than undertake training and make this financial sacrifice. This will oftentimes result in the perpetuation of sporadic underemployment with no real job future. A significant increase in the training allowance system would give older individuals and other persons more latitude and would be helpful in equipping them with the skills required in our society.

Many older workers are unemployed because:

—They are not equipped for the jobs in modern technology.

—They lack the necessary training to move onto gainful employment.

—They live where jobs no longer exist.

—They are seeking the employment of a bygone era.

Many of these older persons can become as productive as their younger counterparts with a flexible and comprehensive training program which is adequately funded and staffed.

Within the next 10 years, our Nation will have to train and retrain substantially more people for jobs than we do now, since industries will be changing manufacturing techniques and products more rapidly than 10 years ago. Ten years from now that pace will be even more accelerated.

II. ECONOMIC CONSEQUENCES OF EARLY RETIREMENT

While earlier retirement is oftentimes attributed to the affluence in our society, many older workers choose this course only as an alternative to long-term unemployment or sporadic underemployment at low wages.

Most men under 65 prefer employment to retirement because they need the larger incomes which jobs provide in order to meet their household and family responsibilities. However, prolonged periods of unemployment or underemployment during the preretirement years have forced many older workers to accept reduced Social Security benefits at an earlier age.

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[5] Abstract from testimony at "Employment Aspects of the Economics of Aging" hearings, Dec. 18, 1969, Axelbank, Rashelle (not in print at time of publication).

In 1968 approximately one-half of all men who began to receive Social Security were less than 65 years old, although this was a high employment year. Generally, these early retirees were more likely to have low lifetime earnings, sporadic work and unemployment in the years preceding their entitlement to Social Security than men who retired at age 65.[6]

According to the Social Security Administration, average earnings in the last year employed were substantially lower for earlier retirees: $2,749 for men aged 62; $3,514 for those who could wait until age 63 or 64; and $4,057 for men waiting until 65. In addition, the percentage of 62-year-old men not working in the year before entitlement was more than twice as high for men aged 65—22 percent for early retirees in contrast to 9 percent for those 65.

Early retirement decreases the size of Social Security benefits for persons who can least afford any reduction in their retirement income. As would be expected, the average monthly benefits for early retirees was significantly lower than for men who waited until age 65 to retire: $95 versus $115 in December 1968.[7]

A recent study[8] of pension income adequacy clearly illustrates the impact that early retirement can have on reducing the amount of wage replacement during retirement from public and private pensions. For example, 89 percent of nonagricultural males retiring before age 60 are projected to have a replacement of 29 percent or less of their preretirement earnings from pension income. For men retiring at ages 60 to 64, about 52 percent will have a replacement below 30 percent of their preretirement earnings. In contrast, only 29 percent of those retiring at age 65 or after are projected to have a replacement below 30 percent of their average earnings 5 years prior to retirement.

On the other hand, only about 3 percent of men retiring before 60 are projected to have a replacement from pension income of 50 percent or more of their average annual earnings. However, about 30 percent of those retiring at age 65 or after will have pension incomes that will equal 50 percent or more of their preretirement earnings.[9]

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[6] Bixby, Lenore, and Rings, E. Eleanor, "Work Experience of Men Claiming Retirement Benefits, 1966," Social Security Bulletin, August 1969.

[7] Testimony at hearings cited in footnote 5.

[8] Source: "Early Retirement Trends and Pension Eligibility Under Social Security," by James H. Schulz U.S. Joint Economic Committee Compendium, pt. III, table 8, p. 167.

[9] Authors of the working paper emphasized that earlier retirement is producing a growing dependency ratio which can "reach a straining point."

In 1950, for every 100 persons of working age (20 to 64 under the most frequently accepted definition of "working age population"), there were 72.6 persons younger than 20 or older than 64. Today the dependency ratio has risen to 93.2, and the older part of that dependency ratio (65 and over) is about 18.2.

However, with the increase in workers claiming Social Security benefits before age 65, this dependency ratio can increases substantially. If workers 60 and over continue to be eased out of the labor force, the dependency ratio could approach 110 in 1970. Moreover, the dependency ratio for the older group would raise considerably from 18.2 to 28.3. The impact of these statistics is that 100 people would then be working to support 28 nonproductive people aged 60 and older.

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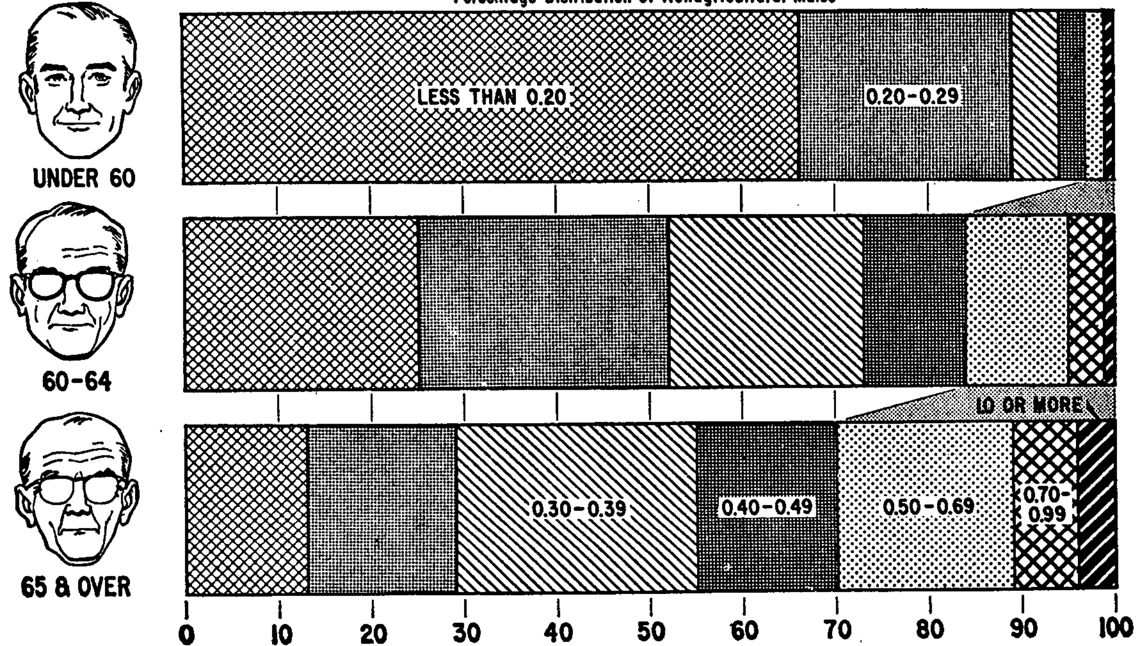
EFFECT OF EARLY RETIREMENT

Projected Ratio of Public and Private Pension Income to Preretirement Earnings

AGE AT RETIREMENT



Source: Joint Economic Committee Compendium, Part IV, p.167

Statistical basis discussed on following page

EFFECT OF EARLY RETIREMENT

SOURCE: "'Early Retirement' Trends and Pension Eligibility Under Social Security," by James H. Schulz, U.S. Joint Economic Committee *Compendium*, part III, table 8, page 167.

TECHNICAL NOTE: Projections were made through a modification of the simulation model described under Chart H.

As part of a broad study of pension income adequacy in the future, preliminary findings are available to assess the effect of early retirement on the amount of wage replacement provided by pensions. Again, the P/E ratio is the ratio of the total of public and private pension income to average annual earnings during the 5 years prior to retirement. The data relate to married males who were age 45 to 60 in 1960.

The projection introduces a moderate upward trend in the male retirement rates between 1960 and 1980. This trend is based on BLS projections of participation rates for older males. Social security retirement benefit eligibility at age 62 is assumed available for men after 1962.

THE FINDINGS: The replacement ratios for men retiring before age 60 are much lower than for those retiring at the "normal" retirement age of 65 or more. Only about 3 percent of those retiring before age 60 are projected to have a replacement of 50 percent or more of their average annual earnings from pension income. In contrast, almost one-third of those retiring at age 65 or after are projected to have a replacement above 50 percent. (See table 14 and discussion, p. 32.)

III. HELP FOR THE OLDER WORKER

Enactment of the Age Discrimination in Employment Act [10] more than 2 years ago led to the widespread hope that enforcement and education could be put to work to help prevent older worker problems. At hearings in 1968 and 1969 before the Subcommittee on Employment and Retirement Income of the Senate Committee on Aging, however, legislators expressed some concern about implementation of the act.

In that same 2-year period, several far-reaching studies and demonstration projects have yielded important new concepts about full utilization of workers past age 45. The Labor Department-funded National Institute of Industrial Gerontology has taken national leadership in publicizing and, in some cases, encouraging promising innovation.

A. Implementation of the Age Discrimination Act

At the end of 1969, only one court proceeding had been instituted under the act. Recently the Department of Labor petitioned the Federal district court in Chicago for a permanent injunction to enjoin a transportation firm from violating the statute by denying employment opportunities to individuals over 40 and by illegal advertising.

Enforcement of the act is the responsibility of the Wage and Hour and Public Contracts Divisions in the Department of Labor. In addition, these units also implement the Fair Labor Standards Act, the Walsh-Healey Public Contracts Act, the Davis-Bacon Act, and several other related statutes. Mr. Ben P. Robertson, Deputy Administrator for the Wage and Hour and Public Contracts Divisions, estimated that these divisions employ slightly fewer than 1,000 investigators in the field. When asked how much of their time was devoted to age discrimination activities, he replied, "not over 10 percent of their time." [11]

Study of involuntary retirement.—Section 5 of the ADEA directs the Secretary of Labor to undertake a study concerning the institutional and other arrangements giving rise to involuntary retirement, but this study still has not been initiated. When asked how the Department was approaching this assignment, Mr. Charles Odell, Director of the U.S. Employment Service, stated:

> Well, I have not been directly involved in this study and I have tried my best to pull together information about its status. As best I can describe the position of the people who have the responsibility, it has been that they felt that they really could not undertake the study until they were funded to do so.

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[10] The Age Discrimination in Employment Act was enacted into law on December 15, 1967, and became effective on June 12, 1968. It protects individuals 40 to 64 years old from age discrimination in matters of hiring, discharge, compensation, and other terms, conditions or privileges of employment. Coverage under the law includes (1) employers of 25 or more persons in an industry affecting interstate commerce, (2) employment agencies serving such employers, and (3) labor organizations with 25 or more members in an industry affecting interstate commerce. When a complaint is filed, efforts must be made to eliminate the discriminatory practice through conciliation, conference and persuasion before legal proceedings may be instituted. Only after such attempts have failed are the civil remedies and recovery procedures available for enforcement of the act.

[11] Testimony at hearings cited in footnote 5.

> * * * However, my view of it and the view I intend to convey to the Department officially after looking into what has not been going on is that there is no reason why on the research agenda of the Manpower Administration for the next fiscal year we cannot undertake at least the beginnings of some of the basic kinds of investigation that are required to fulfill this mandate from the Congress.[12]

Other studies dropped.—In a January 1969 report, former Secretary of Labor Willard Wirtz stated that plans were under consideration to study the air transportation, banking, and electrical machinery and equipment industries, since there is a significantly lower percentage of employees 45 years and older than for other industries.

However, these studies were not initiated because the new administration gave greater priority to other reports.

When asked to specify what other reports had a higher priority, Mr. Robertson stated:

> Reports on the impact of the minimum wage and educational institutions, hospitals and certain of the other areas where we have enforcement responsibilities.
>
> * * * * *
>
> There are basically four major survey reports. One, the report of the effects of the minimum wage under the Fair Labor Standards Act, which goes to the Congress from the Secretary each January; and there are three subordinate reports, one on agricultural processing, one on educational institutions, and one on non-Federal hospitals.[13]

Although some progress has been made since the ADEA became operational, a great deal more remains to be done in order to achieve compliance with the act. A rapid increase in staff personnel to enforce the act is urgently needed if the law is to be enforced effectively. Secondly, the study regarding the insititutional and other arrangements giving rise to involuntary retirement should be undertaken as expeditiously as possible. If specific funding is necessary to undertake the study, it is incumbent upon the Department to request the needed appropriations.

B. Promising New Approaches

First established under a contract with the U.S. Employment Service in June 1969, the National Institute of Industrial Gerontology was funded for an additional 2 years in June 1969. As publisher of a quarterly journal and as sponsor of several workshops since its founding, the institute has called for widespread attention to several promising new innovations in the field, including:

—Advantages of the new "discovery" training method over the traditional types of training in terms of preparing the older worker for new employment.

—Utilization of job redesign to enable a larger number of older workers to remain in their jobs.

[12] Testimony at hearing cited in footnote 5.
[13] Testimony at hearing cited in footnote 5.

—Effectiveness of supportive instruction on verbal learning for older workers.

—The value of retraining mature workers for upgraded jobs.

Matching jobs with applicants.—A computerized job bank established in Baltimore, maintains a daily accounting of all jobs that are known to be available in the metropolitan area. It also permits employment service agencies to use the bank in filling jobs. Job banks are now functioning in 10 additional large cities, and will be operational in 55 major cities at the end of this fiscal year.

In Utah a computer-assisted man-job matching system stores all job orders in a central computerized job bank, and all applications for work are kept in a computerized applicant bank. Work qualifications are being matched by the computer with job orders on a daily basis. If the applicant-job matches are not pursued by the interviewers, the computer is programed to ask "why." As a consequence, older applicants selected by the computer may not be so easily rejected by interviewers or counselors who, in the past, did not have this type of "supervision."

Work capacity measurements.—Significant evidence produced by the Institute points out forcefully that there are other alternatives for today's "older worker" besides earlier retirement. Work capacity measurements strongly suggest that "aging" does not have a material effect on an older person's ability to perform. Although it may take a 60-year-old individual about one-twentieth of a second longer than a 20-year-old to present his decisionmaking response to a stimulus, in most positions, this would do little to impede his competence or jeopardize his safety.

Moreover, the flexibility of older workers to adapt to new training has been amply demonstrated in many industries. For example, many middle-aged and older pilots, who had originally learned to fly propeller aircraft, had to be retrained when the airlines converted to jet airplanes. This major conversion required substantial retraining and unlearning of older techniques. Yet these pilots were able to accomplish this transition with success during their late forties and early fifties.

A work capacity measuring system has been employed by De Havilland Aircraft of Canada Ltd., to assess each job to provide a minimum acceptable profile for it. The following seven categories are considered, and each is graded from one to seven:

G—General physique.
U—Upper extremities.
L—Lower extremities.
H—Hearing.
E—Eyesight.
M—Mentality (intelligence).
P—Personality.

This seven-part profile has been found to be especially useful to describe the minimum level of fitness required for each job.

Plant shutdowns.—An early warning system has also been established by the Department of Labor to provide assistance in localities experiencing a large-scale reduction in the labor force, but it has been conducted on a limited basis. Officials from the Federal office or one of the regional offices work with the company, union, and community leaders to help to ameliorate or eliminate significant unemployment because of plant closings, mass layoffs, or other reasons.

The benefits from these supportive services have been amply demonstrated by these pilot projects and other similar programs.

In addition, the increase in the unemployment rate during 1969 also provides a compelling reason to expand considerably the counseling, placement, and recruitment services to help these individuals in finding needed new employment.

RECOMMENDATIONS FOR ACTION

Although employment opportunities are limited for many disadvantaged older workers, several measures can at least help to equalize the older worker's opportunities for employment with those of others in the work force.

First, it is recommended that a Middle-Age and Older Workers Full Employment Act, similar to that introduced in the Senate (S. 4180)[14] in 1968, be enacted and adequately implemented in order to provide a comprehensive program of employment services and opportunities for persons 45 years of age or older.

A section-by-section analysis of the bill appears on p. 332 of the appendix. A portion of this bill (part B of title III) was introduced as separate legislation (S. 3604—The Older American Community Service Employment Act) on March 18, 1970, by Senators Kennedy and Williams and 15 other cosponsors. S. 3604 would authorize the Secretary of Labor to establish a community senior service program for low-income individuals 55 and over who would render needed services which would not otherwise be provided.

Second, there are effective ways of training and retraining older persons if we have the will to do it.

Employment opportunities for mature workers cannot be increased exclusively by measures designed to eliminate discrimination. Today's older workers will need new opportunities for training and retraining if they are to compete in our rapidly changing economy.

Evidence from the plumbing and pipe-fitting industry and the Port of New York Authority shows that upgrading of skills and retraining can produce important financial dividends in meeting continually changing technological demands in industry. Other studies (e.g., the work of Meredith Belbin in England) demonstrate that certain training techniques are clearly superior to others for mature workers. Government training programs should take these techniques into account.

Third, additional efforts must be taken to encourage policies that will keep mature workers effectively informed about the labor market.

Many older workers are unable to locate new employment simply because they are uninformed about job openings in the work force. The computerized job banks, which are undergoing testing in a number of cities, may provide a useful tool in providing a more effective match between applicants and employment opportunities.

Fourth, the matter of pension rights needs prompt and definitive action.

[14] A similar bill was to be introduced in 1970.

With the curtailment of defense and other contracts, large layoffs in local labor markets are likely to occur. Consideration may be given to the desirability of requiring vested pension rights under defined eligibility conditions for Government contracts. This could be very helpful for workers seeking new work when employers are reluctant to hire them since their age would make them only partially eligible under a company's pension plan.

Fifth, experimentation should be undertaken to provide workers 55 and over with extended unemployment benefits when they lose their jobs because of plant shutdowns, layoffs, relocations, or mergers.

This would help to determine the effectiveness of enhancing their chances to continue their job search, instead of being forced to withdraw from the labor force altogether.

IV. SERVICE OPPORTUNITIES

No matter how many avenues are opened to help the older worker back into the labor force, a growing need exists for development of a national service program in which older Americans can help themselves by helping others.

Service programs can be geared for the special needs and desires of elderly participants, especially those who believe that retirement limits them to empty and neglected lives. For many older Americans service in their community can also mean continued self-development and a most rewarding experience in helping citizens in their locality.

A. Experience Under Existing Service Programs

Abundant evidence on the value of service programs was provided once again in 1969 by experiences of several thousands of Americans who participated in the following federally funded programs.

Foster grandparents.—The foster grandparents program was initiated in August 1965 with 21 demonstration projects as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. Low-income persons 60 and over were recruited, trained, and paid to provide supportive services for handicapped, neglected, dependent, or retarded children under 6 years old. Each foster grandparent was assigned two children, serving each child for 10 hours a week.

The project now has 68 projects with 190 participating institutions in 40 States and Puerto Rico. More than 4,000 foster grandparents serve 8,000 children daily and about 16,000 children annually.

While the basic role of the foster grandparent has remained unchanged, some changes have occurred within the program. First, participants now serve children in a wider range of settings, including hospitals, day care centers, Headstart classrooms and mental health clinics. Secondly, the profile of the foster grandparent has changed. For instance, approximately one out of every five foster grandparents is a grandfather; initially the recruitment of males was difficult. In addition, the number of participants 70 and older has increased—from 29 percent to 37 percent. Moreover, the 1969 amendments transferred the authorization for the program from the Office of Economic Opportunity to the Administration on Aging, and changed

it from a demonstration project to a permanent service program under the new title VI (the national older Americans volunteer program) of the act.[15]

Green Thumb and Green Light.—Green Thumb is a work program for older men and is sponsored by the National Farmers Union. It operates under a grant from the Department of Labor as a part of its "Mainstream" program.

To be eligible for participation in the program, a person must (1) be at least 55-years-old, (2) have a farming or rural background, and (3) be below the poverty income level. The average annual income for participants is $900, but the program permits them to earn up to $1,500 per year. Workers under this program have improved or built more than 350 roadside parks in rural America; planted more than 1 million trees, flowers and shrubbery; and helped to restore and develop historic sites.

In June the Green Light program was established to provide employment opportunities primarily for low income women 55 or older. Green Light is operated as a component of the Green Thumb program. Green Light employees, like Green Thumb workers, can earn up to $1,500 annually by working 3 days a week. Green Light workers provide community services as aides for teachers, nurses, librarians, senior citizens, school lunch programs, and the food stamp program. This program is authorized to employ 277 worker-trainees in 11 States—Arkansas, Oklahoma, Minnesota, South Dakota, Wisconsin, Kentucky, Pennsylvania, New Jersey, New York, Indiana, and Virginia.

These programs provide employment opportunities for more than 3,000 low income people in rural America, and have helped to remove more than 10,000 people from the poverty category.

Senior AIDES.[16]—Senior AIDES is an acronym for *A*lert, *I*ndustrious, *D*edicated, *E*nergetic, *S*ervice. The program provides employment opportunities for low income job applicants in the fields of health, education, welfare, and recreation. Senior AIDES work 20 hours per week at an average wage of $2 per hour.

During 1969 the Department of Labor granted the National Council of Senior Citizens an additional $428,000 for further expansion of the program. The additional funds permitted the hiring of 60 AIDES in each of five new cities, Newark, N.J.; Bridgeport, Conn.; Denver, Colo.; Oakland, Calif.; and San Diego, Calif. These five new projects will increase the total number of Senior AIDES projects to 19. A total of 1,150 men and women 55 and over will be employed at the 19 projects.

Senior community service programs.[17]—Supported by Department of Labor funds and administered by the National Council on the Aging, the Senior Community Service program employs about 500 Senior AIDES in the fields of health and social welfare. Participants in the program earn about $1.80 an hour and work about 20 hours per week.

The original contract in 1968 provided for employment opportunities for about 400 older persons in 10 communities. In March 1969 the agreement was modified to extend the program to Hoboken, N.J., and to increase the number of job opportunities in three other communities.

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[15] See app. 1 for AoA report on Foster-Grandparent program.
[16] See app. 1 for Department of Labor report on this program.
[17] See appendix mentioned in footnote 15.

To be eligible for participation, an applicant must (1) be 55 or older, (2) have an income within the OEO poverty index, (3) be retired or unemployed for 15 weeks or longer, (4) have no reasonable expectation of other employment or training, and (5) reside near the job site.

Project FIND (Friendless, Isolated, Needy, and Disabled).—The project FIND Survey of the elderly poor, conducted by the National Council on the Aging from August 1967 to November 1968 in 12 communities, was undertaken to help understand better and to document the characteristics and needs of this group.[18] It supported action in the following areas to (1) locate the elderly poor and identify their needs, (2) involve the elderly poor in community action programs, and (3) strive for new services for major unmet needs.

During 1969 the research component of Project FIND was continued to tabulate and analyze the data compiled during its 18 months of operation. These findings provided valuable background information and the major focus for an Office of Economic Opportunity National Voluntary Organization Conference in Washington in November 1969.

Approximately 370 aides, ranging in age from 50 to 85, were employed to gather this information. Nearly 50,000 persons were contacted and 44,000 questionnaires were completed. Significant findings include:

—33 percent were not signed up for Part B (Medical Insurance) of Medicare.
—33 percent of the elderly had incomes less than $1,000 per year.
—55 percent had incomes under $1,500.
—24 percent had transportation problems.
—36 percent of the elderly poor considered their health to be poor or very poor.
—31 percent could not prepare their meals without assistance.
—65 percent said that "they could not make ends meet."

The 2-year period for the Senior AIDES program is drawing to an end, and limited funding may soon threaten others.

Therefore, a vital need exists for establishing the national program to continue and broaden the fine work so well demonstrated in the pioneering projects.

The committee renews its recommendation for enactment of legislation for a national Older Americans Community Service program.[19]

B. Another Opportunity: Day Care

H.R. 13520 authorizes the Secretary of HEW to provide grants to public and private agencies in carrying out comprehensive educational and day care programs, including programs which focus on the needs of economically disadvantaged children. Hearings were held on this legislation in 1969 by the Select Subcommittee on Education of the House Education and Labor Committee, and further hearings are scheduled for 1970.

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[18] For futher information see Office of Economic Opportunity report in app. 1.

[19] S. 3604, the Older American Community Service Employment Act, was introduced on Mar. 18, 1970, to provide additional opportunities for community service employment for low-income persons 55 and older.

According to the latest data, there are approximately 4.5 million children under 6 years of age and 6.4 million 6 to 11 years old who have working mothers. However, it is estimated that there are only about 600,000 places in licensed day care centers, although the estimated need is about 3 or 4 million. Federally assisted programs presently provide about 172,000 of the available places.

Older persons may provide a valuable source of manpower for the successful operation of these needed day care centers. Consideration may be given to include language in the bill or other related proposals which would require that a (1) fixed percentage or designated number of persons employed in day care centers be older workers or (2) policy declaration encourage the employment of such persons.

Public Law 91–86, which amends the Labor-Management Relations Act to permit employer contributions to trust funds established to finance child care centers, may also provide employment opportunities for older persons as day care aides.

CHAPTER X

FIGHTING POVERTY AMONG OLDER AMERICANS

In terms of dollar outlay, 1969 brought a slight improvement for older person programs funded by the Office of Economic Opportunity. However, there is still reason for concern. One reason is that 18 percent of all persons living in poverty are 65 and over, and 26.5 percent are 55 and older. In 1959, 15.4 percent of the total population living in poverty were 65 and older, and 23.8 percent were 55 and older. While the total number of older persons in poverty had decreased since 1959, their percentage of the total poverty population has increased.

In 1959 there were 38,766,000 persons living in poverty. By 1968 this figure was reduced significantly to 25,389,000—a 34.5 percent decline. Poverty for persons 55 and older declined from 9,243,000 in 1959 to 6,717,000 in 1968—a 27.3 percent reduction. For persons 65 and over the percentage decrease was significantly lower. Poverty for this age group decreased from 5,972,000 in 1959 to 4,630,000 in 1968—for only a 22.5 percent reduction.

OEO Director, Donald Rumsfeld,[1] pointed to a number of factors concerning the slower reduction in poverty among the elderly:

—The cost of health care after 65 is nearly three times (2.75) that for younger people; and

—An increasing number of elderly poor are women.

I. THE REVISED STATISTICS ON THE ELDERLY POOR

The original poverty index was developed by the Social Security Administration in 1964.[2] This index established a range of poverty income thresholds based on such factors as (1) family size, (2) location of residence, (3) the sex of the head of the family, and (4) the age of family members. At the basis of this definition was the economy food plan, established by the Department of Agriculture for "emergency or temporary use when funds are low." This index was adjusted yearly to reflect changes in the average per capita cost of foods for the economy food plan.

In families with three or more members, the poverty level was set at three times the cost of the economy food plan. This was the average food cost to the family-income relationship determined by a Department survey of food consumption.[3] For smaller families the cost of the economy food plan was multiplied by slightly larger factors to take into account the higher fixed expenses incurred by such house-

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[1] News-Notes No. 13, Fall 1969, Commission on the Aging, National Conference of Catholic Charities, p. 3.

[2] For a detailed discussion of the SSA poverty index, see Mollie Orshansky, "Counting the Poor: Another Look at the Poverty Profile," Social Security Bulletin, January 1965; and "Who's Who Among the Poor: A Demographic View of Poverty," Social Security Bulletin, July 1965.

[3] See U.S. Department of Agriculture, "Food Consumption and Dietary Levels of Households in the United States" (ARS 626), August 1957.

holds. Adjustments were also made for farm families to account for the value of food consumed which they had grown. A 1961 study of household consumption indicated that the value of food produced by farm families for their own consumption amounted to about 30 percent of their total food budget. Consequently, the poverty level for farm families was set at 70 percent of the nonfarm threshold.

A Federal Interagency Committee was established to examine the original poverty index. As a result of its deliberations, the committee recommended that two changes be incorporated into the original poverty definition. First, the Committee recommended that the SSA poverty threshold for nonfarm families should be retained for the 1963 base year, but annual adjustments should reflect changes in the Consumer Price Index rather than changes in the cost of foods included in the economy food plan. The previous method of updating the poverty index did not fully reflect increases in the overall cost of living. For instance, the CPI increased by 13.7 percent from 1959 to 1966, but the poverty threshold increased by 7.9 percent for an "average" family during this period. One advantage in using the CPI is that it clearly shows that the cost of food and nonfood commodities do not always change at the same rate. Moreover, the CPI is generally accepted as a measure of the change in the cost of living.

Secondly, the committee recommended that the farm poverty thresholds should be changed from 70 to 85 percent of the corresponding nonfarm levels. Recent research suggests that the difference in the living costs between farm and nonfarm families is not as great as provided by the 70 percent differential. After examining all available evidence, the committee concluded that narrowing the farm-nonfarm poverty differential to 85 percent would be a more accurate indication of the overall cost of living differences in farm and nonfarm families.[4]

The following tables will illustrate the differences in the poverty thresholds under the original and revised definitions.

[4] Information in this section excerpted from Current Population Reports, Special Studies, "Revision in Poverty Statistics, 1959-1968," series p-23, no. 28, Aug. 12, 1969.

TABLE C.—*Comparison of weighted average thresholds at the poverty level in 1967, 1963, and 1959, by size of family and sex of head, for the United States by farm-nonfarm residence based on revised and original poverty definitions*

Number of family members	Revised definition						
		Nonfarm			Farm		
	Total	Total	Male head	Female head	Total	Male head	Female head
1967							
1 member	$1, 669	$1, 675	$1, 750	$1, 632	$1, 440	$1, 476	$1, 382
2 members	2, 149	2, 168	2, 178	2, 110	1, 835	1, 841	1, 754
3 members	2, 640	2, 661	2, 674	2, 573	2, 256	2, 264	2, 168
4 members	3, 388	3, 410	3, 412	3, 393	2, 906	2, 907	2, 882
5 members	3, 992	4, 019	4, 022	3, 984	3, 431	3, 431	3, 438
6 members	4, 476	4, 516	4, 517	4, 497	3, 851	3, 852	3, 808
7 or more members	5, 486	5, 550	5, 562	5, 433	4, 719	4, 720	4, 667
1963							
1 member	1, 531	1, 539	1, 605	1, 498	1, 314	1, 349	1, 270
2 members	1, 967	1, 988	1, 997	1, 933	1, 684	1, 688	1, 608
3 members	2, 421	2, 442	2, 454	2, 352	2, 067	2, 075	1, 981
4 members	3, 104	3, 128	3, 129	3, 113	2, 664	2, 665	2, 641
5 members	3, 652	3, 685	3, 687	3, 661	3, 139	3, 138	3, 145
6 members	4, 089	4, 135	4, 136	4, 112	3, 538	3, 536	3, 581
7 or more members	5, 008	5, 092	5, 100	5, 000	4, 331	4, 339	4, 226
1959							
1 member	1, 458	1, 467	1, 529	1, 428	1, 256	1, 297	1, 205
2 members	1, 872	1, 894	1, 904	1, 843	1, 609	1, 613	1, 552
3 members	2, 296	2, 324	2, 335	2, 235	1, 972	1, 977	1, 880
4 members	2, 943	2, 973	2, 974	2, 957	2, 539	2, 539	2, 524
5 members	3, 460	3, 506	3, 507	3, 483	2, 988	2, 987	3, 006
6 members	3, 888	3, 944	3, 944	3, 941	3, 355	3, 354	3, 363
7 or more members	4, 725	4, 849	4, 856	4, 763	4, 117	4, 120	4, 040

See footnotes at end of table, p. 131.

TABLE C.—*Comparison of weighted average thresholds at the poverty level in 1967, 1963, and 1959, by size of family and sex of head, for the United States by farm-nonfarm residence based on revised and original poverty definitions*—Con.

Number of family members	Orginial definition						
		Nonfarm			Farm		
	Total	Total	Male head	Female head	Total	Male head	Female head
1967							
1 member	$1, 625	$1, 635	$1, 710	$1, 595	$1, 145	$1, 180	$1, 110
2 members	2, 083	2, 115	2, 128	2, 062	1, 475	1, 482	1, 412
3 members	2, 559	2, 600	2, 613	2, 514	1, 815	1, 822	1, 744
4 members	3, 290	3, 335	3, 334	3, 315	2, 345	2, 347	2, 320
5 members	3, 873	3, 930	3, 930	3, 893	2, 755	2, 772	2, 768
6 members	4, 334	4, 410	4, 414	4, 394	3, 090	3, 085	2, 553
7 or more members	5, 298	5, 430	5, 435	5, 309	3, 790	3, 799	3, 742
1963							
1 member	1, 524	1, 539	1, 605	1, 498	1, 088	1, 116	1, 053
2 members	1, 946	1, 988	1, 997	1, 933	1, 386	1, 390	1, 324
3 members	2, 401	2, 442	2, 454	2, 352	1, 698	1, 708	1, 597
4 members	3, 080	3, 128	3, 129	3, 113	2, 195	2, 195	2, 321
5 members	3, 620	3, 685	3, 687	3, 661	2, 585	2, 585	2, 592
6 members	4, 042	4, 135	4, 136	4, 112	2, 936	2, 923	3, 196
7 or more members	4, 923	5, 092	5, 100	5, 000	3, 567	3, 574	3, 478
1959							
1 member	1, 489	1, 509	1, 573	1, 469	1, 063	1, 099	1, 022
2 members	1, 902	1, 948	1, 958	1, 896	1, 361	1, 365	1, 314
3 members	2, 333	2, 390	2, 402	2, 299	1, 670	1, 676	1, 593
4 members	2, 996	3, 059	3, 060	3, 042	2, 155	2, 155	2, 139
5 members	3, 511	3, 605	3, 606	3, 582	2, 536	2, 530	2, 545
6 members	3, 943	4, 058	4, 056	4, 075	2, 841	2, 841	2, 849
7 or more members	4, 733	4, 987	4, 994	4, 900	3, 495	3, 489	3, 633

Note: Farm poverty thresholds in the revised definition are 85 percent of the nonfarm thresholds, whereas a 70-percent farm-nonfarm differential was employed in the original definition. The revised definition uses the Consumer Price Index to adjust the poverty thresholds annually to account for changes in the cost of living. Annual adjustments in the poverty thresholds under the original definition were based on changes in the per capita cost of the economy food plan. See text for an explanation of these differences between revised and original poverty definitions.

TABLE 1.—*Weighted average thresholds at the poverty level in 1968 by size of family and sex of head, by farm-nonfarm residence*

Number of family members		Nonfarm			Farm		
	Total	Total	Male head	Female head	Total	Male head	Female head
1 member	$1, 742	$1, 748	$1, 827	$1, 700	$1, 487	$1, 523	$1, 441
2 members	2, 242	2, 262	2, 272	2, 202	1, 904	1, 910	1, 812
3 members	2, 754	2, 774	2, 788	2, 678	2, 352	2, 359	2, 258
4 members	3, 531	3, 553	3, 555	3, 536	3, 034	3, 031	3, 018
5 members	4, 158	4, 188	4, 191	4, 142	3, 577	3, 578	3, 565
6 members	4, 664	4, 706	4, 709	4, 670	4, 021	4, 021	4, 020
7 or more members	5, 722	5, 789	5, 804	5, 638	4, 916	4, 919	4, 847

II. USES OF THE SENIOR OPPORTUNITIES AND SERVICES PROGRAM

The Senior Opportunities and Services program (SOS) was authorized as a special emphasis program under the 1967 amendments to the Economic Opportunity Act. It is designed to identify and meet the needs of individuals above the age of 60. These projects serve the elderly poor through senior citizen centers, health planning, community involvement, home health aides, food distribution, and neighborhood outreach programs. Other services are also provided, including consumer education, transportation, and home day care for the infirm elderly. Moreover, a new national demonstration program has been initiated to provide special legal services for the elderly poor and to study their legal problems.

During fiscal year 1969 more than 200 SOS projects were in operation in 45 States.[5] These projects served more than 670,000 older persons at a unit cost of less than $10 per beneficiary. In addition, it is estimated that more than 4,000 senior citizens were trained, referred for employment, or employed under the SOS program.

Although the program has been in existence for a relatively brief period, a number of preliminary evaluations indicate that:

1. The unit cost per beneficiary is low.
2. In many instances participants have been able to improve their economic and psychological status while helping other older individuals.
3. The program has provided a useful outreach and referral service to many poor people, who were frequently unaware of the existence of such services.
4. Increased employment opportunities have been provided to elderly persons as nonprofessional aides in educational, health, and social institutions.

The 1969 Economic Opportunity Amendments (Public Law 91-177) authorized $8.8 million for the SOS program during fiscal year 1970. Approximately $7.6 million will be used to fund projects currently in operation, including those originally supported by local initiative. With regard to new project starts, emphasis will be placed on rural areas having high concentrations of elderly poor persons, and urban areas where the existing resource base can be utilized at a minimal incremental cost.[6]

III. MAINSTREAM

Mainstream, which is administered by the Department of Labor, is directed at the needs of the chronically unemployed poor who have limited employment prospects because of age or other disadvantages. In December 1968 an administrative notice recommended that 40 percent of all enrollees in the Mainstream program should be 55 and older.

To be eligible for participation, an individual must be at least 22 years old and come from a family whose income is below the poverty level. Priority is given to persons who (1) have been unemployed for

[5] Report from the Office of Economic Opportunity to the Senate Special Committee on Aging, appendix 1, p. 255.
[6] Report cited in footnote 5.

15 consecutive weeks or longer, repeatedly unemployed during the past 2 years, or employed less than 20 hours per week for more than 26 consecutive weeks; (2) have completed some training but still remain unemployed; or (3) lack current prospects for training or employment because of age or other reasons.

Individuals enrolled in Mainstream during the first half of fiscal 1969 had the following characteristics:

—Eighty percent were male;

—Eighty percent had less than 12 years of formal education, and 67 percent had completed no more than nine grades;

—Estimated annual family income of most enrollees was between $2,000 and $5,000, but 25 percent reported income of less than $2,000; and

—Seventeen percent of the families were receiving public assistance.

A number of training and employment projects are designed to provide employment opportunities for persons with a history of long-term unemployment or underemployment. In addition, necessary supportive services are made available to individuals in need of such assistance. Participants in the program provide a wide variety of useful services, including community beautification; conservation of natural resources; and extension of health, day care, and recreational services. Surveys and interviews have revealed great enthusiasm among the enrollees, since employment is helpful in restoring their confidence and self respect. Moreover, the program is providing services to communities which would not otherwise be possible.

During fiscal 1969 the Department of Labor funded more than 200 Mainstream programs. A total of 12,787 enrollee spaces were funded during the year, and over 21,000 persons were served.

Moreover, five national contracts for employment opportunities for older workers were funded during 1969, which provided about 4,500 enrollment opportunities. These projects normally provide community service work for low-income senior citizens, who work about 20 hours per week. The five project sponsors include:

Sponsor	Authorized funds	Jobs
National Council of Senior Citizens	$3, 200, 000	1, 132
National Farmers Union	5, 200, 000	2, 314
(Green Thumb)	(4, 700, 000)	(2, 044)
(Green Light)	(500, 000)	(270)
National Council on the Aging	2, 300, 000	500
National Retired Teachers Association	738, 000	313
Virginia State College	320, 000	115

IV. POVERTY AMONG MINORITY GROUP ELDERLY

Although about one out of every four persons 65 and older would be considered poor, the percentage among minority groups is nearly twice as great. Among nonwhite persons 65 and over, 46.6 percent are victims of poverty. Nearly one out of every two (47.7 percent) Negroes 65 and older is poor. Moreover, the nonwhite poor appear to suffer from deeper extremes of poverty, and their efforts to escape are frequently compounded because of prejudices in our society.

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Because of the prevalence and persistence of poverty among the elderly in minority groups, a substantial increase in minimum payments under Social Security may be of particular assistance to them. It is estimated that the 15 percent across-the-board increase in Social Security benefits provided in the Tax Reform Act (Public Law 91-172) will remove 910,000 persons 65 and older from the poverty category. However, if the minimum benefit had been increased from $55 for a single individual to $90, another 400,000 would have escaped from poverty.[7]

Under the Williams-Gilbert proposal,[8] Social Security benefits would be increased by another 5 percent in 1970, and the minimum benefit for a single person would be raised to $90. Approximately 2.1 million persons would move out of poverty under this approach—nearly 1.4 million persons 65 and over and another 700,000 younger than 65.

Although Social Security is not generally viewed as an antipoverty weapon, it has been the most formidable means of reducing poverty in the United States. In the Department of Health, Education, and Welfare annual report, submitted in January 1969, Secretary Wilbur Cohen said:

> For the first time since the world began, we, as a Nation, have the capacity to end poverty. The most formidable weapon in our arsenal is one most Americans have not usually thought of as an antipoverty program—Social Security. The Social Security and unemployment insurance systems moderate the loss in earnings due to retirement, death, disability, and temporary unemployment. They offer American workers and their families basic, necessary protection.
>
> For instance, Social Security is the main source of continuing income for retired people—many would be destitute without it. Social Security benefits keep 10 million people above the poverty level. Without these benefits, they would have to depend on relatives who often could not readily afford such support, or they would have to go on relief rolls. Without these benefits, 19 out of 20 beneficiaries would not achieve even a moderate living standard.

Improvements in this essential, but imperfect system, can allow many minority group elderly persons to escape from poverty.

The Mexican-Americans.—The Senate Special Committee on Aging during 1969 continued its study of "Usefulness and Availability of Federal Services and Programs to Elderly Mexican-Americans."[9] One fundamental problem, discussed at every hearing by almost every witness, was the poverty faced by most older Americans in this minority group. Social Security levels are generally low because of: limited employment opportunities, work in areas not covered by the program, and confusion about eligibility.

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[7] Estimates from Social Security Administration.

[8] S. 3100 introduced by Senator Harrison Williams on Nov. 3, 1969. H.R. 14430 introduced by Congressman Gilbert on Oct. 21, 1969. For summary of major provisions see appendix 3, item 3, p. 332.

[9] Hearings on "Usefulness and Availability of Federal Programs and Services to Elderly Mexican-Americans," pt. I, Los Angeles, Calif., Dec. 17, 1968; pt. II, El Paso, Tex., Dec. 18, 1968; pt. III, San Antonio, Tex., Dec. 19, 1968; pt. IV, Washington, D.C., Jan. 14 and 15, 1969; and pt. V, Washington, D.C., Nov. 21 and 22, 1969.

Senator Ralph Yarborough—who announced late in 1969 that the committee study would continue with at least one more hearing—also raised the following questions:

> When the new administration went in we postponed these hearings until now, November, to give the new administration an opportunity to look at what has been done and think about what they would do. We did not think very much could be testified to in May or June.
>
> We want to know the following:
>
> —What more has been done since January to hire and train bilingual field personnel who can counsel and help elderly Mexican-Americans on such matters as Social Security coverage, housing, health care, and the like?
>
> —What more has been done since January to establish, within our Federal departments and agencies, a communication and specialist network capable of dealing more effectively with needs of all Mexican-Americans, including the elderly?
>
> —What more has been done since January to cope with the special problems of those elderly Mexican-Americans who stand in need of housing and do not now receive help from any federally assisted program?
>
> —What more has been done since January to resolve problems along the Mexican-United States border that are of direct concern to the elderly Mexican-American, including a high incidence of tuberculosis in some areas?
>
> —And finally, what dialog exists between the present administration and the leaders of Mexican-American organizations to bring these results about?

CHAPTER XI

THE ADMINISTRATION ON AGING: BROADENED ROLE, FUNDING PROBLEMS

The Administration on Aging, which was created in 1965 to provide a Federal focus and apparatus for programs and other activities to improve the lives of older Americans, was given new responsibility when the Congress passed the Older Americans Act Amendments of 1969 and sent them to President Nixon for his signature on September 17, 1969. But along with the legislation went questions about funding and about the role of the AoA itself.

I. OLDER AMERICANS ACT—SERVING A MILLION PEOPLE

The Administration on Aging estimated in 1969 that more than 1 million individuals received direct service under the programs authorized under the Older Americans Act.

Today only four States do not have title III[1] State and community programs on aging in operation. Approximately 1,100 title III projects were funded during fiscal 1969:

- 99,100 older Americans were served through home maintenance, friendly visiting, or telephone reassurance;
- 38,400 received personal counseling services;
- 79,700 benefited from transportation service;
- 532,000 participated in recreational and leisure programs;
- 10,000 received homemaker or home health services;
- 20,300 benefited from meal services; and
- 15,400 received employment referral services.[2]

II. AMENDMENTS BOLSTER AoA

Adopted with overwhelming support, the 1969 amendments[3] to the Older Americans Act made far-reaching changes.

A major innovation was the establishment of a new retired senior volunteer program ("RSVP") to recruit persons 60 and over to provide needed services in their communities.[4]

A new title VI (National Older Americans Volunteer Program) was added to the act and provided for the transfer of the foster grandparent program from the Office of Economic Opportunity to the AoA.

State agencies on aging were provided with additional funding authorizations and broad new responsibilities for planning, coordination, and evaluation of all State programs for older Americans.

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[1] Title III is the AoA grant program which makes Federal funds available to States to help communities initiate a wide variety of service programs.
[2] For a detailed AoA report, see app. 1, item 1.
[3] Public Law 91-69, Older Americans Act Amendments of 1969, approved Sept. 17, 1969.
[4] For additional information see Ch. IV. Areas of Special Need.

As a further measure to strengthen State and community services, the amendments authorized a program for areawide model projects under title III to provide services, or create opportunities, for older persons. Under this program the Secretary of Health, Education, and Welfare would be authorized to enter into contracts with or make grants to State agencies to pay 75 percent of the cost of the projects.

Another important amendment repealed the prohibition of Federal support after 3 years for title III community planning, services and training projects, and would permit 50-percent Federal support for certain selected projects for an unlimited number of years. Previously, Federal support was available for 3 years on a declining 75-, 60-, 50-percent matching formula. This amendment would provide State agencies with greater flexibility to determine the timespan for title III projects, which show significant promise of continued benefit to older people and contribute to the development of comprehensive services for older Americans.

III. STRUGGLE FOR FUNDING

In recognition of the increased need for expanded services and new opportunities for older Americans, the 1969 amendments also made significant increases in the authorizations for programs under the Older Americans Act. A 3-year authorization of $252 million was provided under the amendments, and $62 million was authorized for fiscal 1970.

The original budget estimate for fiscal 1970 by the Johnson administration requested $29,500,000 in appropriations to carry out the purposes of the Older Americans Act. The revised budget estimate by the present administration reduced this figure to $28,360,000—approximately $1.42 per senior citizen.

In testifying before the Senate Appropriations Committee in November, John Martin, U.S. Commissioner on Aging, stated:

> The recent amendments to the Older Americans Act provide expanded authorizations and add new programs. The 1970 budget request for $28,360,000 was not designed to provide funds for the implementation of these changes; however, certain shifts of funds must be made to enable the current minimum legal requirements of the act to be met.[5]

The cutback in the fiscal 1970 appropriations for programs for the aging represents a serious turn of events, which could possibly nullify to a substantial degree the accomplishments made under the Older Americans Act during its first 4 years. It is recommended that the funding for the AOA programs be increased substantially to fulfill the intent the Congress as expressed in the 1969 amendments.

Percy amendment.—In January the Johnson administration recommended $11.5 million in funding for fiscal 1970 for the title III community planning and services programs. This amount was reduced to $9 million by the new administration. This would fund about 700 projects, approximately 400 fewer than in fiscal 1969.

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[5] John Martin, Special Assistant to the President, for the Aging. Hearing, before the Subcommittee of the Senate Appropriations Committee on H.R. 13111, making appropriations for the Departments of Labor and Health, Education, and Welfare, Nov. 19, 1969, p. 3333.

In November 1969 Senator Percy introduced an amendment to the Labor-HEW appropriations bill to increase the funding for title III projects to $20 million. In his statement on the Senate floor, Senator Percy said:

> The additional funds provided by this amendment will make a significant impact in every State. For Illinois, they will make the difference between a $700,000 grant—a slight increase from the $613,000 approved last year—or a $318,087 grant for title III programs representing almost a 50-percent decrease from the previous year. They will thus contribute to the expansion rather than the reduction of many worthwhile projects. There is no earthly reason why in a rich America of the 1970's we cannot provide better for poor senior citizens in great need of help.[6]

At the urging of Senator Percy and Senator Williams of New Jersey, the Senate Appropriations Committee provided an additional $7 million for the title III programs. In recommending the increase, the committee report said:

> This will provide for a more adequate implementation of the new legislation than would be possible with the budget estimate. The committee sees no reason to postpone this implementation until the 1971 budget.[7]

In spite of this bipartisan support, the additional $7 million for title III under the Senate-passed bill was removed when the appropriations bill was considered in conference committee.

Four years of successful operations have amply demonstrated the need for title III programs, but significant increases in appropriations are necessary to enable many more older Americans to benefit from these successful projects.

IV. AREAS OF SPECIAL NEED

A. RSVP: Welcomed, But Not Funded

The retired senior volunteer program was enacted to provide new opportunities for community service for senior citizens who would serve their communities without compensation, except for reimbursement for transportation, meals, and other out-of-pocket expenses.

RSVP would provide a new national resource to allow communities to benefit from the skills and experience of senior citizens, including counseling and tutoring of schoolchildren; assisting schools as lunchroom supervisors, playground monitors, and teacher aides; rendering services in hospitals and nursing homes, providing companionship for lonely older Americans, and assisting their communities in other needed services.

Witnesses at the hearings enthusiastically endorsed the program and indicated that there could be as many as 1 million older persons who would be interested in serving their communities. For example, Mrs. Janet Sainer, project director of SERVE,[8] testified:[9]

[6] Cong. Rec., Nov. 13, 1969, p. S. 14267.
[7] S. Rept. 91-610 to accompany H.R. 13111, p. 77.
[8] An AoA-supported program which has enlisted hundreds of volunteers to serve in institutions and service agencies of Staten Island.
[9] Hearing before the Special Subcommittee on Aging of the Senate Labor and Public Welfare Committee on bills to amend the Older Americans Act of 1965, June 19, 1969.

> This national older Americans volunteer program is a forward-looking concept of care and concern for the elderly, stressing the positive potential of the older person and emphasizing his dignity and self-esteem.
>
> Such a program enables him to be the giver rather than the receiver of services. Such a program gives him the status and the recognition that is often lacking in the later years and such a program creates a new image of the aging in the community.
>
> Our experience in SERVE * * * has shown that older persons can contribute in many significant ways if encouraged and if given the opportunity.[10]

William Hutton, executive director for the National Council of Senior Citizens, also expressed support:

> Under the legislation communities will be encouraged to make use of the talents, skills, and know-how of the many retired men and women who do not have to work for wages but would like to work for community betterment.[11]

A $5 million authorization for the RSVP program was provided to enable many of these individuals to participate in meaningful community activities, but no funding was requested in the fiscal 1970 revised budget estimate submitted by the new administration.

Many pilot programs have already demonstrated that older persons can make valuable contributions in a wide variety of public service type activities. However, without funds for RSVP, many older Americans will continue to be excluded from purposeful activities in their communities.

B. Training: "A Critical Shortage"

Title V of the Older Americans Act was enacted to help provide the trained personnel vitally needed in the field of aging. Federal assistance is authorized under this title to (1) support recruitment and training of personnel in the field of aging, (2) develop university curricula and training material for social planning and responsive services, (3) assess the supply of and demand for personnel for older Americans, and (4) assess the skills required for leadership and responsible performance in emergent occupations serving elderly persons.

In recognition of the importance of trained personnel for the elderly, a provision in the 1967 amendments to the act directed the Secretary of Health, Education, and Welfare to study and evaluate (1) the immediate and foreseeable need for specialized training personnel to carry out the objectives of the act and (2) the availability and adequacy of educational resources for persons preparing for work in the field of aging. This study, entitled "The Demand for Personnel and Training in the Field of Aging," declared in 1968 that there is a critical shortage of trained and specialized personnel in programs serving the elderly. For example, the report declares:

> Although some progress has been made in developing appropriate training programs it is far behind the expanding

[10] Testimony at hearing in footnote 9, p. 127.
[11] Testimony at hearing in footnote 9, p. 110.

need. As a result most, if not all, service programs are faced with critical shortages of trained personnel. The outlook is for little improvement in this regard unless drastic changes are made in the scope and character of the training effort.[11a]

Commissioner Martin recognized in testimony last June [12] that there is a pressing need for trained personnel to serve older Americans.

This report [the Surveys & Research Corporation Survey, Oct. 1, 1968] estimates that personnel required for programs devoted solely to primarily serving older people will increase from approximately 330,000 today to at least 1 million by the early 1970's; that within the next 2 or 3 years there will be a need for 500 or more additional persons to serve in State and Federal planning, coordination, and evaluation agencies; 800 more senior center directors; from 8,000 to 13,000 management personnel for retirement housing projects; and from 23,000 to 31,000 additional trained workers for recreation programs for older people.

Moreover, the S. & R. report estimated that fewer than 10 to 20 percent of the 330,000 professional and technical workers have had formal preparation to work with the elderly.

In January the outgoing administration recommended $3.5 million in funding for the title V training program, approximately $600,000 more than in fiscal 1969. This was in recognition of the documented need for more adequately trained personnel in the field of aging. In the revised budget submitted by the present administration, the funding for title V was reduced to $2,610,000—a 25-percent reduction. It was estimated that this amount would support 18 continuation projects which would fund about 285 long-term career students and a few short-term trainees. The Senate Appropriations Committee recommended an additional $290,000 to restore the training program at approximately the fiscal 1969 funding.

During the consideration of the Labor-HEW appropriations bill, the Senate adopted the Williams amendment which increased the funding in the committee bill for the training program by $600,000, from $2.9 million to $3.5 million.

In the House-Senate conference committee, the increase in funding under the committee bill and the Williams amendment was deleted.

The need for personnel with specialized knowledge in the field of aging is reaching emergency proportions. An immediate all-out effort on the part of Government and educational institutions is essential if the situation is to be improved. Implementation of the recommendations contained in "The Demand for Personnel and Training in the Field of Aging" should be the very minimum action taken to meet the need for trained personnel in programs serving the elderly. Omnibus legislation for this purpose should be introduced at the earliest feasible date.

[11a] Page VIII.
[12] Testimony at hearing in footnote 9, p. 127.

C. Research: Steps Toward Goal Definition

Title IV (Research and Demonstration) of the Older Americans Act was enacted to help provide answers to many questions and problems affecting elderly persons. Grants and contracts are awarded for research and demonstration projects that develop, study, or illustrate methods of (1) increasing opportunities to participate in community activities, (2) retaining social productivity, (3) maintaining essential human contacts, (4) coordinating community social, health, and welfare services to increase their efficiency for older persons, (5) defining the effects of changing social conditions on the lives of older people, and (6) identifying factors that are beneficial or detrimental to their well-being.

Since its inception in 1966, the title IV research and demonstration program has funded 99 out of the total of over 300 formal applications for assistance. Findings from these projects have provided significant information about aging. In addition, these findings have helped in the program and policy development at all levels of Government.

Examples of the impressive results from the research and demonstration projects are many. For instance, a new area of knowledge is being opened for the first time as title IV projects examine the dynamics of the relationship between transportation in terms of availability, accessibility, and cost and the ability of senior citizens to utilize health, social, and other services.

A study conducted by the University of Denver refutes the stereotype of the older driver as a high-insurance risk. In fact, the study reveals that older drivers have fewer accidents per driver than does the total population. In some States older individuals have fewer accidents and better driving records than drivers of all other ages. Commissioner Martin, in testifying before the Senate Appropriations Committee, said:

> These findings have contributed significantly to recent recommended rate reductions by the insurance rating board which could result in savings amounting to $50 million in a single year to all older drivers in this country.[13]

Social gerontology.—Important as individual research projects may be, the Administration on Aging and the National Gerontological Society have seen a need "to define areas and problems of research explicitly aimed to answer questions of social policy about matters that affect the lives of people in their middle and later years—income, living arrangements, family relations, comfort, and satisfaction." [14]

Acting to meet that need, the AoA in 1969 provided funds for the society to establish a Committee on Research and Development Goals in Social Gerontology. Its major responsibilities are: To survey existing research, recommend certain subjects as especially worthy of support by public and private funding agencies, focus on areas that promise to be especially valuable as bases for determining social policies and guiding governmental and private practices; and further delineating research problems within these areas.

[13] Testimony at hearings in footnote 5, p. 3337.

[14] From "Research and Development Goals in Social Gerontology," a report of a Special Committee of the Gerontological Society, Robert J. Havighurst, chairman, published in the Gerontologist, winter 1969.

During 1969 the committee met those areas of major significance, and issued an interim report which—in the words of its authors—"stands as proof that there remain a host of questions in the minds of researchers in the field of aging."

During the second phase of its work, the committee will make detailed recommendations related to the four areas described as of major significance for social policy:

1. Work, leisure, and education: Flexible life styles.
2. Living arrangements of older people: Ecology.
3. Social services for older people.
4. The economics of aging.

Under AoA sponsorship, representatives of many disciplines on aging met in Washington, D.C., on December 9 for a day-long workshop on research goals. AoA Commissioner Martin described the event as a major step toward a research enterprise enlisting participants from governmental and private sources.[15]

Sixty-five participants—meeting at the call of the Gerontological Society—deliberated at afternoon workshops and produced a set of mutually agreed upon directions:

1. A call for the development of a Center for Research and Training within Child Health and Human Development (NICHD);
2. Development of a National Commission on Mental Illness of the Aged. The purpose would be to secure a comprehensive plan and report on needs of the elderly. The subjects would include the needs of the aged for organization of services with implications for research as well as scientific and professional training;
3. A recommendation that the Special Adviser to the President on Aging, John Martin, establish a scientific advisory panel prepared to monitor ongoing research activities of the Federal Government in aging;
4. A high-priority request to the National Institutes of Health to establish a Gerontology Study Section; and
5. A call for the various national organizations to coalesce their efforts in matters of social policy and information regarding legislation.

FUNDING

A total of $3,250,000 was requested for title IV projects in fiscal 1970, approximately $900,000 less than in fiscal 1969. This amount would fund 49 projects, 20 fewer than in fiscal 1969.

The variety of issues, policy questions, and research areas present cogent reasons for continuing work in the field of research and demonstration. Identification of such questions can be a significant step in continuing to expand our knowledge about the problems of the elderly and recommendations for improvement. To make this goal a reality, vitally needed funding will be necessary to meet the policy goals established in authorization legislation.

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[15] See app. 1, p. 205 for AoA report on this workshop.

D. White House Conference on Aging

On September 28, 1968, President Johnson signed a joint resolution into law (Public Law 90-526) to authorize $1,900,000 for a White House Conference on Aging to be held in 1971. The law directed the Secretary of Health, Education, and Welfare to plan and conduct the Conference, appoint an advisory committee of not more than 28 professional and lay members, and establish technical advisory committees to assist in the planning of the Conference. In addition, the law provided that a final report shall be submitted to the President within 120 days after the Conference is called. Moreover, the Secretary of Health, Education, and Welfare would be directed to submit recommendations, within 90 days after the submission of this report, for administration action and legislation necessary to implement the proposals contained in the report.

In recognition of the importance of preliminary planning for the Conference, the House Education and Labor Committee report emphasized that "* * * it is essential for the success of the Conference that there be no lengthy delays in making seed money available for planning grants, staffing, and the updating of materials from the last Conference."[16] This report also stressed that there must be sufficient pre-Conference time for the grassroots development of State organizations to insure that a broad range of persons will be aware and ready to work toward the implementation of the Conference recommendations.

Appropriations for $250,000 were requested by the administration for fiscal 1970 to conduct preliminary planning arrangements for the 1971 Conference.[17]

> **At the end of 1969 only 23 months remained before the scheduled conference in November 1971. Because of the substantial number of activities to be planned, coordinated, and carried out during this time, it is essential that additional steps must be taken immediately to lay the groundwork for the conference. Additional funding and planning will be necessary to enable private organizations, individuals, and Federal, State, and local governments to plan and develop action programs to identify and make recommendations to meet the needs of older Americans.**

V. ROLE OF THE AoA

Congress, when it enacted the Older Americans Act in 1965, made clear its intention that the new Administration on Aging should not only concern itself with the problems of the elderly but also with their opportunities to live productive and satisfying lives. The AoA was directed to stimulate greater utilization of existing resources and available services for elderly persons and to be the focal point for the Federal Government's concern for older Americans.

Earlier reports by this committee[18] have expressed concern about a reorganization within the Department of Health, Education, and

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[16] H. Rept. 90-1792 to accompany H.J. Res. 1371, p. 7.

[17] See additional details in report cited in footnote 15.

[18] See "Developments in Aging—1967," pp. 128-131 and "Developments in Aging, 1968," p. X (comments by Senator Harrison Williams).

Welfare, which in 1967 made the AoA a unit in the newly established Social and Rehabilitation Service. It was pointed out that the Congress had clearly intended that the AoA Commissioner should have a direct line of authority from the Health, Education, and Welfare Secretary. It was also feared that the AoA might become submerged by welfare oriented and other programs within S.R.S.

What will be the role of the AoA under the Administration which began in 1969? A new factor has been added to the issue by President Nixon's decision to name his Commissioner on Aging, John Martin[19] as Special Assistant to the President on Aging. Thus, Mr. Martin has been given a title meant to suggest that he has access to the highest levels of the Executive Branch.

Since taking office, Mr. Martin has made several speeches and policy declarations which strongly suggest that he is attempting to use his dual capacity to broaden the role of AoA in its own right as an agency while he seeks greater responsiveness to older Americans in other Federal units.[20]

For example, he had this to say to the Senate Special Subcommittee on Aging in the Labor and Public Welfare Committee:

> Many programs which serve older persons exist through the Federal and State structure; however, few of them focus on older persons as whole persons. Instead, most programs deal with one or more special aspects of the life of the older person. The Older Americans Act, therefore, was intended to provide a specific point of concern within the Federal and State structures for older persons as older persons. In my judgment, it ought to be given broader application as a coordinating force for all programs affecting older persons.[21]

The Commissioner, in testimony before the Senate Committee on Aging and subcommittees, has given specific examples of his intentions for the AoA as a "coordinating force." At hearings on the model cities and the elderly, for example, he gave details on work by the AoA with the Model Cities Administration (see chapter VIII). In testimony about Health Aspects of the Economics of Aging, he served as the major witness for a panel of HEW witnesses. In calling for the "research enterprise" described earlier in this chapter, the Commissioner was implicitly calling for greater AoA leadership in this wide-ranging area. Perhaps one of his most clearcut descriptions of the role of AoA in any given area was the statement he made at a hearing on long-term care. He called for a "continuum of care," which "has got to be carried out if we are going to have the kind of service that we ought to have instead of the fractionated and fragmented service that we have today."[22] To reach that goal, Commissioner Martin said he would call upon the Advisory Committee on Older Americans, the President's Council on Aging, and the White House Conference on Aging "to help me articulate the dimensions of the kind of policy I have in mind." Mr. Martin said that policy would address itself to

[19] Mr. Martin was appointed U.S. Commissioner on Aging on May 28, 1969, and Special Assistant to the President for Aging on June 24. He had served as a member of the National Planning Advisory Committee for the White House Conference on Aging on January 1, 1961; and he was Vice-Chairman of the Michigan Commission on Aging from 1960 to 1963 and its Chairman from May 1963 to March 1967. An attorney, Mr. Martin served as a member of the United States Prosecutor's Staff at the Nuremberg War Trials.

[20] See Appendix 1, Report from Administration on Aging, for excerpts from Mr. Martin's statements.

[21] Testimony at hearing cited in footnote 9, p. 64.

[22] P. 27 "Trends in Long-Term Care," Part I. Washington, D.C., July 30, 1969.

five specific elements: an expansion in the supply of facilities, shortages of nurses and paraprofessionals, need for more skilled managerial personnel, "a full range of care which represents an alternative to long-term institutionalization; and alternative care services to older persons at the local level, to be "delivered comprehensively and in a coordinated fashion." [23]

In terms of policy enunciation, the AoA commissioner has set major tasks for that agency. The role of AoA, however, remains ambiguous. Its funding levels are lower than required for healthy growth of State and community programs. It does not have the "visibility" envisioned for it by the Congress. Serious thought should be given, before and during the White House Conference on Aging in 1971, to far-reaching proposals for constructive change that will enable the AoA to fulfill the vital missions assigned to it.

[23] Testimony at hearing cited in footnote 22, p. 28.

CHAPTER XII

RETIREMENT: THREAT OR FULFILLMENT?

Throughout its study of the "Economics of Aging,"[1] the Senate Committee on Aging has paid much heed to the financial consequences of retirement. For most Americans, departure from the labor force brings a substantial decrease in income. For those who decide to retire—willingly or unwillingly—before the traditional age of 65, the drop in income is often severe and sometimes tragic.[2]

But, important as financial consequences may be, the psychological impact of retirement cannot be overlooked. Earlier reports by this committee have described "a retirement revolution"[3] for which this Nation evidentally is unprepared, in terms of individual adjustment and in terms of societal uneasiness.

During 1969, the Subcommittee on Retirement and the Individual continued its study of retirement as an institution by focusing its attention[4] upon the Federal Government and asking:

—What more can be done to prepare Federal employees for retirement?

—What useful alterations can be made in the traditional life pattern: one-third for education, one-third or a little more for employment; and the last third or thereabouts for retirement?

The subcommittee interest was based partially on numbers—the Federal Government employs about 400,000 persons of age 55 and over, and it "retires" about 50,000 to 55,000 annually. Another factor was the concept of the Federal civil service as a model for others. If so prominent and influential an employer were to take the lead, new preretirement and work lifetime patterns could catch on elsewhere.

I. FEDERAL PRERETIREMENT TRAINING: SPARSE

A recent study conducted by Dr. Daniel Sinick, professor of education at George Washington University,[5] revealed that less than 18 percent of Federal employees approaching retirement had a preretirement planning program available for them.

Several reasons were mentioned concerning the slow progress by the Federal Government in developing a comprehensive preretirement counseling and training program:

—Lack of specific legislation directing the establishment of such a program;

—A shortage of staff and funds to carry out this undertaking;

[1] Discussed in ch. I, of this report.
[2] See ch. IX, discussion of trend to early retirement.
[3] See ch. VIII, "Developments in Aging—1967;" and ch. XIV, "Developments in Aging—1968."
[4] "The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns," Washington, D.C., Friday, July 25, 1969.
[5] This study is described in detail in the Civil Service Commission's publication entitled "Retirement Planning Programs," Dec. 1968.

—Lack of interest on the part of many Government officials; and
—Low priority given the subject by many personnel specialists.[6]

Witnesses at the 1969 subcommittee hearing expressed concern over the failure of the Federal Government to assume a more active leadership role in assisting individuals to prepare for retirement. Moreover, the testimony stressed that leadership from the Federal Government is indispensible. For example, Administration on Aging Commissioner John B. Martin, Jr. stated:

> In the Administration on Aging we are convinced that it is just as logical to prepare for the later stages of life as it is for the earlier stages. We agree with the view of the subcommittee expressed in 1967 that participation in programs of this kind is essential. We think, Mr. Chairman, that this is the time for a much expanded effort in this area. I suggest that the time has come to promote the widespread expansion of retirement preparation with the announced objective of making it available in the foreseeable future to all middle aged and older people who can be encouraged to take advantage of it. In our opinion there are a number of models that have been developed and tested sufficiently to warrant their being publicized and being made available for immediate use.
>
> I particularly want to stress this point. I have been surprised and discouraged to find on my return to Federal service that probably *not more than one-third of the departments and agencies in the Federal Government have offered or are offering organized opportunities for retirement preparation to their employees.* It seems to me, Mr. Chairman, that the Federal Government, which is the Nation's largest single employer, is admirably equipped for assuming leadership in this area and that it should do so. Failure to assist its own employees to anticipate and prepare for their retirement years is also a failure to set an example for others [7] [emphasis added].

SUGGESTIONS FOR IMPROVEMENT

While there was virtually unanimous support for preretirement counseling, several recommendations were urged to improve existing efforts. Dr. Sinick suggested a number of improvements:

—A substantial increase in the number of preretirement planning programs.
—A revision in program practices, such as inviting the employee's spouse to attend; expanding programs to cover more topics; and holding counseling sessions during working hours (80 percent of participants in preretirement counseling programs reported that their spouses were not invited to attend; yet, 80 percent of all participating employees wanted their spouses to attend).

[6] Mr. William L. Mitchell, p. 43 of hearing cited footnote 4.
[7] Commissioner John B. Martin, p. 5 of hearing cited footnote 4.

—Increased emphasis on essential matters, such as finances; health; social and personal topics; and the use of time, particularly opportunities for paid employment.
—Post retirement contact with employees.

While retirement preparation is usually viewed in terms of lectures or classes on special topics, several witnesses saw a need for innovative techniques. William Fitch suggested the use of television to make information available to persons who cannot attend the program sessions. In addition, he also emphasized the necessity of looking at the total preparatory plan.

> We think planning should begin in the middle years and be concerned with the total lifespan. Some of the programs in which I have participated place too much emphasis on the preretirement rather than preparation for the later years. This could start it at any age.[8]

S. 2554.—In July Senator Mondale introduced with bipartisan support S. 2554, which would provide Federal employees with a comprehensive program of preretirement counseling and assistance. In his statement on the Senate floor, Senator Mondale said:

> I believe that retirement from a job need not lead to retirement from life. Scientists tell us that as a man slows physically he often matures mentally; as one's capacity for productive output decreases his facility for creative work often increases. Yet to maximize the retirement potential one must prepare himself in advance; he must develop his interests and resources over the years against the day of his retirement. He must learn the importance of remaining active and of maintaining the vital, lifegiving interest in others. He must, in a phrase, learn the technique which John Gardner has called self-renewal. That technique encourages an openness and flexibility in personal life which facilitates fulfillment and growth in every situation.[9]

Later he added:

> The bill I am introducing today provides the statutory muscle for the Civil Service Commission by requiring that all Federal employees who are eligible for or approaching retirement shall have available an appropriate program of retirement assistance. It also calls upon the Civil Service Commission to establish standards for such programs, provide training for agency retirement advisers, and study and publish guidelines about related worklife programs such as phased retirement, trial retirement, new kinds of part-time work, and sabbaticals.
>
> Enactment of this bill will, I believe, greatly reduce the anxiety and dread of Federal employees who approach retirement. Hopefully, it will stimulate positive thinking about retirement by providing employees with the factual information and counseling which will enable them to under-

[8] Mr. William C. Fitch, p. 73 of hearing as cited footnote 4.
[9] P. S7570, Congressional Record, vol. 115, 91st Cong., July 7, 1969.

stand the nature of retirement problems and to plan their leisure years intelligently.[10]

Support for the bill is widespread. For instance, Mr. William Mitchell, a consultant for the American Association of Retired Persons, said:

> All of this leads me to the same conclusion I expressed when I last appeared before this committee: I think we need legislation of a forthright nature that will leave no doubt in the minds of Government administrators that Congress wants to see to it that Government personnel are aided in preparing for retirement.
>
> Senate bill 2295 which you, Mr. Chairman, introduced in the 90th Congress would probably have gone a long way toward accomplishing the purposes which I have in mind. However, your new bill, S. 2554, which you introduced on July 7, 1969, is, in my opinion, a better bill. The Association of Retired Persons is prepared to give its full support to the bill and hopes for its early enactment.[11]

It is increasingly apparent that legislation will be necessary to provide the impetus for the Federal Government to prepare older workers for their retirement years. Prompt enactment of the Federal Employees Retirement Assistance Act, S. 2554, would be a major step in helping Federal employees make the crucial adjustments in preparing for their retirement.

II. NEW WORK LIFETIME PATTERNS

As our society becomes increasingly automated, startling changes have occurred in our concept of work and the traditional educational-work-retirement patterns. Our workweek is becoming shorter, providing more time for leisure or study. More and more workers feel a need to change jobs in their middle years as technological changes necessitate new skills. In addition, there is an increased reluctance on the part of many workers to be bound to only one type of employment for their lifetime.

Although counseling can be very beneficial for older workers, additional measures are also needed, such as innovative experimentation to deal more effectively with the changing traditional work-lifetime patterns. Dr. Max Kaplan, director of the Institute for the Studies of Leisure at the University of South Florida, emphasized the need for considering retirement as it relates to much broader issues:

> The institute submits that we cannot deal with the problem of retirement, or indeed with the problems of leisure, apart from the largest issues of the meaning of technology, the shape of new values, and the impact of such factors as cybernation, affluence, urbanization, mass literacy, or mass education. No one begins his retirement on the day he leaves his office or plant; he carries out of the door with him a

[10] P. S7571, Congressional Record cited footnote 9.
[11] Mr. William L. Mitchell, p. 44 of hearing cited footnote 4.

whole set of meanings about himself; his worth, his work, and his aspirations. How he masters himself in retirement is a continuity, or at least a manifestation of how he has mastered his resources throughout his life.

With all due respect, referring to the earlier testimony of this morning, I submit that thinking along the line of whether a man is to be counseled a year or two or even 5 years before retirement is increasingly an irrelevant problem. The old line which has traditionally been drawn between work and nonwork is shifting and diminishing.

Apparently what is beginning to happen and may crystallize more in the seventies and eighties is a life based on affluence and enormous machine energy, leading to a kind of a life pattern that will be a flexible, "simultaneous" one—school, work, school again, retirement in the middle years, work again, school, and so forth.

Therefore, the data we need for the issues of the committee are as much qualitative as quantitative as we consider not alone a preretirement counseling, but counseling for a life which embraces both work and nonwork in new dynamic interactions. This is facilitated by the drop in work from about 3,000 hours to 2,000 hours of work per year since the beginning of the century. Among the choices which face us with cybernation is the further reduction of hours. We may, as a people, choose more goods, early retirement, or combinations of these—with little respect for the old ethic of work—or even reduce our general work year to 1,000 hours with a 20-hour average per week.

Now this means that we raise possibilities far more important than earlier retirement or counseling for retirement. A man can work 8 hours a day, or a couple years away, he can work 4 hours a day and produce the same amount of energy. He may want to work 8 hours one day and nothing the next day. By calculating his income on a 4-hour day, he may decide to work half a day, half a week, half a month, year, or even half a lifetime.[12]

Dr. Kaplan concluded his statement by making four recommendations to adjust to the new work-life patterns:

—The creation of a special committee, composed of members from the Civil Service Commission and the AoA, to consider issues of flexible life patterns, such as sabbatical leaves for Federal employees;

—The submission of a special report to the White House Conference on Aging by the proposed committee;

—A national study of labor and business thinking and policies regarding preparation for retirement; and

—A special study of pre- and post-retirement in the military.[13]

Pilot programs: Several pilot programs conducted by the Federal Government and private nonprofit organizations have amply demonstrated the benefits to be derived from a preretirement planning program.[14]

[12] Dr. Max Kaplan, pp. 57 and 58 of hearing cited footnote 4.
[13] Dr. Max Kaplan, p. 59 of hearing cited footnote 4.
[14] See in particular statements by Carl B. Barnes, pp. 32-37, and E. J. Paid, pp. 64-71, of hearing cited in footnote 4.

Gradual or phased retirement, for example, may provide a period of transitional adjustment for increased leisure time during retirement years. For an individual who would prefer a less rigorous work schedule as he grows older, such an arrangement can permit him to continue to make a contribution in our work-oriented society. Moreover, the Nation can benefit from the experience and service of qualified individuals who do not wish to work 40 hours a week.

However, under our existing manpower planning and budgeting system, this valuable manpower resource is not used as effectively as it could be. Mr. John Cole, Deputy Assistant Secretary for Personnel and Training in the Department of HEW, urged a reshaping of our present thinking in manpower planning.

> The other point that I want to make, Mr. Chairman—which I touch on in my statement but I would like to emphasize it, if I may—is the system or process that the Government has for manpower planning and budgeting and personnel accounting as related to the problem of gradual retirement.
>
> It is argued that we are going to have to reshape our thinking in manpower planning to look more effectively at opportunities for part-time employment, part-time utilization of the labor force. I think this is true not only when you talk about part-time employment of preretirees or part-time reappointment of annuitants, but I think generally that our Government has to look for better ways of utilizing valuable manpower resources that are available in the labor market but which are excluded from Government service because we are preoccupied with the 40-hour week and 8-hour day.
>
> When we budget for positions we concentrate on full-time permanent positions. In so doing, of course, we also tack on the other than full-time permanent employees as a part of the budgeting process; but we are really not thinking in terms of organization planning and our manpower planning of a substantial part-time element in the work force. Thus we exclude not only older persons who could be preretired on a reduced schedule; we also exclude other people in our society who could be made available to Government service and on a part-time basis.
>
> We have had some experience with this in connection with what we call our professional and executive corps, which is made up of highly qualified professional women who are not available in the labor market for a 40-hour week or an 8-hour day. Here we have had to take some deliberate steps to set up some part-time positions to employ these people on a reduced schedule. If we are going to look at gradual retirement programs, or if we are going to look more broadly at employing those members of the labor force who are not available to work on a full-time basis, we have to rethink our budgeting process, our manpower planning process, and our personnel accounting process to take advantage of this untapped resource.[15]

[15] Mr. John D. R. Cole, pp. 31 and 32 of hearing cited footnote 4.

As traditional work lifetime patterns change very rapidly and dramatically, new knowledge is essential to consider these issues in their proper perspective. It is recommended that Federal actions be taken in order to provide valuable pilot projects and research findings that will prove useful for future policy decisions in this crucial area.

MINORITY VIEWS

MINORITY VIEWS OF MESSRS. PROUTY, FONG, MILLER, HANSEN, MURPHY, FANNIN, GURNEY, SAXBE, AND SMITH OF ILLINOIS

INTRODUCTION

Few challenges facing America in the 1970's are as important as a new policy on aging—one leading to decent living standards, independence, and meaningful retirement years for all older Americans.

Multiplication of choices open to each older person in his or her continuing pursuit of rewarding experiences is essential.

National policy should encourage older Americans to make full use of their growing potential for economic, spiritual and social involvement in family, community and national life.

Solutions to problems of senior citizens must relate to changing patterns in the aging process. Life expectancy will continue to lengthen, not shorten. Individual physical and mental abilities will grow, not decline. Reasonable needs for income to afford necessities and niceties of life will expand, not contract. Capacity and desire to take care of one's own needs, and demands for more diversified opportunities to do so, will increase, not diminish.

If society continues to ignore dynamic progress in aging, it will compound an already serious problem. Persistent reliance on inadequate stopgap measures relating solely to the most compelling economic needs of the elderly can only postpone or severely limit meaningful retirement years for countless individuals.

Creation of sound national approaches to aging will require many changes in attitudes. Imaginative and intelligent responses will be required by all elements of society, including senior citizens themselves.

Modification of retirement patterns and employment rules in recognition of expanding capacities and desires of many older Americans for active participation, full or part time, in the Nation's economic life should be a major ingredient.

Development of adequate community service opportunities for older persons whose retirement brings a desire for new socially oriented careers should play an important part.

Society's responses to individual needs at all ages should recognize that most people will grow old. Failures of society at early ages create and aggravate problems in later life. One preventive measure deserving high priority is expansion of work opportunities for persons who have not reached retirement age, but are denied jobs because of age. They are thus forced into situations which make their retirement years a prospect of social and economic deprivation.

Obviously improvements in Social Security, private pension plans and other sources of financial support designed to assure adequate retirement incomes are imperative. These should offer greater flexibility so as to increase individual options.

Achievement of a golden age in aging will take time. No one knows this better than the older American who has been misled by overly optimistic promises or suffered dashed hopes as he competes unsuccessfully with other demands on our Nation's resources.

The magnitude of the problem, however, is no excuse for delay. Certain actions should be taken now. As a minimum, therefore, we urgently recommend early action by the Congress which will look to:

1. Automatic cost-of-living increases in Social Security benefits to prevent hardships due to inflation.
2. Across-the-board increases in Social Security benefits.[1]
3. One hundred percent of primary Social Security benefits to older widows.
4. Major liberalization of the Social Security earnings test so as to prevent discrimination against those who continue to work, full or part time, especially those with relatively low Social Security benefits.
5. Upward adjustments, actuarially determined, in Social Security benefits for those who defer retirement beyond 65, so that their continuation in the work force will not be penalized.
6. An Older Americans Income Assurance Program offering income supplements to the elderly who otherwise would not be able to attain a decent standard of living or would be forced onto public assistance.
7. Medicare coverage for persons past 65 not presently covered and in need of such coverage.
8. Improvements in medicare service and financing which will reduce excessive burdens imposed by current deficiencies.
9. Updating of retirement income tax credit provisions of the Internal Revenue Code.
10. Exclusion, subject to a reasonable ceiling, of medical and drug expenses from older persons' income subject to Federal taxation.
11. Adequate financing for research in aging.
12. Sound governmental policies which will help bring inflation, the most universally serious problem for older Americans, under control.

NATIONAL POLICY IN AGING—A LONG VIEW

If we are to achieve the valid objectives of today's older Americans and acceptable roles for those who grow old in the future, it is necessary to develop broad new national policies in aging that recognize how outdated are 19th century stereotypes of older persons.

Implementation of humane and realistic policies will require major changes in attitudes toward aging on the part of government, business, education and all other elements of society including older persons themselves.

Recognition must be given to the expanded ability of persons at all ages to participate as fully as they desire in the Nation's economic

[1] Senator Miller notes that a 15-percent increase in benefits went into effect on Jan. 1, 1970, so that an automatic increase in benefits to keep pace with increases in the cost of living should be adequate, with exceptions to be covered by an Older Americans Income Assurance Program. (See recommendation 6.)

and social life and to the growing emotional need of people in their sixties, seventies, and even their eighties for involvement in the mainstream of life.

There should be a reversal of social and economic patterns which force millions of older Americans, usually against their wills, into situations of rejection and dependence.

Rejection as first-class citizens capable of full participation in the responsibilities and rewards of active life is incompatible with the competence which most older people can bring to the challenges facing the Nation.

Dependence for many older Americans is especially abhorrent when, as is often the case, such dependence means inadequate incomes and denial of even minimal social opportunities.

In a nation where demand for skills, wisdom, and experience increases almost daily, it is totally inconsistent to erect barriers which restrict opportunities for individuals possessing such talents from making them available as fully as possible, either for hire or as volunteers. This is true whether such barriers are rigid and clearly visible or the insidious product of misguided custom and attitudes toward the aging.

There should be compassion toward older persons in need, but few older Americans really want compassion. They want to receive what is their's by right. First among these rights is the right to choose.

Maximization of choices open to each older person should be the objective of a new national policy on aging—choices with dignity and independence to which all senior Americans are entitled.

It is to be hoped that the 1971 White House Conference on Aging will seriously address itself to this question. It can be especially important because it is unrealistic to assume that creation of maximum choices can come overnight or without a massive, concerted effort. We cannot, however, ignore immediate consideration of present impediments to decent opportunities for older Americans. Their problems are too serious, too important.

It is appropriate at this point to cite certain fundamental steps which deserve prompt consideration.

Obviously there is no meaningful choice when millions of older Americans, through no fault of their own, are unable to pay for the barest necessities of life. Correction of this situation deserves highest congressional priority.

There is no choice when individuals are forced against their wills to leave their employment at an arbitrary age without regard for their abilities or desires. Compulsory retirement policies need careful reexamination by every individual and organization with responsibility for employment practices.

There is little choice in retirement when policies of employers and even Federal programs, such as Social Security, prevent or discourage individual efforts to supplement income with part-time employment.

It is not uncommon for persons to enter retirement with the prospect of 20, 25, or more years remaining in their lives. Most, if not all of these years, may be accompanied by a zest for living which mitigates against nonparticipation.

As suggested by observations which follow regarding changes in aging patterns, it appears prudent to consider modifications of common ideas about what retirement can and should be.

Many older Americans have concluded that part-time work is essential to their own happy retirement and have accordingly maintained or resumed a modified role in the work force. Many more, particularly men, have been denied opportunities for such participation because of employer attitudes, or have passed up what they regard as desirable opportunities because of their fears as to the effect such work would have on their Social Security benefits.

We believe it is accurate to say that a high percentage of those now past 65 believe a comprehensive review of the Nation's retirement attitudes is in order. We believe that such reappraisal, looking at all factors, including economic, social, physical, emotional, spiritual and psychological, should make full use of what retirees themselves think as well as the results of research in these areas.

Countless other items of significance to the future of aging and older Americans deserve review. The time to begin reexamination and changes of attitudes is now.

As we enter the last three decades of the 20th century, therefore, it is appropriate to look, however briefly here, at American developments in aging—present, past and future.

The first 35 years after 1900 saw dramatic progress in medical science, public health, education and living standards. Together they produced better levels of health, higher average life expectancy, and substantial increases in the number and percentage of older people.

The second 35 years brought new economic responses, such as social security and private pension plans, which established a retirement income base on which we must now build. It would be erroneous to assume, however, that the best approach to the needs of older people should rely solely on such programs. If better ways or new additions to this base are available, they should be used. The objective must be what is best for senior citizens, not what is best for systems we have created.

Concurrent with these developments has been an increase in both the capacity of older persons to participate vigorously in all aspects of life and an increase in their need for higher incomes generated by this expanding personal capacity for enjoyment of life. The latter has been accelerated by more sophisticated appetites for the good things of life among all people as living patterns have improved.

The next three decades, if available evidence is even partially reliable, will see further increases in length of life, in physical and mental abilities, and in social and economic appetites among older people as a result of continuing progress.

Not the least as a contributing factor in such growth is expectation of dramatic developments in control of major killers and cripplers of persons in middle and later years as we now construe those terms. This is logical as more and more effort formerly applied to acute illness of youth is directed at medical problems associated with advancing age.

Serious students of the physiology of aging predict that by A.D. 2000 average life expectancy may be 90 or 100 years. Some researchers suggest even more dramatic shifts. In a century such as this, with serious plans developing for trips to Mars, who can ignore the optimism of science?

If an increase of 20 or 30 years in life expectancy is accompanied by probably improved levels of health and physical-mental potentials at all ages, it is obvious that present attitudes in aging, particularly re-

garding the proper patterns of retirement, will be completely inadequate. There is serious question as to whether many are not already out of date.

Despite progress—in some instances because of it—the Nation now faces problems among many older people greater than ever before. The most obviously critical of these are economic.

Continuation of current trends in the economics of aging, as documented elsewhere in this Committee on Aging report, offers little hope for the kind of satisfying later years which are due older Americans—little hope unless there are some fundamental changes.

Recent years have seen emergence of a curious paradox in aging. Better health and education are raising abilities of older persons to participate in the Nation's mainstream—and their desire to do so. Simultaneously there has been a marked increase in pre-65 retirement.

If this were proof of America's success in solving the retirement income problem, there would be no grounds for complaint. Such is not the case. If, on the other hand, it represents a failure of society to meet the needs of a revolution in aging, it takes little imagination to see that additional increases in life expectancy will but compound an already serious problem.

Data reviewed by this committee shows that much of early retirement is by persons with lowest incomes—lowest incomes both before and after retirement. Decisions of many persons to "retire" have resulted from loss of jobs and inability to obtain other suitable employment. More have been encouraged to retire by suasions of various retirement programs, reinforced by social pressures to quit, even though personally reluctant to do so. Many, both underprivileged and affluent, have been forced out of their life work prematurely by rigid retirement policies. The fact that income inadequacies are most serious among the oldest older persons suggests that often decisions as to income adequacy made at the time of retirement were based on needs and costs as they saw them then rather than recognition of what living expenses ultimately might become.

Many older Americans have been and are resentful of the negative compulsion applied to them by society during their sixties and seventies. They rightfully feel they should have more choices as long as they live and are capable of enjoying the responsibilities and rewards of life.

Successful response to the highly varied economic, social, physical, and psychological needs of tens of millions of older Americans requires study, thought and imagination. Expansion of choices for each individual should be the objective.

Complexity of the problem, however, in no way justifies delay in congressional action on problems that are obvious and immediate.

SOCIAL SECURITY

As has always been the case, the greatest problem for older Americans is income. Large numbers of persons past 65 obviously do not have the money necessary to meet the costs of decent standards of living. Others have experienced severe losses in purchasing power because of inflation during the last 10 years. Many who retired in comfort now find themselves in or near straitened circumstances.

Our Nation's most immediate goal should be steps to assure all older Americans at least a decent minimum standard of living.

This effort calls for improvements in private pension programs, successful implementation of President Nixon's campaign to bring inflation under control, expansion of opportunities for individuals to supplement retirement income through their own efforts, and a variety of other measures.

Few congressional actions would have more widespread immediate effect, of course, than improvements in Social Security.

The recently adopted 15-percent increase in benefits is commendable, but it only represents a beginning in necessary upgrading of the Social Security system.

One improvement which minority members of the Committee on Aging and the Republican Party have long advocated is provision for an automatic cost-of-living increase in benefits to provide immediate response to rising price levels when they occur.

As when introduced first in the Senate by Senator Jack Miller of Iowa, such an automatic escalation in benefits requires no increase in the Social Security tax rates. It would obviate the game of "catch-up" which has characterized Social Security since its inception, a game in which beneficiaries have been consistent losers.

Adoption of this proposal would give assurances to younger potential beneficiaries that their benefits would be payable in amounts at least equivalent to the dollars they are paying in current taxes. This becomes important to the whole system's integrity as evidence grows of reluctance on the part of younger people to support rising costs of the Social Security program.

It is time to quit playing political football with Social Security and the needs of the aging. Too often past increases, actually amounting to no more than living-cost adjustments, have been voted by the Congress only after delay has forced many beneficiaries into inexcusable financial difficulties. Such increases could have been made automatically within the fiscal competence of the Social Security system when the aging needed them most rather than when they offered political advantage to Members of Congress. It is such immediate responses to needs of beneficiaries that is recommended through the proposal for automatic living-cost adjustments.

Precedent has been set for such a policy in other federally supported pension programs. Why should it not be extended at once to the mass of older Americans relying on Social Security?

We have been pleased to observe the growing bipartisan support, however reluctant, for this proposal. With President Nixon's commitment to its adoption and approval from both political parties, we trust that enactment of automatic living-cost increases in Social Security will be given prompt attention by the Congress.

While living-cost increases are important in modernization of Social Security, they are not a substitute for increasing the overall adequacy of the system in its design to provide income for older Americans. There is also need for across-the-board increases.[2]

The plight of widows and discrimination against them in the Social Security benefit structure likewise deserve prompt attention.

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[2] See footnote 1, p. 154.

Elsewhere in this Committee on Aging report and repeatedly in those published in the past, it has been observed that no group among the elderly is subject to more severe economic handicap than aged widows. One contributing factor is failure to pay the same Social Security benefits to surviving wives as is paid to surviving husbands. Normally the latter receive 100 percent of primary Social Security benefit on the death of their spouse; the widow, however, receives only 82½ percent. There seems to be no excuse for such discrimination and we recommend its prompt correction.

Two other changes in the Social Security system are of pressing importance if we are to increase choices available to older Americans.

The first of these relates to limitations on earnings by a beneficiary.

Current limitations of $1,680 per year on the amount one can earn without penalty is totally unrealistic. The provision that a beneficiary lose only half of earned income between $1,680 and $2,880 is awkward and cumbersome.

The present limitation discourages many who would like to supplement pension payments with income from part-time work. In times of inflation this can be most important. The restriction virtually prohibits gainful full-time employment by others, often including those whose incomes are lowest and those who derive their greatest satisfaction from employment.

There is evidence the earnings limitation sometimes reduces the amount paid to those who insist on working. Without it, they would receive more money for the same work.

A careful review of the effect of the earnings limitation on amounts paid to older persons might show that this provision has had a generally depressant effect on wages as a whole in some areas. If this is true, it may be disadvantageous to some younger people as well as the Social Security beneficiary. A study of this question appears in order.

It should be noted, too, that while a person may receive large income from other sources without penalty, the earnings limitation applies as much to those receiving minimum Social Security benefits of $64 a month as to persons receiving maximum benefits.

As suggested in previous minority views, one way of meeting the older person's need could be provision that there would be no reduction of Social Security benefits unless the combination of earnings and Social Security payments together exceed a specified amount (i.e. $4,200 per year).

In any event, this earnings limitation as now applied is seriously and properly objected to by older Americans. Its substantial liberalization would be a major step in increasing choices available to them. We recommend early consideration of such a change.

A second step which would increase choices open to Social Security beneficiaries would be through expanding the program's flexibility for those who choose to continue work after 65.

Without flexibility in the system, it is difficult for individuals to tailor it to personal situations they face in later years of life.

Some flexibility has been gained by changes which permit persons to elect receipt of benefits before age 65. Lower payments are received when such election is made.

When a person elects to defer benefits until age 66 or 68 or 70, however, he gains virtually nothing. Indeed, without increasing his benefits, he is actually required to pay additional Social Security taxes. The inequity of such a practice is obvious.

This discrimination against the person who desires to continue employment not only goes against the personal preference of many senior citizens, but also against professional opinion as to what is best for older persons.

We advocate consideration of improvement in the Social Security system which would permit realistic annual increments in benefits for persons electing to postpone retirement to ages beyond 65.

If Social Security fails to offer meaningful choices, it is failing the expectations of American citizens, young or old.

INCOME ASSURANCE PROGRAM

Important as improvements in Social Security may be, it must be recognized that they have their limitations.

For this reason we urge that Congress give most careful consideration to development of an Older Americans Income Assurance Program, outside the welfare pattern, which will assure at least minimum income, through governmental supplements, to all the elderly who otherwise would not be able to receive a decent standard of living.

Whether such a program should be completely financed and administered by the Federal Government, or involve a combination of Federal and State funds may be subject to argument. The fact remains, however, that some such approach appears necessary if this Nation is to meet its obligation that all older persons enjoy decent standards of living.

One such proposal was offered in the 90th Congress and with modifications again in the 91st Congress by Senator Winston Prouty of Vermont. Senator Prouty's bill, S. 3554, provides that there be a Federal supplement to bring the total income of each unmarried person over 65 up to $1,800 a year and each married couple up to $2,400. The amount of subsidy would be the difference between other income of the individual or couple and the $1,800 and $2,400 respectively.

Some mechanism such as this seems to be the one way that the problem of income inadequacy can be met at a cost in keeping with the willingness of younger people to pay the bill, and this is particularly true if financing occurs out of the general fund rather than through Social Security taxes.

As an income supplement program, the cost to the taxpayer would be substantially lower than that required by any effort to raise Social Security minimum benefits to comparable levels. This is extremely important because there appears to be little disposition on the part of the Congress to raise minimums to such levels in the near future. Congressional reluctance is undoubtedly inspired by the feeling of younger people who must pay the taxes necessary for any Federal program which is financed through Social Security taxes.

Senator William B. Saxbe of Ohio has approached it in another way by offering an amendment to the Administration's proposed Family Assistance Act which would provide for supplements to a minimum of $155 monthly for persons age 72 or over.

However desirable it might be to promise older Americans that their basic economic needs can be met through raising Social Security minimum benefits now to $125 or $150 a month or more, it is grossly unfair to do so. Nothing in the 35-year history of Social Security suggests that Congress will take such dramatic action, regardless of how badly it might be needed. The obvious reason that such promises are unrealistic is the cost and destruction of the concept of Social Security as "insurance" rather than a welfare program.

Sympathetic as they may be to the importance of caring for their seniors, young workers appear unwilling to pay the increased Social Security taxes necessary to support such minimum Social Security benefits. Their attitudes are reflected in the hesitancy of the Congress to pass such proposals.

It is a fact that many young Americans, struggling to meet immediate family expenses, are paying Social Security taxes greater than their Federal income tax liability. Simultaneously, as much as 40 percent of income subject to Federal income taxes is exempt from Social Security taxation, much of it in the hands of persons most able to pay.

How the conflict of needs between young and old can be resolved is a question which obviously requires most careful study. It would appear that the genius of this Nation should be able to come up with a solution which meets the needs of both.

For the present, however, the one approach which would be responsive to the needs of the aged and do so with a price tag which could be borne by the young appears to be that offered by an income assurance plan. This could help those who need help most without creating a windfall for those now able to take care of their own financial needs.

A general income supplement program would also serve the many persons not now covered by Social Security, such as some school teachers, State and Federal government employees, and others whose employment is not or was not covered in the past by Social Security. Large numbers of these persons are among those with lowest incomes.

Efforts to provide some protection to persons not covered by Social Security began in 1965 with the Prouty amendment which authorized payments in the amount of $35 monthly (now $46) to such persons age 72 and over who had no other pensions. Even with all the limiting amendments imposed by Congress on this proposal, the problem's magnitude is indicated by the fact that over 600,000 persons qualified. For many it was the only source of cash income.

It should be noted that an income supplement program, however devised, would have an advantage as a mechanism to eliminate abject poverty among the elderly because it would avoid unearned increments to persons, some of them wealthy, who are not in need.

This is why the total net cost to the taxpayer, important to favorable consideration for any proposal, would be much lower than a comparable Social Security minimum benefit.

One major advantage of an Older American Income Assurance Program would come from its removal from old age assistance of many, if not all, of the 2 million persons now receiving such welfare payments. It would afford help, help to which these persons are entitled, with dignity and grace.

We cannot urge too strongly the importance of early consideration of this new approach supplementing private pensions and Social Security efforts to meet the needs of deprived older Americans.

MEDICARE

After 3 years of operation, the Medicare program obviously is beset by numerous problems. Since these are now under examination by congressional committees with legislative responsibility in these areas, it is unnecessary here to review the numerous shortcomings which have been encountered. Even with Medicaid as a supplement, however, it appears necessary for revisions in delivery of medical care under programs supported entirely or in part by Federal funds to see that they more satisfactorily meet the most critical medical needs of the aged.

Financial and service delivery problems are making it increasingly difficult for Medicare to fulfill promises made for the program. Simultaneously there have been numerous complaints from beneficiaries because of service inadequacies. Difficult as the task may be, it is evident that attention first must be given to correction of these deficiencies as a prelude to broadening provisions of the law. Such revisions should recognize, however, that there are many serious unmet medical needs among the elderly to which careful attention should be given.

One problem of particular concern to us is provision of long-term care to older persons with varying degrees of disability and illness. We believe it imperative that Congress address itself most carefully to this problem so as to ease the heavy burdens now imposed by protracted terminal illness and highly expensive, irreversible chronic disease.

The percentage of older persons, whose disability and illness needs can efficiently be met through institutional care such as offered in homes for the aged, nursing homes and similar institutions, is small. None-the-less the cost of their care remains one of the most frightening possibilities facing older Americans and their families.

Possibly provision of assistance in meeting this problem might best be developed outside of the framework of Medicare, which is now aimed primarily at acute illness. Perhaps such institutional care efforts should give more attention to "person-orientation" than to "patient-orientation." It is high time, in any event, that the Congress seriously concern itself with this problem. It is most critical for those it strikes; it is most fear-inspiring for all who recognize that it could strike them.

We recommend, further, that Medicare be extended to all persons over 65, regardless of Social Security status, who are in need of such coverage. Many persons not now covered have financial need as great as those who are beneficiaries. Financing of such coverage should come from the general fund of the Treasury, otherwise those who pay Social Security taxes will be paying for a program not primarily designed as "Insurance."

TAXATION

One serious problem facing many older persons, as revealed repeatedly in Committee on Aging hearings, is that created by rising taxes.

Property taxes appear to be of the greatest consequence. State and local in character, they are least responsive to congressional action. Even so, it appears prudent to study thoroughly whether any Federal action might be developed to provide some relief for this concomittant of inflation and a growing Nation.

There are at least two other areas which are clearly subject to effective Federal tax relief.

We recommend updating of retirement income tax credit provisions of the Internal Revenue Code. The retirement income credit section of the code was enacted in 1954. It established for certain retirees a tax benefit similar to that others have by means of the tax-free income they receive from Social Security. The retirement income credit was computed on the maximum Social Security benefit. By the language of the tax code, however, the tax base still stands at $1,524 which was the appropriate figure 8 years ago. Since that time there have been several Social Security increases, but no comparable adjustment in the retirement income credit provision. The Congress should consider updating section 37 of the 1954 Internal Revenue Code to provide as nearly as possible equal tax treatment for all retirement income.

We urge action further to simplify that portion of tax return forms related to retirement income credit in recognition of the fact that its present complexity results in many older persons paying taxes in excess of the law's requirements.

We also recommend that medical and drug expenses of older people, including those related to dental services, be made deductible, subject to a reasonable ceiling, from income subject to Federal taxation. This could be a reinstatement of deductibility for persons past 65 as applied to Federal income tax prior to 1967.

Medical expenses remain a major cost to older persons despite Medicare. Much of such expense is related to medical regimens which reduce the burden on Medicare. For those not subject to Federal income taxes, the assumption may be made that help in meeting such expenses should be forthcoming from Medicaid programs of the several States. Equitable relief for older Americans who pay income taxes appears equally appropriate.

RESEARCH IN AGING

Early congressional consideration of the foregoing recommendations for direct and immediate action aimed at meeting problems of older Americans should not permit us to lose sight, as previously observed, of the need for long-range planning.

If our objectives for all older Americans are to be achieved with reasonable speed, the Nation needs facts—facts about the present and facts about what may be in the future.

In a word, we need research.

We strongly recommend increased support, financial and otherwise, for immediate expansion of research in the field of aging.

Doubtless almost all basic and applied scientific research is of benefit to the old as well as the young. There needs to be more careful determination, however, of how the products of such research may be applied to the particular problems of those in middle and later years.

There is need, too, for more effective research directed specifically at the implications of age in order to develop realistic and flexible national policies and attitudes toward aging which can more satisfactorily meet the needs of people.

Such research efforts should be reinforced by improved dissemination of information so that lessons learned are rapidly communicated to

both the professional and nonprofessional community which may, in the final analysis, have the say in determining what policies and attitudes are to be.

Obviously the Nation needs more distinguished scholarship such as the work at the University of South Florida, University of Iowa, Drake University, Duke University and the Ethel Percy Andrus Gerontology Center at the University of Southern California. That it be the sense of the Congress that such gerontological centers be encouraged has been called for in Senate Concurrent Resolution 24 introduced by Senator George Murphy of California for himself and other minority members.

Because of the importance of carrying the results of sound research to all types of leadership in all parts of the Nation, it may be desirable that such centers be widely distributed geographically, drawing upon experts in all regions of the country.

Research obviously should range far beyond the physical sciences. Possibly the greatest need may be for research in the economic and social aspects of the aging phenomenon.

Practical research should also permit full expression by older Americans themselves about their problems, desires and estimates of what is needed for the future.

To ignore the importance of research is to invite continuation of today's unsatisfactory situation among the aging.

INFLATION

No review of today's needs of older Americans would be complete without reference to the most serious and universal economic problem they face—inflation.

President Nixon deserves highest commendation for placing control of inflation at the top of his domestic objectives. His efforts to reduce the costly involvement in the Vietnam war, uppermost in his foreign policy, is equally important in administration efforts to establish a dollar with more stable purchasing power.

Any effort to preserve the value of the older American's fixed income should be applauded. We urge the Congress to give the President full support in this campaign.

While some economic indicators offer hope that living costs soon will be brought under control, the past year's record shows how difficult the task will be, how deep rooted are inflationary elements created by the Federal Government in the last 10 years.

Minority members of this committe have repeatedly taken the lead in recognizing that the most universal and serious sources of problems of older Americans is the massive loss of real income through inflation.

We have maintained, with wide support from economic experts, that control of inflation can only be achieved through Federal policies which are fiscally sound and by roll call votes of Members of Congress which are consistent with such policies.

The record of the Republican membership measures up to these requirements.

We have stressed that a stable dollar requires cuts in unnecessary and wasteful expenditures such as have characterized recent Democratic-controlled Congresses. Intelligent priorities for spending programs must be established, a basic principle of good government which has too long been absent.

We reiterate our concern for reduction in and postponement of unjustifiable or low-priority Federal expenditures. It is essential that those in control of the Congress face up to their responsibilities and put an end to rising public deficits and debt, which lay the foundation for inflation and high interest rates.

Previous minority reports of this committee have discussed how inflation injures the worker in factory, shop, office, or on the farm. The facts are too evident to require repetition here now. The truth is all citizens, save possibly the very rich, are hurt by rising living costs. None suffer more, however, than older persons.

As members of the Committee on Aging, we are compelled, therefore, to urge the Congress to get behind President Nixon in his determination to control inflation. Such support is meaningless unless expressed in votes on the floor of the House of Representatives and the Senate.

WINSTON L. PROUTY,
HIRAM L. FONG,
JACK MILLER,
CLIFFORD P. HANSEN,
GEORGE MURPHY,
PAUL J. FANNIN,
EDWARD J. GURNEY,
WILLIAM B. SAXBE,
RALPH T. SMITH.

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APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1: ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., February 2, 1970.

DEAR MR. CHAIRMAN: As you recently requested, enclosed is a report on the activities of the Administration on Aging during 1969. We have made an effort to include in it all the information you requested. Unfortunately a copy of my remarks before the National Association of State Units on Aging is not available at this time. However, we are working on reproducing it, and shall send it to you as soon as possible.

Sincerely yours,

JOHN B. MARTIN, *Commissioner.*

[Enclosures]

THE ADMINISTRATION ON AGING—1969

For the Administration on Aging, 1969 was a year of continuing progress toward improving the later years. To summarize the various sections of this report:

—The Older Americans Act Amendments of 1969 were enacted (Public Law 91–69).
—Commissioner Martin was appointed and served as the President's Special Assistant on Aging, giving AoA's Commissioner for the first time a voice in the highest counsels of Government.
—AoA and State agencies on aging continued to cooperate in carrying out a variety of State and community programs on aging.
—AoA continued its research and development activities, emphasizing during 1969 research and demonstrations on nutrition for older persons, as directed by Congress.
—After approximately 4 years of operation AoA's training grant program began to send significant numbers of trained personnel into service to the elderly.
—The Older Americans Act Amendments of 1969 for the first time gave specific ongoing statutory authorization for the foster grandparent program, and gave AoA sole responsibility and authority to administer the Program.
—AoA was heavily involved in model cities activities, in cooperation with the Department of Housing and Urban Development and State and local governments and their aging agencies.
—President Nixon issued the call for the 1971 White House Conference on Aging, and planning for the Conference proceeded to the extent possible without a specific appropriation for this purpose.
—AoA carried on an extensive information program, including information activities connected with Senior Citizens Month (May 1969).
—AoA was one of the major organizations participating in the Eighth International Congress of Gerontology, held in Washington, D.C., August 24–29.
—AoA cooperated with a number of other Federal agencies on aging activities of mutual concern.

Public Law 91-69

President Nixon on September 17 signed into law the Older Americans Act Amendments of 1969. It extended the duration of the grant programs of the Older Americans Act of 1965, authorized a national older Americans volunteer program, provided assistance to strengthen State agencies on aging and community projects, authorized areawide model projects, and made other changes.

While the new public law represents a step forward in various aspects of aging policy, it is perhaps most significant in—

(1) Opening new doors of opportunity for older persons who wish to be of service to others; and

(2) Increasing and strengthening the leadership role of State commissions and agencies on aging in their efforts to build strong Statewide and local programs of services and opportunities for their older citizens.

The details of the new public law are summarized in exhibit A, attached.

Commissioner Martin's Activities as President's Special Assistant for the Aging

The responsibilities of the Special Assistant to the President for the Aging to some degree interweave with his responsibilities as Commissioner on Aging. The Special Assistant has the added opportunity to maintain direct contact with the White House and to discuss with the White House staff policy matters relating to the welfare of the Nation's aging population, including steps which can be taken to increase the level of living and possibilities for independent living under conditions adequate to promote a sense of worth and dignity. In cooperation with the White House staff, the Special Assistant can develop initiatives and assist in policy determinations which will be productive of long- and short-range benefits for the aging.

The Special Assistant has worked closely with the Presidential Task Force on the Aging, furnishing it with such technical and staff assistance as have been requested by the Chairman of the task force. This has been a demanding assignment, since the task force was operating under a short deadline for the submission of its report. It is believed that this report can be the basis for action by the administration and by Congress when released.

The Special Assistant has also cooperated with the National Goals Research Staff in the taking of preliminary steps to develop projected national goals based on varying hypotheses. The goals staff is developing information in the nature of forecasts to enable those responsible for programs on aging to better estimate the effect of present policy or of alternate models. Meetings have been held of both non-Government and Government personnel to examine the possibilities of such forecasting and the steps necessary to achieve results in the area.

The Special Assistant is working with the Urban Affairs Council staff in the preparation of material for submission to the Council. He has reviewed with the White House staff preliminary thinking in connection with the holding of the White House Conference in November 1971.

He has also been active, in consultation with the Gerontological Society, in bringing together social, biological, and behavioral scientists in the field of gerontology to give increased focus to scientific efforts and to stimulate support for research activity.

In addition to the above responsibilities, the Special Assistant has been available for periodic consultation with White House staff on various matters arising in connection with older Americans' affairs. An example of this was the national effort by the General Federation of Women's Clubs to promote the holding of Thanksgiving dinners with and for older people in all parts of the country including the White House.

State and Community Programs on Aging

In administering title III of the Older Americans Act, the Administration on Aging has continued to focus its efforts on a wide range of activities that will better assure the delivery of services to aged persons in all walks of life at the community level. It has continued to assume an active role in the model cities program by assuring that the guidelines for the program give consideration to the special needs of the aged and include programs designed specifically for them. It has also initiated plans to work cooperatively with voluntary and public health and welfare agencies to provide leadership in assessing, coordinating, and developing programs to provide services for all aged persons in the community.

The Administration on Aging has given increasing attention to assessing the growing number of community projects and services for the aged relative to their effectiveness in meeting needs of the elderly, and contributing toward meeting the long-range objectives of the Older Americans Act as amended.

STATE AGENCY ACTIVITIES

The most significant development for the older Americans program in the States during 1969 was the passage of the 1969 Amendments to the Older Americans Act.

The amendments under title III provide substantially increased Federal support to the State agencies at a more favorable matching ratio (75 percent Federal, 25 percent State) for statewide planning, coordination, evaluation, and administration activities on behalf of older persons.

While widely recognized that more emphasis was needed in planning, coordina tion, and evaluation of programs for the elderly, most States were not able to function adequately in these areas because of inadequate staff and financial resources. Since the amendments were signed by the President on September 17, 1969, States have made great strides in strengthening their operational capacities. Additional positions have been cleared, recruitment is underway, and in several cases additional staff is already onboard. It is anticipated that by the end of fiscal year 1970, total professional staff at the State agency level will be increased by approximately 100 persons over the fiscal year 1969 level.

Even with the limited resources available in 1969, many State agencies made significant progress in providing leadership in program development and advocacy on behalf of the elderly citizens of their States. Following are examples of various accomplishments of State agencies during fiscal year 1969 in these areas:

—In Florida, Michigan, and Washington, the State agency on aging was responsible for a series of public hearings held throughout the State. Elderly persons, as well as representatives of the elderly, testified on the problems and needs of the older population and made suggestions for legislative actions. Large numbers of elderly attended and participated in these hearings, as did various State officials including legislative representatives.

—The Virginia Commission on the Aging employed a consultant to develop a demonstration program for an ongoing system of planning and delivery of services for older persons in two Virginia planning districts. The Governor's planning office participated in this program. This initial plan has been completed and implementation of the plan is now underway. Title III project moneys, as well as additional State funds, are being committed to this program.

—Recognizing the lack of trained manpower in aging, the District of Columbia State Agency held a series of workshops for staffs of public and private agencies who work with the elderly.

—The New Hampshire Council on Aging has been given responsibility by the Governor for conducting a study of tax burdens on older persons.

—The Massachusetts Senate established a "Commission on Hunger and Malnutrition" which is holding hearings throughout the Commonwealth. The director of the State Agency on Aging is an ex-officio member of this commission resulting in problems of the elderly being emphasized.

The Administration on Aging's Older Americans Service Division and the State agencies with which AOA works have been active in promoting the cause of the elderly in model city neighborhoods, as detailed below in this report's section on model cities.

COMMUNITY PROGRAM ACTIVITIES

Two additional State plans were approved under title III of the Older Americans Act in 1969—for Mississippi and Guam. A total of 51 State plans had been approved by the end of 1969. However, one plan was inactive.

In fiscal 1969, 816,000 older persons were served by 786 title III projects under the Older Americans Act. Title III provides funds to States to make grants for:

1. Community planning and coordination of programs on aging.
2. Demonstration of new programs or activities beneficial to older people.
3. Establishment of new programs or expansion of existing programs, including senior centers, which contribute to opportunities for a better life for older persons.
4. Training of special personnel to carry out such programs.

Title III community grants are awarded by State agencies to strengthen State and community services to the aging and to stimulate new interests on the part of the States and communities in meeting the needs of their older residents.

SERVICES FOR INDEPENDENT LIVING

Services which fostered independent living and which helped older persons maintain their own homes were provided to 165,800 persons in 1969. These in-home and out-of-home services played an important part in helping older persons remain independent in their community, in surroundings familiar and congenial to them, and often at considerably less cost than the more expensive alternatives of nursing home care, hospitalization, or institutionalization. Homemaker-home health aide services alone were provided to 9,500 persons by 65 projects.

Home maintenance, often referred to as "chore services," friendly visiting, and telephone reassurance services were provided to 97,500 persons. Many of the services were provided by older persons themselves. Meals were provided to 16,900 persons in 62 projects. Foster home services and protective services were provided for 4,300 older persons by 66 projects and health services were provided to 34,600 persons through 127 projects.

The 65 homemaker-home health aide projects were located in 32 States. One project in Pennsylvania was providing homemaker-home health aide services to all older persons, including old-age assistance recipients.

Through coordination of available resources, the needs of all older persons in the county are being identified and efforts initiated to meet them.

PROVIDING OPPORTUNITIES TO PARTICIPATE IN COMMUNITY LIFE

Another important category of service rendered by title III projects provides opportunities for older persons to continue to lead active and meaningful lives in their community. Employment opportunities were provided to 15,400 older persons interested in supplementing social security and other benefits or utilizing special skills to supplement income after retirement. Adult education activities were offered to 103,900 older persons by 230 projects. Some 505,000 elderly persons participated in recreation and other leisure type activities under title III. Counseling was provided for 44,900 by 230 projects. Transportation services were also offered to some 76,600 persons. One project in Maryland purchased surplus school buses, which were used to provide transportation for older persons to participate in senior center and other community activities at a very nominal cost.

Under title III, State agencies provided support for 425 senior centers which also provided many of the services mentioned above to maintain independent living and opportunities for active engagement in community life. The senior center has often become the focal point for planning, coordinating, developing, and delivering services to the aged in the community. The center is the channel through which contact is made and maintained with the elderly in the community through outreach, referral, and information services. The older persons, through involvement and participation, become aware and knowledgeable of the resources available to them and the gaps in services which they as a group may help develop. Multipurpose senior centers served some 509,000 persons in fiscal year 1969 alone. Senior centers located in both rural and urban settings, are situated in housing projects, churches, and public and private buildings. They provide varied recreation, counseling, referral and information services and opportunities for meaningful volunteer activities. Frequently, older persons themselves have provided services to other persons, young and old. Health services such as screening were offered to 21,900 persons by 101 projects in senior centers.

The Senior Citizens, Inc. of Nashville is demonstrating the value of a comprehensive program of opportunities and services for older people. This program operates a multipurpose senior center with 12 neighborhood satellite centers also in operation under the direction of trained older persons. Programs and activities in these centers are varied and tailored specifically to the interests of each neighborhood group.

VOLUNTEER OPPORTUNITIES

Opportunities and interest in volunteer activities by older persons in title III projects has been significant. Some 40,700 older volunteers are providing a variety of services to their community through 625 projects. Beneficiaries of these services include the aged, young, families and other community groups.

For example, senior volunteers assist in directing of leisure-time activities in senior centers, they staff information and referral operations, they visit and help the homebound, they provide tutorial services for students, they provide transportation for other older persons to shop, attend church, and keep medical appointments. They also provide telephone reassurance to the isolated, ill and handicapped, and provide service to both the aged, families and children receiving assistance from voluntary and public health and welfare agencies. By serving others, senior volunteers are adding significantly new meanings and interests to their own lives.

In Worcester, Mass., a program which initiated as the Doll Making Workshop volunteers showed a new sense of purpose when the focus of the program was shifted to preparation of materials to help the mentally retarded of the community. In Maryland volunteers are providing needed in-home services for the homebound older persons. They shop for food, obtain prescriptions, prepare meals, do the laundry and straighten up the house. Their presence in the home is often a final "pipeline" to the community for the older persons. In emergencies they remain with the aged individual giving comfort and reassurance that someone cares, until other arrangements for care are made.

TRAINING OF PERSONNEL

A total of 59 training projects provided short-term training for 10,690 persons to serve the elderly. A total of 900,797 man-hours of training were provided with an average of 84 hours per trainee. Two projects specialized in developing a training curriculum in aging for other programs to follow. Many of these training projects prepared specialized personnel, professional and nonprofessional, to better serve the elderly. Title III project and center staff numbering 5,573 received a total of 351,940 hours of training through 11 projects. Orientation on aging was provided by 16 projects to 2,477 trainees, including community leaders. Training for providing medical services to the elderly by both professional and nonprofessional personnel, was provided to 1,329 persons through eight projects.

In Missouri, home health aides were trained under a jointly funded AoA and OEO project to serve the elderly in seven counties. Delaware is training and locating employment for geriatric aides who serve the elderly in their own homes.

In Illinois five nonprofessionals were trained by the Chicago Hearing Society to teach speech reading to 80 elderly persons with impaired hearing. It was estimated that one-fifth of the persons 65 and over had a hearing impairment severe enough to interfere with normal communication.

COMMUNITY PLANNING

Approximately 5.4 million older persons reside in the areas covered by the 130 planning programs initiated under title III in 1969. Thirty-three of these projects were located in rural areas and 97 projects in urban areas. The planning area varied from a neighborhood to countywide in scope—often involving even larger areas. Such projects enable the community to survey and assess the needs of the elderly, the resources available to meet the special needs of its aging population, and stimulate local support for the initiation and development of direct service programs.

In one community in New York, the special needs of the aging were more clearly focused through information, referral, and short-term counseling services. Plans for improvement of existing services in the community through coordination resulted in more effective utilization of the resources by older persons, and development of new services to fill identified gaps.

A project recently funded in Trenton, N.J., will make it possible to establish a coordinator of programs for older adults to coordinate existing services provided by health and welfare agencies, hospitals, visiting nurse associations, voluntary family agencies, and the city recreation department. Thus, the needs of older persons in that community should be met better.

In conjunction with planning, information and referral services were provided to 348,500 by 413 projects in fiscal year 1969. These services also provide a means for identifying needs of the aged, resources in the community and the gaps in service and are vital to the community planning process.

The Administration on Aging has worked to obtain adequate recognition and inclusion of the needs of aging in model cities planning. It has prepared information materials on the special needs of older persons, participated in the planning and provided consultation for the development of services for the elderly; 179 community grants have been awarded by State agencies to model cities programs under the Older Americans Act.

Research and Demonstration

Research and demonstration project grants under title IV of the Older Americans Act are contributing significantly to knowledge and improved practices in aging. During 1969, 63 new and continuation projects were funded at a cost of approximately $4,155,000.

Data for differentiating the needs, interests, and abilities of low- and middle-income elderly, between the "younger" and "older" senior citizen, and the aging in varying environmental settings is being accumulated. Exploration of the relationship of these personal and social differences to the utilization of services and the ability to remain independent, will have far-reaching significance for the design, thrust, and cost of efforts in behalf of older people in the future.

Findings from research and demonstration projects are being transmitted as rapidly as possible to States, communities, professional groups through such mechanisms as administrative papers and project summaries in the AoA publication, Aging. Project reports have been presented at workshops, and at regional and national conferences. Project directors have published a number of articles in professional journals. Knowledge and experience from research and demonstration projects is being fed to those involved with administration of title III to increase program effectiveness, expand the range of readily usable services, and to make these available at reasonable cost.

There has been keen competition for title IV funds. Only one in four applications reviewed by the Technical Advisory Committee has been funded. These grants have been concentrated in several priority areas. Examples of projects in some of these priority areas are as follows:

Nutrition

In 1968, Congress earmarked $2 million to initiate a special program to improve nutrition services for the elderly under title IV. Under this program 31 grants have been made, eight of which have been completed; 23 projects are currently in operation in 18 States and in the District of Columbia.

The projects are designed to test techniques and delivery systems for improving the diets of the elderly and for combatting social and psychological impediments to good dietary habits. Of the 23 projects now in progress, 21 are demonstrations and two are concerned with related research; 17 of the demonstrations are in metropolitan areas and four are in nonmetropolitan areas.

The research projects are providing comprehensive data and knowledge related to nutritional status and dietary habits; as well as the cost and acceptance of different delivery systems. There are three elements common to all demonstration projects: group meals in a social setting; nutrition education; and evaluation of the effectiveness, feasibility, an cost of the particular type of service tried.

Existing facilities in the community such as schools, recreation centers, community centers, homes for the aged and social halls in public housing, churches and fraternal organizations—provide the setting for the projects. Staff includes professionals, volunteers, and paid employees, part time and full time, the elderly and the young. Almost all projects employ senior citizens.

In addition to the three basic components, other techniques to meet the nutritional needs of the elderly are being tested and evaluated in many projects. Take home meals for weekends, pot-luck dinners, weekend dining clubs; delivery of meals, mealtime companions and friendly visitors for the shut-ins; health services and referral services; and leisure time and recreation activities. Transportation is offered in many projects where participants do not live within easy walking distance of the project.

Data available at this time indicates that the nutrition problems of the aged stem from multiple causes and that no single approach can effectively overcome the obstacles to adequate food and nutrition. In addition to the two major causes of malnutrition and undernutrition in America—lack of income and ignorance about what constitutes an adequate diet—the additional social and psychological factors associated with aging affect the dietary habits of older people. Preliminary findings tend to support the conclusion that the meal is the effective drawing card in motivating lone, lonely, and isolated elderly persons to come together for all sorts of activities and that the elderly eat better when with others in a social atmosphere.

Comprehensive Coordinated Community Services

The new and continuing title IV coordinated services projects currently in operation represent an intensive, long-range attack on problems of coordinating

community services for the aging. These projects attack the problem at various levels of the public and private sectors. Their ultimate objectives are to assist communities in acquiring both the wherewithal and expertise to recognize, seek out, and serve their elderly residents. Researchers are studying older people's ever-changing social needs in different types of communities and geographical areas so that policymakers can have the kind of information necessary for decisionmaking. Some of the nation's top gerontological experts are developing and testing different techniques for administering comprehensive community services. Studies and demonstrations of a range of specific services such as transportation, retirement planning and counseling, senior centers, volunteer and paid community service employment, and home-help programs to assist those threatened with institutionalization or dependency, will equip communities with the knowledge essential for serving older citizens successfully.

In Philadelphia, field interviewing for a comparative study of the service needs and availability of services to aged noninstitutionalized Negro and white residents of an urban low-income area threw additional light on the nature of the problems for which older people in this type of neighborhood need to be referred for social services. On the whole, the percentage of referrals for services to help deal with these problems was highest for the Negro group. Lack of knowledge of the existence and nature of social services and means of obtaining them is apparent even in persons with long-time roots in the community and those who actively participate in community affairs. But lack of knowledge is mutual. A companion survey of health and welfare administrators in agencies serving the area revealed that they were unaware of many of the service needs within it and of the "communications gap" preventing them from serving the area effectively.

Four projects, two research and two demonstrations, are concerned with various aspects of the organization, administration, and coordination of comprehensive community services for older residents.

A gerontological society project is delineating goals and developing guidelines for the stimulation and implementation of research and development programs to improve the lot of older Americans during the 1970's. In New York State, researchers are examining the social organization and service utilization patterns of older people in 145 communities throughout the State. New York City's effort to intensify and improve the city's battery of services to older people is being individualized through demonstration neighborhood offices operating as arms of a newly established city office on aging. Kansas City is demonstrating how a newly created office, responsible to both city and county governmental units, can identify available public and private agency resources and program their use more effectively.

MOBILITY—TRANSPORTATION

The dynamics of the relationship between transportation and older people's ability to utilize medical, social, and welfare services are being explored in five title IV projects.

In Chicago, a project jointly funded by the Department of Transportation is studying the impact of a reduced fare program on the social and economic circumstances of the elderly and the transportation system itself to provide systematic data that will enable other municipalities to determine the feasibility of a reduced mass transit rate for the elderly, and to provide information that can lead to new approaches to the problem of marketing urban transportation services for the elderly.

Fisk University, in a project jointly funded with the Department of Housing and Urban Development, is conducting a study to determine whether older people's life styles and mobility habits have a direct influence on their use of various transportation modes, and whether changes in life styles can produce changes in the use of various modes of transportation.

Two studies in New York City seek to determine (1) the effects of the reduced fare program on transit authority revenues through measurement of changes in elderly ridership patterns resulting from the reduced fare; (2) the social effects of such a program, such as its effects on older people's financial situation, their mobility, morale and use of social and other community services and facilities.

A study by the Langley Porter Neuropsychiatric Institute is seeking to identify the major factors that determine the transportation habits, preferences, needs, and problems of older people in urban settings.

RETIREMENT LIVING

In identifying the basic characteristics of retired persons as a preliminary part of a larger study to determine why older people move to retirement communities outside their home State, investigators in Wisconsin found that older persons residing in the rural community being studied experienced a greater increase in financial problems after retirement than those in two more urban communities. Differing definitions of a comfortable level of living existing among the retirees in these three communities indicate that in discussing the financial problems of the retired, it is important to distinguish between those relating primarily to maintaining an accustomed level of living and those related to other factors.

Retirees in the rural community made less use of formal medical services than do the others. Over half of the persons in all three communities had made no financial or activity plans for retirement. Four out of five of these retired persons expressed satisfaction with retirement, yet over half did not feel as useful as before and had difficulty filling their time.

Older people themselves, working in paid or volunteer capacities, are proving highly capable in performing community service roles. Several projects have demonstrated that senior citizens, working as teacher aides, community outreach workers, research aides and interviewers, food service assistants, and in libraries and homes for the ill and disabled, can vitalize community service programs and at the same time increase their own sense of worth and well-being.

The city of Martin's Ferry, Ohio, developed and is operating a city-backed business which offers services and income opportunities to older citizens. The project is demonstrating that a small city can significantly increase such opportunities in the community at reasonable cost, that these opportunities often replace boredom and despair with new interests in living for a retired person, and that the services rendered or the handiwork produced by the older participants benefit the community. The information developed should be valuable to many communities seeking better ways to help their senior citizens with the problem of meaningful use of time in retirement; opportunities to interact with others and supplemental income from tasks tailored to their skills, energies, and interests.

TRAINING

The training grant program, administered under title V of the Older Americans Act, began to send significant numbers of graduates into responsible positions serving the older population. By the end of 1969, 10 of the participating schools had graduated 82 persons trained for careers in such areas as: program planning and administration, community organization, senior center direction, recreation leadership, and housing management in the field of aging.

New training programs were initiated in four institutions—University of Arizona, University of Chicago, Portland State University, and University of Southern California—bringing to 17 the total number of universities conducting AoA-supported, career training programs. The number of students enrolled in these full-time programs reached 363, an increase of 50 percent over 1968.

Some 1,751 persons received short-term training to improve their knowledge and skills in aging, or to equip them for moving into the field.

A draft of a programed manual for use in teaching was completed by the staff of one university, and circulated for comment. A home study course in social gerontology, being developed under an AoA grant was nearing completion.

Most of the career training institutions were or became involved in the model cities program. More than one-half of the institutions were assigning students to model city programs for their field work experience. The faculty in aging at one university accepted responsibility for developing the program in aging in one city. A graduate of an AoA-supported program is in charge of the aging component in another city.

CAREER TRAINING

An increasing portion of title V funds was allocated to long-term, career training, pursuant to the findings of the manpower studies conducted in 1968. These studies confirmed the existence of critical needs for personnel equipped for responsible leadership in most areas of the field of aging. Table 1 shows the number of long-term and short-term programs supported each year, and the distribution of funds.

TABLE 1.—PROGRAMS AND SUPPORT FOR TRAINING IN AGING, UNDER TITLE V OF THE OLDER AMERICANS ACT, 1966-69

Year	Programs			Aggregate amount of awards (in thousands of dollars)		
	Total	Long-term	Short-term	Total	Long-term	Short-term
1966	12	2	10	$420	$136	$284
1967	23	8	15	1,330	853	472
1968	30	13	17	2,220	1,701	519
1969	28	17	11	2,845	2,558	307

The new programs supported in 1969 are preparing students for careers in aging within the fields of architecture and design, community organization, retirement housing management, and urban planning. The training objectives of the students enrolled in the 15 programs involve 17 universities, range over most of the priority areas established by the Administration on Aging. The programs and their training objectives are shown in table 2.

TABLE 2.—LONG TERM TRAINING PROGRAMS AND PRIORITIES, SUPPORTED UNDER TITLE V OF THE OLDER AMERICANS ACT IN 1969

Universities	Training objectives						
	Administration and planning	Housing and institutional management	Community organization	Recreation and senior centers	Architectural and urban design	General [1]	Others [2]
Arizona		X					
Brandeis	X					X	
California			X				
Chicago			X				
Columbia				X			
Michigan-Wayne State	X	X	X	X	X		X
Minnesota	X						
North Carolina				X			X
North Texas	X	X				X	X
Oregon-Portland State	X			X	X		X
San Diego			X				
South Florida						X	
Southern California					X		X
Washington			X				
Wisconsin			X				

[1] Training in applied social gerontology with generalized work objectives, with master's degree or doctorate in aging.
[2] Includes such objectives as library science, counseling, health education, adult education, social work.

It is significant that the career training programs are attracting a wide range of students. Sixty percent of the 1969 enrollees were men; 40 percent women. They ranged in age from the early twenties to the late fifties; more than one-half being 30 years or more of age. One-third of the students entered the programs with 5 or more years of experience in an area relevant to their training objectives. Thus, it became apparent that the programs are reaching considerable numbers of mid-career people, such as retired military personnel, who are seeking to find new careers in aging.

The number of persons receiving short-term training increased from something over 900 in each of the first 2 years of the program to 1,751 in 1969, as shown in table 3.

TABLE 3.—LONG-TERM CAREER STUDENTS AND SHORT-TERM TRAINEES IN AOA-SUPPORTED TRAINING PROGRAMS, 1966-69

Year	Career students and short-term trainees		
	Total	Long-term students	Short-term trainees
1966	934	12	922
1967	1,024	78	946
1968	1,689	214	1,475
1969	2,114	363	1,751

Especially significant during 1969 were continuing short-term projects conducted by—

The New Jersey Division on Aging for college and university faculty members who are developing courses or course content in aging.

The University of Georgia which provided training in aging and management skills to 120 managers of retirement housing facilities.

The Jewish Home and Hospital for the Aged, in New York City, which reached more than 694 professional and semiprofessional personnel in health, welfare, and recreation occupations—through a catalog of courses.

The University of Southern California, which gave intensive summer courses in gerontology for 28 professional workers and college and university teachers.

The York County, Maine council on aging, which recruited 35 middle-aged, lay persons for community leadership in aging, bringing to 115 the total trained since the program was started.

The University of Michigan-Wayne State University 14-week Residential Institutes which provided intensive training for 100 mainly employed workers in retirement housing and institutional management, mental hospital milieu therapy, and retirement preparation leadership. Of the total number of persons trained and certificated through 1969, some 83 percent were employed in positions serving older people.

The policy of the Administration on Aging is to use title V short-term funds for the support of training projects which are nationwide in scope or distinctly innovative and beyond the capacities of the States to finance. States are encouraged to support training for local project personnel from allocations made under title III of the Older Americans Act. The policy has worked well: title V funds have supported 53 short-term training, materials development, and manpower study projects, while State agencies on aging have supported more than 15,000 projects which have had a primary focus on training or have included a training element. The Administration on Aging has also encouraged training institutions to utilize other sources of support, such as vocational education, Higher Education Act, and Health Service on Mental Health Administration funds.

The Administration on Aging is increasingly convinced of the need for university-based centers for training, research, and service in aging. The Institute of Gerontology at the University of Michigan-Wayne State University, the Gerontology Center at the University of Southern California, and the Center for the Study of Aging and Human Development at Duke University have shown that these multifaceted agencies, involving representatives of several subject-matter fields, are exceedingly useful to the national effort in aging and to the regions and States in which they are located. Title V programs supported at North Texas State University, the University of Oregon-Portland State University, and the University of South Florida are enabling these universities to extend their usefulness and influence by moving toward the center concept.

This report shows that the training program launched under title V of the Older Americans Act is being successful in stimulating the development of training programs addressed to meeting needs for personnel especially trained for the field of aging. Tragically, the 363 career students and the 1,751 persons who received short-term training in 1969, represent only a tiny fraction of the thousands needed, as reported in the U.S. Senate's Special Committee on Aging publication, Developments in Aging, 1968 (S. Rept. 91–119).

Foster Grandparent Program

The foster grandparent program continues to be an exceedingly popular program for older persons. The program was first developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. The program was administered jointly from then until September 17, 1969, when the Older Americans Act Amendments of 1969 (Public Law 91–69) became effective. These amendments provided for the complete transfer of the program to the Department of Health, Education, and Welfare, where it is now being administered solely by the Administration on Aging.

The purpose of the program when it was established was to explore, evaluate, and demonstrate the feasibility and the potential benefits of using the services of older persons for the enrichment of the social environment of institutionalized infants and young children. Four years' experience with the program has produced abundant evidence of the feasibility of using older persons in meaningful activities and of the beneficial effects on the children of the personal care and

attention of an interested adult. They have that precious commodity, time, which is so necessary in working with children, and the love and patience to help them learn the social skills used in everyday living.

Since the funding of the initial 21 projects, in 1965, the program has expanded to include 68 projects in 40 States and Puerto Rico. There are 183 participating institutions in which 4,000 foster grandparents serve 8,000 children on any one day, and about 16,000 children a year. For the past 2 years, however, the number of projects and the number of older persons serving in the program has remained the same. The number of children served has also remained unchanged.

There are other areas, however, in which some changes have occurred. Ten million dollars was allocated for this program in fiscal year 1968, $9 million was allocated in fiscal year 1969, and an estimated $8.7 million will be allocated in fiscal year 1970. Also, the profile of individuals serving as foster grandparents has changed. Initially, recruitment of males was difficult. Today, one foster grandparent in every five is a grandfather. Nonwhite participation has increased from 26 to 32 percent. Encouraging is the fact that the 70 and over age group has increased from 30 to 41 percent of the total participants during this period. The younger foster grandparents, the 60- to 64-year-olds, have decreased comparably. In addition, foster grandparents today are generally from lower income groups than when the program began. The average income is now $1,052 for single grandparents and $1,675 for two-member families, excluding the stipend they receive as foster grandparents of about $1,700. In addition to the stipend, foster grandparents receive an allowance to help defray transportation costs, an annual physical examination, and, wherever possible, a nutritious meal each day.

The attitudes of institutions have changed also. When this program began, it was difficult to locate agencies and child care institutions willing to participate. Now, literally hundreds of requests each year for Federal help to start new projects are turned away. The institutions also now show a greater acceptance of the older person, of the nonwhite, and of the poor. The success of this program is readily revealed in some of the following statements submitted to the Administration on Aging by staff of various institutions. These are but a few that could be cited:

> "Kids are walking. Kids are talking. Kids who used to have to be tranquilized aren't being tranquilized any more. Kids who couldn't go to school, go to school now. It just makes all the difference in the world. For the first time in a child's life, he's got someone who is all his."

> "As a result of foster grandparents' calming influence upon our emotionally disturbed and hyperactive children, we frequently receive unit clinical team recommendations that a foster grandparent be assigned to a particular child . . . These recommendations (are) based upon our psychiatrist's evaluations, and supported by the social service, psychological and medical clinical team members."

Foster grandparents themselves receive many benefits from participation, including enhanced self-esteem and a sense of purpose in living, improved health or at least a greater feeling of well-being, and increased security from the added income. Although the income is a major factor, since the foster grandparents are selected from persons whose incomes are below the poverty index, they consider as equally important the new meaning their lives have because of their association with these deprived and handicapped children. Comments such as the following are heard from foster grandparents at projects throughout the United States: "I have something to look forward to." "I have a reason to get up in the morning." "It's good to be needed again." It is interesting, and significant, that the attendance records of the grandparents are as good as, and sometimes better than that of the regular employees.

One of the distinguishing features of the foster grandparent program is in the area of social services to the grandparents. In addition to the stipend, foster grandparents receive counseling on personal matters and information regarding benefits available through medicare, social security, legal services, and community and other Federal programs. These are some of the extra services provided through the project staff. An ancillary benefit to the foster grandparents which many of them consider of major importance is the opportunity to serve with other persons of their own generation. Many of these older persons consider this aspect of the program second in importance only to the meaningfulness of helping "their children."

The foster grandparent program clearly serves two needy groups in our society, older adults and deprived children. Many older persons want to be of service to their community but often have not had the opportunity and have been relegated

to the rocking chair and a life of loneliness. Similarly, many needy children in institutions have never had the close, meaningful relationship with an adult essential to the development of a healthy and mature personality. Bringing these two groups together has added new meaning to the lives of both. It provides the grandparent with a renewed sense of purpose while making a meaningful contribution by "rescuing children from the blight of impersonal living." Foster grandparents have demonstrated through this program that the love, understanding, and maturity developed through the years add an ingredient to the lives of children for which there is no substitute.

RETIRED SENIOR VOLUNTEER PROGRAM

The retired senior volunteer program, although authorized by the Older Americans Act Amendments of 1969, has received no appropriations to begin operating. While awaiting the funds needed, the Administration on Aging has answered inquiries concerning the program. It is anticipated that when funds to initiate it become available, application procedures, model programs, and guidelines for program operation will be ready.

AOA Model Cities Activities

Since 33 percent of all Americans age 65 or over live in central cities and 27 percent of them are in the poverty status, the Administration on Aging has devoted an increasing amount of attention to the needs of the elderly in model cities areas. Since these elderly often have severe transportation and mobility problems, accessible services are essential to them. Increased health and welfare services are a critical need along with improved housing. Too, there is an important concern for the involvement of older persons themselves in the model cities planning process, plus the necessity of acquainting model cities personnel with the problems of the elderly and offering them technical assistance.

AOA activity in the model cities program has taken several directions. AOA has its own task force on model cities. Within AOA the title III, IV and V programs have given high priority to model cities. The Administration on Aging has actively cooperated with other agencies within HEW on special model cities efforts as well as in the HEW coordinated model cities effort. The Administration on Aging, through an agreement between HEW and HUD, has moved ahead on programs for the elderly in direct concert with the model cities administration.

TITLE III

When AOA discovered several barriers to participation of State units on aging in model cities, it began efforts to overcome them. As a result 79 percent of the State units with their title III project directors have ongoing services for neighborhood residents in model cities. There are nearly 125 title III projects with current or potential impact in model cities.

State agencies on aging, whose operating expenses are defrayed, in part, with title III funds from AOA, have provided active leadership in serving the elderly in model cities. The Georgia Commission on Aging, for example, hired an additional staff member whose primary responsibility is to work in the model cities program area. The Florida Bureau on Aging, in cooperation with the University of South Florida, the Tampa Demonstration Agency, and a county advisory council on aging, conducted an extensive door-to-door survey of older residents in the model city area to determine their location and specific needs.

State agencies on aging in four States (Connecticut, Georgia, Michigan, and New Jersey) have sponsored meetings on "Model Cities and the Elderly." These meetings have brought together representatives from AOA, HUD, OEO, Department of Labor, private organizations concerned with the elderly, staff of city demonstration agencies and elderly model city neighborhood residents. The meetings formulated action plans for assuring that elderly model city residents participate in the planning of and benefit from model city programs.

TITLE IV

Current research and demonstration grants are keyed to model cities needs in 14 cities in seven regions. Commitment of AOA Research and Demonstration funds to the coordinated HEW Model Cities thrust will add three additional cities and one region in the 1970 fiscal year.

In addition a grant to the Syracuse University School of Social Work has as its central objective the development of appropriate guidelines to enable model

cities programs throughout the United States to clarify and develop ranges of living arrangements, care, and service alternatives. It will also include an identification of the characteristics and ranges of needs of the elderly in model city areas as a basis for methods and procedures to achieve the overall objectives of comprehensive, unified, and innovative services and service delivery systems. A further component is an evaluation system to assess the effectiveness of planning efforts—physical, economic, and social—in meeting the needs of the elderly and how best to enable them to function and participate in family, neighborhood, and community life.

The Seattle model city area is the testing base for the Syracuse University project. Tentative propositions will be presented early in 1970 in a workshop involving selected model cities planners, before extension to the field generally. Seattle was selected as the testing base because an research and demonstration grant for "coordination of comprehensive services for the aging" was already operational.

TITLE V

Cooperation of schools operating training programs has been secured. Trainees have been given field experience in model cities programs. Too, trainees and graduates have been assisting in the development of aging components in model cities plans. Curricula are including the model city problems with the expectation that students will find this an area of interest and become available for professional positions on model city staffs or in projects serving model city residents.

AOA-MCA COOPERATION

On August 12, Robert H. Finch, Secretary of Health, Education, and Welfare, and George W. Romney, Secretary of Housing and Urban Development, announced a joint campaign to provide older people with increased services in the model cities program and to encourage them to take a greater role in planning and developing these services. (See Exhibits B and C).

The two Cabinet officers said the operation would be carried on jointly by the Administration on Aging of HEW and the Model Cities Administration of HUD. John B. Martin, Commissioner of the Administration on Aging and President Nixon's Special Assistant for the Aging, and Floyd H. Hyde, Assistant Secretary (for Model Cities and Governmental Relations) of Housing and Urban Development were given the joint administrative responsibility.

Under the HEW-HUD agreement, every community participating in the model cities program was encouraged to assure representation of the elderly on each model city board or planning body. The model cities administration program development staff added a special consultant to review projects for their content on aging and to assist local boards and planning bodies in involving older citizens.

AOA in turn urged all State agencies on aging to offer their communities technical and financial assistance for model city developments and to designate a State agency staff member to be responsible for model city activities. AOA and MCA agreed to joint sponsorship of a series of meetings in various parts of the Nation to stimulate greater involvement of older people in the program.

The two agencies as the result of the agreement held a 2 day workshop at the University of Maryland on coordinated services for title IV project directors in model cities and four statewide meetings. The State meetings were in Connecticut, Georgia, Michigan and New Jersey. Additional meetings are planned in 1970. AOA also convened a meeting of national organizations of older persons and received their pledge to cooperate in model cities planning programs.

The statewide meetings were jointly sponsored by AOA, MCA, and the State units on aging. In addition to directors of aging programs and Model Cities planners, those attending included providers of services such as welfare, health, housing, recreation, adult education, and State and local government. The senior citizen organizations, universities and various voluntary agencies also attended. In most instances the meetings demonstrated the previous lack of planning for needs of the elderly and opened avenues for planners to obtain assistance in filling this gap. Commitments for future action to assure equity to the aging in Model Cities were made by many of the agencies and organizations which participated

WHITE HOUSE CONFERENCE ON AGING

President Nixon on October 6, 1969, issued the call for the White House Conference on Aging. The President in his statement (exhibit D, attached) pointed

out that considerable progress has been made as the result of the 1961 Conference called by President Eisenhower.

The President established the Conference timing, direction and broad objectives with this statement:

"Today I am issuing a formal call for the second White House Conference on Aging to meet in Washington, D.C., in November in 1971. With careful advance planning and with broad, representative participation, this Conference can help develop a more adequate national policy for older Americans. I hope that it will fully consider the many factors which have a special influence on the lives of the aging and that it will address precise recommendations, not only to the Federal Government, but also to government at other levels and to the private and voluntary sectors as well. The Conference will be directed by John B. Martin, Commissioner on Aging and Special Assistant to the President on Aging."

At the press conference when the President's statement was released, John Martin, Commissioner on Aging and Special Assistant to the President on Aging, also made a statement (exhibit E, attached) in which he likewise noted progress on behalf of older Americans since the 1961 Conference. Mr. Martin also sketched broad plans for the 1971 Conference saying, "State and regional surveys, hearings, and conferences will precede the national Conference. Older people themselves will be represented in the meetings at all levels, as will the providers of service, professionals in the field of aging, and national organizations and churches of the Nation.

"There are still great problems to meet on behalf of older people—income, health, housing, employment, and retirement roles and activities. The major and overriding problem, I believe, is that as a people we have still not developed a real philosophy of aging.

"The President, in calling the Conference, gives us a magnificent opportunity to make a commitment to our older Americans as first class citizens fully participating in our national life. This will assure a firm place for older people in the administration's broad and continuing development of national goals."

Planning for the White House Conference on Aging has been based on the emergence since 1961 of three distinct and concerned groups. These groups are the older people themselves, those who provide services of various kinds to older Americans, and specialists or professionals in the field of aging. Each of them is important in policy determination and implementation. Collectively, they can contribute to the formulation of a national policy on aging and can assist in its establishment. The 1971 White House Conference on Aging plans will attempt to involve and give participation to these three divergent groups in the most meaningful manner.

Most of the members of these three major groups are affiliated with one or more of a broad range of national senior citizens, professional, or voluntary organizations. It is anticipated that these organizations along with government at local, State and Federal levels will have an appropriate part. At the same time the planning for the Conference structure will seek to prevent any single group or organization from dominating the deliberations.

Conference planning is being directed by the Commissioner on Aging and Special Assistant to the President on Aging. As the Conference director, he will be supported by knowledgeable persons in the field of aging who are competent to staff activities of the 28 man advisory committee and technical committees specified in the legislation and to develop Conference plans and materials, including films. In addition, it is planned that staff will work closely with the States and regions in pre-Conference activities. The possibility of a series of regional hearings on the Conference subject matter is being considered.

It is contemplated that States will engage in a variety of pre-Conference activities, such as making surveys and studies, conducting workshops and hearings, and holding conferences looking toward the formulation and implementation of national policy with regard to older Americans. This activity would include substantial numbers of older people, providers of service and professionals in the field and should make use of the educational resources and expertise of each State. We believe that there also should be an opportunity through regional committees composed of representatives selected from each State to consolidate State recommendations. Every effort will be made to get State and regional groups to limit recommendations to matters of major significance and to identify priorities.

Subject to further study by the advisory committee, preliminary Conference planning is based on the belief that needs of the elderly fall into seven principal basic categories which include health, income, housing, employment and retirement, retirement roles and activity, spiritual, and education. Panels dealing

with these substantive areas would consider all related aspects from a standpoint of older people themselves, providers of service and professional assistance. The contemplated focus of the Conference would be on the formulation of long-range goals and interim or short-range objectives. All of this would be aimed at action within a time framework designed to reflect current conditions and practical possibilities.

Establishment of firm plans and procedures is subject to receipt of a fiscal year 1970 appropriation for the Conference and subsequent review by the advisory committee. Suggestions of persons to serve on the advisory and technical committees have been solicited from interested national organizations.

It is our belief that the Conference, developed as outlined above, will provide a result entirely different from the proliferation of resolutions of the 1961 Conference and be related to specific needs of our older people and the means to meet those needs.

AOA Information Activities

During the early part of 1969, AOA's Information Division concentrated on efforts to make Senior Citizens Month a truly nationwide observance.

In cooperation with the National Safety Council, AOA produced a safety course for older people which could be conducted not only during May but in subsequent months and years. An instructor's guide for the course, Handle Yourself with Care, (15,000 first printing) and a related booklet for individuals were published by the Administration on Aging early in the year. An initial 150,000 copies of the individual booklet were distributed and additional requests required a second printing of 100,000. Visual aids for the course were also prepared and distributed. By the end of the year, the course had been given or was scheduled in 20 States, the Virgin Islands, Puerto Rico. In New York the accident prevention consultant in the State Department of Health distributed copies of the Instructor's Guide to all units in the State, and the American Nurses Association provided the material to its 80 geriatric nursing chapters.

Another first observance this year was celebrated May 1 with the issuance of a special Grandma Moses Stamp honoring all older Americans. In cooperation with the Post Office Department, AOA sponsored the first day issuance ceremony in the U.S. Department of Health, Education, and Welfare auditorium. The Post Office Department later reported that 367,880 first day covers of the stamp were sold.

Before the month began, AOA had printed 75,000 copies of President Nixon's proclamation, an equal number of posters, and 100,000 copies of a special preprint of the May issue of Aging. These were distributed through State agencies on aging, national voluntary organizations, and other channels. In addition, What Is Your Community Doing for Senior Citizens Month 1969? a booklet of newspaper clippings with text making it a handbook of publicity ideas for local senior groups, was in sufficient demand to go into a modest second printing.

During 1969, the Consumers Guide for Older People, AOA's popular wallet card, continued in strong demand. The Administration on Aging has printed and distributed a total of a million free copies, and the Government Printing Office, to fill its own requests, has ordered a second printing of 250,000 for sale.

Two awards were received by AOA's Information Division during the year. One was to Division Director Dorothea J. Lewis, presented by Senator Edmund S. Muskie, from the Federal Editors Society for the publication The Fitness Challenge in the Later Years. Olivia W. Coulter, editor of Aging, received a certificate of appreciation from the Volunteer Council for Community Care Geriatric Services, Inc., for publicizing its volunteer program in 43 nursing homes in Austin, Tex.

The Information Division prepared a number of special statements and articles for publication during the year in connection with the appointment of John B. Martin as new Commissioner on Aging and the passage of the 1969 amendments to the Older Americans Act. In addition, it assisted program people with articles on the foster grandparent program, now AOA's full responsibility.

In September the Public Inquiries Division, Social and Rehabilitation Service, was abolished and responsibility for answering the increasing numbers of inquiries concerning older people was returned to the AOA Information Division.

AOA's newsmagazine, Aging, appeared only eight times during the year because of budgetary and staff restrictions, but the total number of copies of each issue distributed increased. The Office of Economic Opportunity which had been receiving 1,500 copies from AOA's stock, agreed to ride the HEW printing requisition

for the magazine so that the cost of these copies will not be charged to AOA's budget.

The Information Division, with other AOA units, cooperated in arrangements for the University of Michigan's 21st Conference on Aging in June and the Eighth International Congress of Gerontology in Washington in August.

In addition, the Division published the following booklets in its "Designs for Action" series: (904) Employment Referral; (905) Group Volunteer Service; (906) A Centralized Comprehensive Program; and (907) Countrywide Information and Referral.

Eighth International Congress of Gerontology

A major event of the year was the Eighth International Congress of Gerontology held in Washington, D.C., August 24 to 29. The 1,800 participants were welcomed by Commissioner on Aging Martin. He invited the guests from the 34 foreign countries represented to share the knowledge and experience they had gained in studying and working with older people.

United States and world experience was shared in two plenary sessions, 26 symposia, and 56 meetings. Presentations were organized according to four areas: biological, clinical medicine, psychology and social science, and applied social research. A unique feature of the Congress was the scheduling of 105 small discussion groups which afforded opportunity for everyone who attended the conference to have a meaningful part in it. Conferees visited numerous facilities for older people in the metropolitan area, and were taken to Baltimore to visit the new Gerontology Center of the National Institute of Child Health and Human Development.

The Administration on Aging organized two symposia for foreign guests interested in learning about U.S. Government programs in aging. The Commissioner on Aging and several staff members presented papers and led discussions. Virtually the entire professional staff was on duty at the Administration on Aging exhibit and in AOA's offices during the Congress to provide information and to make arrangements for visitors to observe programs and talk with key officials.

At the closing session of the Congress, Dr. Alex Comfort of the United Kingdom pleaded for major support for research which he felt could lead to marked control over the life span within 10 years. He argued that the knowledge gained might well postpone the onset of the major diseases of the later years to significantly higher ages. Dr. James Birren, of the University of Southern California, urged that parallel effort be made to improve the environment for older people in order to give quality to their lives. Dr. Birren urged greater activity in training personnel for the field, and called the establishment of university centers on aging essential to the achievement of the goals expressed during the congress.

Several special events enhanced the 5-day congress period. The U.S. Senate Special Committee on Aging held an all-day hearing at which representatives of foreign countries described many of their programs for older people. The Gerontological Society, Inc., of the United States, presented a daylong confrontation on "Social Policy Priorities: Age Vs. Youth". At an evening meeting and reception organized by the Administration on Aging, the establishment of a new International Center for Social Gerontology was announced. The center, headquartered in Paris, will promote research and training, and serve as a world clearinghouse for storage and retrieval of gerontological information.

The Eighth International Congress was cosponsored by the Gerontological Society, Inc., and the American Geriatrics Society, and was organized and conducted under the direction of Dr. Nathan W. Shock, Director of the Gerontology Research Center, NICHD. The Administration on Aging, the National Institute of Child Health and Human Development, the National Science Foundation, and the Atomic Energy Commission joined these organizations in providing financial support for the congress.

Dr. Shock was named President of the International Association of Gerontology for the 3-year period, 1969–72. It was decided to hold the Ninth Congress in Kiev in 1972, under the chairmanship of President-elect Dr. D. F. Chebotareu of the Kiev Institute of Gerontology. The 10th meeting will take place in Israel in 1975.

Interagency Cooperation

During 1969, the Administration on Aging was alert to opportunities to coordinate its efforts with activities in aging of other Federal Departments and agencies. The following are examples of such interagency cooperation:

1. AOA cooperated with the Model Cities Administration of the Department of Housing and Urban Development (discussed earlier in this report);

2. AOA cooperated with the Gerontological Society in planning and conducting a 1-day interagency workshop on research in gerontology in Washington, D.C. on December 9, 1969, to which were invited representatives of various Federal agencies involved in or interested in research in aging. Among the agencies represented at the meeting, in addition to the Administration on Aging, were the Social and Rehabilitation Service, the National Institutes of Health, the Social Security Administration, the National Science Foundation, the Atomic Energy Commission, and the Veterans' Administration;

3. AOA worked with the Office of Economic Opportunity in effecting a smooth transition in the administration of the foster grandparent program. This implemented the provisions of the Older Americans Act Amendments of 1969 which severed all authority and control of OEO over the program, vesting it completely in AOA;

4. AOA cooperated with the Department of Agriculture in efforts to improve food programs for the needy, including the elderly poor;

5. AOA jointly funded with the Department of Transportation and the Department of Housing and Urban Development respectively two research and development projects on transportation for older Americans. These were the Chicago and Fisk University projects, discussed earlier in connection with AOA's research and demonstration activities.

6. With the Social Security Administration, AOA jointly funded a "senior friends project" in Cincinnati to test the viability of the concept of older persons providing representative payee and other assistance to elderly persons in need of such services.

7. AOA and the Department of Labor jointly funded a project at Drake University to demonstrate and evaluate different methods of preretirement counseling, in which approximately 500 older workers each year will participate.

Exhibit A

Summary of Older Americans Act Amendments of 1969

The grant and contract programs of the Older Americans Act of 1965 were extended beyond their June 30, 1969, expiration date, and a modest increase in the authorizations for these programs was effected. Title III (grants for State and community programs on aging) authorizations were increased from $16 million for fiscal year 1969 to $20 million for 1970, $25 million for 1971, and $30 million for 1972 (plus $5 million in each of those years for State plan administration and $5 million in 1970 and $10 million in 1971 and 1972 for "statewide, regional, metropolitan area, or other areawide model projects.") Authorizations for title IV (research and development projects) and title V (training projects) were increased from $10 million for fiscal year 1969 to $12 million for 1970, $15 million for 1971, and $20 million for 1972.

Authorized a "national older Americans volunteer program," providing service opportunities for older Americans. As one component of this program, authorized a "retired senior volunteer program (RSVP)" to recruit individuals aged 60 or over to provide services needed in their own communities, without compensation other than for transportation, meals, and other out-of-pocket expenses incident to their services. Authorizations for these programs are $5 million for 1970, $10 million for 1971, and $15 million for 1972. As the other component of the "national older Americans volunteer program," authorized the foster grandparent program. While the Administration on Aging had previously administered a foster grandparent program with funds from the Office of Economic Opportunity, the new public law for the first time provides specific legislative authorization for the program as an ongoing program and gives direct authorization to the Administration on Aging to administer it with its own funds, thus effecting a complete transfer of the program from the Office of Economic Opportunity. Although this part of the act removed the program from OEO, it also required that new participants be "older persons of low income who are no longer in the regular work force." Authorizations for the foster grandparent program are $15 million for 1970; $20 million for 1971, and $25 million for 1972.

In addition to the two major changes described above, the act makes a number of technical amendments to improve the administration of the Older Americans Act of 1965:

(*a*) Repealed the prohibition of Federal support for title III projects beyond 3 years, and permits Federal support for certain selected projects for unlimited number of years at 50 percent for fourth and subsequent years.

(*b*) Inserted a new State plan requirement that the State plan "provide for statewide planning, coordination, and evaluation of programs and activities related to the purposes of the act, in accordance with criteria established by the Secretary after consultation with representatives of the State agencies * * *".

(*c*) Authorized appropriations for State plan administration separate from the authorization for title III project support (previously, both purposes were achieved from the same authorization and appropriation); $5 million was authorized for fiscal year 1970 and for each of the next 2 fiscal years. These funds are allotted to States and territories on the basis of a formula, with a minimum of $75,000 to each State. The Secretary is authorized to reallot any such allotment which he determines will not be required for this purpose in that State. However, his power to reallot is restricted where a State, during a portion of the fiscal year 1970 or 1971 does not have authority under State law to expend the full amount of its allotment.

(*d*) Added a new requirement that the State plan provide reasonable assurance that there will be expended for carrying out the plan for each fiscal year, from State funds other than Federal funds, not less than the amount expended for fiscal year 1969.

(*e*) The minimum allotment to each State for State plan administration was increased from $25,000 to $75,000.

(*f*) The percentage of costs of State plan administration that can be paid from Federal funds was increased from 50 to 75 percent.

(*g*) The Secretary was authorized (under a separate title III authorization) to pay up to 75 percent of the cost of the development and operation of statewide, regional, metropolitan area, or other areawide model projects for carrying out the purposes of title III. Not more than 10 percent of title III funds can be set aside for this purpose.

(*h*) Authorized the Secretary to reallot to other States any portion of a State's title III allotment which he determines that State will not need for carrying out the State plan. (Replaces the requirement that the State to which such funds are allotted notify the Secretary that they are not needed.)

(*i*) Authorized the Secretary to make contracts with (but not grants to) any agency, organization or institution (even though it is not a nonprofit organization) for research and development and training projects. Leaves in effect the rule that grants can only be made to public or nonprofit private agencies, organizations, or institutions.

Exhibit B

News Release, August 12, 1969

Robert H. Finch, Secretary of Health, Education, and Welfare, and George W. Romney, Secretary of Housing and Urban Development, today announced a joint campaign to provide older people with increased services in the model cities program and to encourage them to take a greater role in planning and developing these services.

The two Cabinet officers said the operation will be carried on jointly by the Administration on Aging of HEW and the Model Cities Administration of HUD. John B. Martin, Commissioner of the Administration on Aging and President Nixon's Special Assistant for the Aging, and Floyd H. Hyde, Assistant Secretary (for model cities and governmental relations) of Housing and Urban Development will share administrative responsibility.

Under the HEW-HUD agreement, every community participating in the model cities program will be encouraged to assure representation of the elderly on each model city board or planning body. In Washington, the Model Cities Administration program development staff will hire a special consultant to review projects for their content on aging and to assist local boards and planning bodies in involving older citizens.

AOA will urge all State agencies on aging to offer their communities technical and financial assistance for model city developments and to designate a State

agency staff member to be responsible for model city activities. In addition, AOA is directly funding research and demonstration projects in model city neighborhoods to provide information on services which can be adapted to needs in many communities. MCA will work with AOA in preparation and distribution of program models and guidance materials to community development agencies.

During August, September, and October, AOA and MCA will jointly sponsor a series of meetings in various parts of the Nation to stimulate greater involvement of older people in the program.

The model cities program is designed to demonstrate how the living environment and general welfare of people in slum and blighted neighborhoods can be substantially improved in cities of all sizes and in all parts of the country. It is intended to mobilize the resources of Federal, State, and local public and private agencies to rebuild and revitalize their neighborhoods.

Older people make up a significant percentage of the populations of many model city neighborhoods—usually out of proportion to their numbers in the general population—and generally have less opportunity to "escape" from the inner city than younger residents.

"For this reason," Commissioner Martin said in explaining the AOA-MCA agreement, "the Administration on Aging has a great stake in the program. Assistant Secretary Hyde and I have been disturbed because most model cities plans submitted to date have included very few services for older people. We want this program to fulfill its promise to older people everywhere; that is the purpose of this new campaign."

Assistant Secretary Hyde said: "I welcome with enthusiasm the support of Commissioner Martin for greater involvement of older people in the model city program. This can provide our program with a firsthand knowledge of their needs and desires. It will also offer the model cities major resources to draw upon in providing services. I urge all cities to accelerate the process of assuring equity for the elderly in the model cities program."

Exhibit C

News Release—Statement by John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging at Joint HEW-HUD Model Cities Meeting, Rutgers University, Trenton, N.J., December 10

The model cities program offers great possibilities for improving the lives of older people but only if advocates for the elderly are active in local urban planning and program operation, John B. Martin, Special Assistant to the President for Aging and U.S. Commissioner on Aging, told participants in a joint AOA-MCA-sponsored meeting at Rutgers today (December 10).

Support at the Federal level for services to and by older citizens in model city areas cannot take the place of local support and interest, Martin said. He reported that he came to his job in Washington last spring full of enthusiasm for the promise the model cities program held for a better life for thousands of older people trapped in city slums. "But," he said, "at that time it was largely only a promise. The first model cities plans submitted to Washington and reviewed by AOA had little in them for the old."

Martin said that Floyd Hyde, HUD's Assistant Secretary for Model Cities and Governmental Relations, was "as much concerned as I was at the lack of content for the elderly. We talked with Secretary Romney and Secretary Finch and on August 12 the two Secretaries announced a joint effort to increase services to older people in model cities and to open up opportunities for them to participate in planning and provision of services.

"Since that time, three earlier model cities' State meetings such as today's have been held—in Connecticut, Georgia, and Michigan bringing together representatives of the two Federal programs and State and local people involved in both aging and model cities. Some of the State and local agency people are meeting for the first time across agency lines. We find we have taken on quite a job. It is far from enough just to call attention to the needs of the elderly in the cities. We have to make certain that there is a deeply concerned advocate for older people on every layer of board and committee involved in the program or older people won't get much.

"We need three things: visibility of needs, technical assistance, and a cooperative effort at the State and community level involving the same kind of meshing of objectives and pooling of resources as now exists at the Federal level."

Martin pointed out that older people made up a high percentage of the population of many model city areas—usually out of proportion to their numbers in the general population. They have less chance of "escaping" from the inner city than do younger residents.

In some communities, the program is fulfilling hopes of local residents for help to the elderly. In Seattle, for example—one of the first four cities to receive its development grant after planning approval, the local committee on aging worked to include five programs for the elderly in its plan. These are: foster homes for older people; household aid (homemakers) and handyman services for the elderly; "portable parents", described as a foster grandparent type program of employment for people over 60 in various day care programs; establishment of drop-in senior day centers; and survey of nursing homes to discover why the elderly nonwhite population is not using them, what care is being provided, and what is needed—in preparation for providing it.

Commissioner Martin also cited a cooperative project of AOA with the Social Security Administration in the Cincinnati model city area, through which senior companions—older people themselves—serve elderly residents of high-rise apartments and nursing homes by receiving their social security checks, paying their bills, shopping for them, and providing other services under supervision of a project director.

This project, Martin said, could serve as a model for other communities to improve delivery of social security benefits to aged SSA beneficiaries unable to manage for themselves and to provide supplemental income and a role in retirement to well older people.

The Commissioner urged the State and community representatives present at the meeting to provide opportunities for low-income older people in the model city neighborhoods to supplement their "tragically low" incomes in providing services to others. "Several million older people throughout the Nation," Martin said, "have the good health and capacity for worthwhile and constructive work. They offer us a real reservoir of experience and skills as aids to professionals in social and health-related services. These are their neighborhoods and their neighbors. They understand the people and the needs.

"I testified last week on the desirability of employing older people to help provide day care for the children of working mothers—or of mothers who need and wish to work. And the idea met with a warm reception in the Congress. In the model city neighborhoods, day care is a vital service and offers opportunity to help several groups of needy people in one simple, inexpensive, and direct operation. It helps the elderly, who need work, income, and to be needed; helps the younger woman who also needs work and income and someone to care for her children; and helps the children who need care and attention. Everybody benefits. Our foster grandparent program has illustrated daily for 4 years now just how effective is the combination of the older person with love to give and the children who need it."

Martin praised the New Jersey Division on Aging (of the State's Department of Community Affairs) for its statewide program for older people and cited in particular its effective training program in basic understanding of aging for practitioners working with older people. Mrs. Eone Harger is executive director of the New Jersey State program under the Older Americans Act.

Exhibit D

Statement By The President

The White House, *October 6, 1969.*

Ever since Benjamin Franklin, at the age of 70, served on the committee which drafted the Declaration of Independence, older Americans have played a vitally important role in the life of this Nation.

Since Franklin's time the United States of America has grown in size and complexity. With that growth have come new challenges and new opportunities for the older citizens of this country. They have met these challenges and seized these opportunities with great determination and energy. At the same time, the entire Nation and its government have increasingly recognized their responsibility for helping older Americans to play active and constructive roles in our society.

This administration is fully committed to carrying out that responsibility. It was in keeping with this commitment that I recently asked the Congress to raise social security benefits by 10 percent and to provide for automatic increases

thereafter, so that payments will always keep pace with the cost of living. These measures, and other improvements which I have proposed for the social security system, will protect older Americans—so many of whom live on fixed incomes—against one of their worst enemies, the rising cost of living caused by inflation. My specific recommendations give maximum protection without further aggravating inflationary pressures. I earnestly hope that Congress will give these proposals its prompt consideration and approval.

Social security improvements are an important first step in our program for the older generation. But there are also other areas in which we must move forward. We must fully explore and carefully consider a variety of suggestions for helping the more than 19 million Americans who are now 65 and over—and the many millions more who will soon be in that category—to live healthier and more productive lives. We must find better ways for our society to tap their wisdom and talent and experience.

Much of the progress which has been made can be traced back to the last White House Conference on Aging which was called by President Eisenhower and held nearly a decade ago. Remembering that landmark conference and the valuable findings which it produced, the Congress last year authorized a new White House Conference on Aging. I enthusiastically supported such a conference in my campaign a year ago.

Today I am issuing a formal call for the second White House Conference on Aging to meet in Washington, D.C., in November in 1971. With careful advance planning and with broad, representative participation, this Conference can help develop a more adequate national policy for older Americans. I hope that it will fully consider the many factors which have a special influence on the lives of the aging and that it will address precise recommendations, not only to the Federal Government, but also to government at other levels and to the private and voluntary sectors as well. The Conference will be directed by John B. Martin, Commissioner on Aging and Special Assistant to the President on Aging.

Members of the older generation have given much to their country. Through the White House Conference on Aging, a grateful nation can recognize these contributions. More than that, the Conference can move this Nation toward the goal of making old age a time of contribution and satisfaction.

Exhibit E

STATEMENT OF JOHN B. MARTIN, U.S. COMMISSIONER ON AGING AND SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING ON THE OCCASION OF THE CALLING OF THE WHITE HOUSE CONFERENCE ON AGING

President Nixon's call today for a White House Conference on Aging in November 1971 gives this country an opportunity to develop a long overdue national policy on aging.

This conference, the second in our history, will build upon the results of the first, held in January 1961 at the call of President Eisenhower. In the years between, this country has moved well forward in serving its older people. Medicare, medicaid, and the Administration on Aging itself, which I head, grew out of that earlier conference. The President has recently taken major steps with respect to social security benefits and the creation of a $90 Federal floor under the aging. There are now State agencies on aging in almost every State, and new programs and opportunities for the elderly in thousands of local communities. And so we start preparations for the conference from an advanced position.

State and regional surveys, hearings, and conferences will precede the national conference. Older people themselves will be represented in the meetings at all levels, as will the providers of service, professionals in the field of aging, and national organizations and churches of the Nation.

There are still great problems to meet on behalf of older people—income, health, housing, employment, and retirement roles and activities. The major and overriding problem, I believe, is that as a people we have still not developed a real philosophy of aging.

The President, in calling the conference, gives us a magnificent opportunity to make a commitment to our older Americans as first-class citizens fully participating in our national life. This will assure a firm place for older people in the administration's broad and continuing development of national goals.

It will be most satisfying and stimulating to have a part in this conference. I am very grateful to the President for the opportunity.

Exhibit F

Materials Relating to Addresses of Commissioner Martin During 1969

Statement by John B. Martin, U.S. Commissioner on Aging, to The National Council of Senior Citizens—June 6, 1969

In the field of aging, The National Council of Senior Citizens is an "activist" group (in the best sense of the word, as Webster says, "devoted to a cause, movement or principle").

Perhaps "crusading" is the proper adjective but that has an old and historic sound about it. And I think of the National Council, for all its history of achievement, as totally contemporary.

You are interested in senior power—in visibility—in action—inclusion—involvement.

And so are we in AOA.

There are some things we can do as a Federal agency which you cannot outside of Government.

There are many things you can do as a strong, voluntary, nongovernment national organization, that we can't.

Between us then, there should be much we can accomplish for older people, if we pool our abilities and opportunities.

And, as should be obvious but isn't always, whatever affirmative is accomplished for the good of today's 20 million older people will have meaning in time for every American. The very quality of life expectancy in this country is involved in our program—yours and mine.

I would like to enlist your help today then in a modern crusade—involving the place of older people in the model cities program.

The model cities program is designed to demonstrate how the living environment and general welfare of people living in slum and blighted neighborhoods can be substantially improved in cities of all sizes and in all parts of the country. It is intended to mobilize the resources of Federal, State, and local public and private agencies to rebuild and revitalize these neighborhoods.

The Federal Government pays 80 percent of the cost of planning and 80 percent of developing the city programs if approved after planning. Approved programs will also be eligible to receive supplemental grant funds from grant programs administered by a number of Federal agencies, including the Administration on Aging.

Already 150 cities have had their model cities planning grants approved and yet in the plans we have seen there is not very much included for older people. We want to change that.

The idea and inspiration behind this great program is to go at the job with every tool possible—everybody working together—to make what have been some of the most disadvantaged areas in the United States into models of what a community could be to its citizens—to develop cities for man.

Because older people make up a high percentage of the population of many of these areas—usually out of proportion to their numbers in the general population—and have far less chance of escaping from the inner city than younger residents, we have a great stake in the effort.

In some communities, the program is fulfilling hopes of local residents for its promise to the elderly. In Seattle, for example—one of the first four cities to receive its development grant (after planning approval) the local committee on aging worked to include five programs for the elderly in its plan. These are: foster homes for older people; household aid (homemakers) and handyman services for the elderly; "portable parents," described as a foster grandparent type program of employment for people over 60 in various day care programs; establishment of drop-in senior day centers; and surveys of nursing homes to discover why the elderly nonwhite population is not using them, what care is being provided, and what is needed—in preparation for providing it.

In some other communities, frustration is the mood—plans have evolved with no input, no plans for older people, no awareness of their needs or possibilities.

We want this program to fulfill its promise everywhere to older people in each and every single one of the model cities. We need your help. I will be inviting the officers of leading national organizations in the field of aging, including your organization, of course, to meet with me in the Administration on Aging at an early date to discuss in detail just how we can best pool our resources to see that the needs and wishes of older people are included in model cities planning, development, and provision of services.

Your people are the very grass roots we so often hear talked about. These developments are happening where many of them live. They are entitled to be heard in the model cities planning process. Your organization can and should take a major responsibility in seeing that their voices are heard. And if nothing happens, you, along with us, will have to bear some of the burden of not having encouraged them to participate and supported their efforts.

For I am convinced that though there may be many kinds of power, there is nothing more potent than aroused senior power. It is the power to protest legally and legitimately, to petition, and to speak up on behalf of the needs of 20 million Americans—8 million of whom are poor, whose housing is the worst, whose health is the poorest, whose education is often the least, and whose options are the most limited. I hope you will use this challenging opportunity to help to bring these older people into the mainstream.

Social Gerontology's Research Findings and Their Use for Social Policy in Aging: Some Perspectives, Problems, and Prospects*

As the head of an agency that has the administration of a research and development grants program as one of its responsibilities, I am something of a middleman between researchers and social action planners and administrators. While all of the AOA's offices are heavily involved in national policy formulation, my research and development staff has the added responsibility of taking the lead in implementing promising research and experimentation in social gerontology. Our statutory charge to generate information and techniques that can provide a scientific basis for planned programs of intervention for older people naturally involves me in the issues before this panel.

I begin with an assertion that may be apparent to many:

The use of social research findings in formulating social policy is today more an ideal or goal that may motivate professional behavior, give substance to aspirations, or be used to justify research and development efforts, than it is in reality a normal operating procedure, a widely accepted practice, or even a readily comprehensible enterprise. Why is this so?

The social consciousness of researchers in social gerontology can scarcely be debated. Perhaps more than any other group of social scientists, social gerontologists are extremely aware, and quick to point out, that their work has implications for social policy and program planning. Our research proposals and journal articles are replete with well-intended statements and allusions to the significance of research for improving the societal and personal circumstances of the Nation's aged. Yet, I observe that for the most part these statements reflect unrealized ambitions, ambitions that are currently impeded or diluted by a host of problems. Some of the latter are inherent in the nature of our work and the relative youth of our discipline. Others are generated from without.

Thus there are two basic sources of such problems which determine their nature in turn.

The research enterprise itself is one source of problems. That is, the state of scientific knowledge and the nature of findings in social gerontology figure as a source of problems. A second source are certain cultural phenomena. These include professional traditions and attitudes, institutional arrangements, and audience orientations. Problems arising from the latter challenge us to communicate with a variety of audiences, to implement "research utilization" activities, and to clarify roles in policy formulation.

In the remainder of my discussion of the use of research findings in formulating social policy relative to human aging, I ask you to review with me first some problems related to the research enterprise itself, then some problems with cultural roots, and finally to consider some ways to overcome or ameliorate such problems.

RESEARCH ENTERPRISE PROBLEMS

Credibility

Credibility is one of the problems that arises out of the research enterprise in social gerontology. As Riley and Foner point out in their recent and comprehensive inventory or research findings in aging:

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* Address delivered by John B. Martin, Commissioner on Aging, Administration on Aging, U.S. Department of Health, Education, and Welfare, at the 8th International Congress of Gerontology, Sheraton-Park Hotel: Washington, D.C., August 25, 1969.

" * * * a degree of scientific skepticism is necessary in using [specific social science findings on human beings in their middle and later years]. * * * the widely used [longitudinal and cross-sectional research approaches] each deal only with selected components of aging * * * a fuller analysis of the underlying processes requires various elaborations of these basic approaches * * * which though occasionally applied with provocative results, are not yet widely developed or used.[1]

Stated another way, the reliability and validity of findings in social gerontology often may be called into question; the findings often do not have sufficient scientific respectability. This makes for the problem of credibility.

Substantive relevance

Added to this is the problem of relevance. There are only very limited bodies of data having relevance for policy in most substantive areas. It is thus necessary to ask: Are the investigations pursued in the universities, under Federal grant programs, and elsewhere, relevant not only to the development of the scientific discipline but also to current policy needs? Can there be a real meeting ground between the two? How is their convergence to be assured? To what extent are social gerontologists truly committed to undertaking research with potential for assisting policy formulation? Where should responsibility for defining policy-relevant research areas be lodged?

These are difficult questions and worthy of a separate discussion. Very simply however, I venture that there has been and can be a meeting ground between theoretical and practical interests, that many in our field are committed to such enterprises, and that both research sponsors and individual researchers have certain responsibilities for seeing that policy-relevant research is undertaken and its results utilized.

But to assure this, a number of things are needed. One is responsible leadership, that is, an organization or groups of individuals able to conceptualize policy-relevant research needs. We also need mechanisms for communicating the needs. Third, financial and moral support for the latter, as well as for the actual research is required. Finally, we need audiences willing and able to receive, react to, and act upon results. I shall touch upon some of these needs later in my discussion. For the moment, let me give examples of some already conceptualized substantive gaps from whose closing both theory and policy could benefit. We need:

—Further specified knowledge of the impact of migration on the communities older people leave and enter and on the migrants themselves.[2]

—Extensive refinement of existing findings on class-associated changes in role opportunities both before and after retirement.

—An accumulation of data on the relationship of physical mobility to life styles and time perceptions among subgroups of older persons, especially aged minority group populations.

—Additional data on the role of the social and physical environment in mediating class-associated differences in older people's social participation in urban and rural settings.

Communication of relevant findings

Another problem is that substantively relevant findings remain meaningless communicated intelligibly to those who influence or make social policy. This problem is generally thought to be that of scientists using an esoteric vocabulary beyond the comprehension of particular audiences or of inadequate dissemination of research findings. Although these claims probably have some validity, the problem of communication has some other, more significant, dimensions.

It is not enough to declare that a particular set of findings are objective and relevant because they have been generated via scientific processes. Communicating findings in ways that make them appear relevant entails more than a "translation" from the language of science to the idiom of the layman. It requires laying a groundwork, the creation of a climate in which an audience is made receptive to recognizing data as potentially helpful for assisting with policy formulation. Thus this communication problem also involves a range of organizational and other techniques for preparing audiences to accept the merchandise the scientist can deliver.

[1] Mathilda White Riley and Anne Foner, "Aging and Society: An Inventory of Research Findings." New York: Russell Sage, 1968, preface.

[2] Eugene A. Friedmann, "The Impact of Aging on the Social Structure," in Clark Tibbitts (ed.) *Handbook of Social Gerontology*. Chicago: University of Chicago, 1960. pp. 120–144.

A conclusion

In personally reflecting on the foregoing, I am forced to conclude that scientists may be as guilty of fostering under-utilization of research as of using its results prematurely. Too often, their appreciation of the difference between findings and facts may lead them to shy away from using tentative or interim data as a basis for policy recommendations relating to vast expenditures of scarce resources and affecting millions of older people. The scientist may not stand alone; perhaps "conscience is making cowards of us all."

Certainly, not all action need await the results of definitive research. Admittedly, it is more comfortable to utilize research findings as a basis for evaluating the merits of extant social policies than for formulating new ones.

So much for problems I attribute largely to the nature of the research enterprise. A second series of problems are those arising out of professional traditions and attitudes, institutional arrangements, and the cultural climate in the larger society.

CULTURAL PHENOMENA LEADING TO RESEARCH UTILIZATION PROBLEMS

Role confusion

First, but not necessarily in order of priority, is confusion regarding roles. Here's an illustrative anecdote.

Some weeks ago, a young anthropologist who had recently published a book offering a new interpretation of man's group behavior [3] was interviewed on a network television show. During the interview the reporter asked him to comment on the significance of his findings for our current war policies. Curtly, the young man responded, "Please, I'm a scientist, not a propagandist." Ironically enough, about a week afterward, a feature news article coauthored by this self-same anthropologist [4] proposed rules for the declaration of war. The rules were based on the young man's theories of group behavior.

Who is responsible for spelling out the implications of research results? Is the researcher's identity such that it prevents all but a very few from taking interest in a courtship of information and action? [5] Is interpretation of results the responsibility of the agency supporting the research; of interested journalists or congressional staff, any of whom may have a specific point to make? I propose that each has a greater responsibility than each has accepted so far.

Lack of responsible research utilization organizations and groups

Another problem is that our field lacks sufficient identifiable groups that have charters to interpret research findings for the variety of policymakers and those who influence them—the general public, practitioners in aging, government personnel, special interest groups. In aging, there are no centers for research on utilization of scientific knowledge such as that currently operating at the Institute of Social Research, University of Michigan, under a Kellogg Foundation grant. Social gerontology may need such centers. If we had them:

(*a*) Agencies aware of their troubles and needs would have somewhere to turn in order to retrieve relevant knowledge and receive help in applying it to solutions of their problems;

(*b*) Policy-relevant areas of knowledge in aging could be summarized and interpreted to answer needs of specific consumer groups;

(*c*) "Perceptions of relevance" would be fostered in consumer groups, including legislators and government officials as well as well as practitioners.[6]

Any dearth of activity in taking this general route to the utilization of research findings reflects the fact that we also lack the resources necessary for building and maintaining it. It is obvious that elaborating the policy implications of research findings requires more than publishing papers, mechanical dissemination of research materials, and operating information retrieval systems. While these are invaluable, they alone are certainly not enough. An efficient delivery system for aging will also require still more research and demonstruation, personnel possessed of that breadth of background necessary for grasping the relationships between findings and policy issues, and rearrangements or changes in tenacious values, attitudes, and structures.

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[3] Lionel Tiger, "Men in Groups." New York: Random House, 1969.

[4] Robin Fox and Lionel Tiger, "Man's Past as Hunter Haunts Him Yet," Washington Post, July 6, 1969. pp. B1, B5.

[5] In this connection, I am heartened by what promises to be a milestone in the history of our discipline. This is the imminent publication of Riley and Foner's second volume, "Aging and The Professions," which will discuss the implications of research findings for practititoners.

[6] These points are paraphrased from a memo from B. W. Griffis, SRS Research Utilization Branch, to G. A. Engstrom, Chief, SRS Research Utilization Branch, dated Dec. 7, 1968.

Audience attitudes

This brings us to another problem, consumer audience attitudes.

Without claiming a uniform cultural aversion to the subject of aging and older people, it may be observed that there is general antipathy to discussing loneliness, poverty, infirmity, squalor and the imminence of death. Yet these are some of the major phenomena for research in this field. Thus, acquisition of a good press for aging may be one of the greatest challenges to use of social gerontology's findings in framing social policy.

To date, we at the Federal level have met with some success in influencing policy formulation with project findings. However, it is my impression that most acceptance of findings has not been due to a good press or widespread interest in aging but, rather, to the fact that certain studies of older people produce results significant in other contexts already commanding wide interest. For example: AOA-supported studies indicating that older drivers do not constitute a high traffic accident risk (when compared to other age groups), are leading insurance companies to consider reductions in their auto insurance premiums for older people and States to enact statutes to assure more equitable insurance practices.[7]

While the world in general may not be particularly interested in how and why older people leave their homes, transit companies and local governments are exceedingly interested in a reduced fare program's impact on their revenues. Thus they eagerly await the results of the AOA's two current reduced elderly transit fare studies in Chicago and New York City.[8] These may be able to answer their question, "Is transportation for older people a 'business' or a 'welfare' proposition?"

Consequently, the "press" for aging becomes better as findings move closer to issues with immediate relevance for social policy. A byproduct of this is that we also contribute to public awareness of older people's problems, problems that might be ignored or denied if presented in a purely descriptive manner.

SOME SUGGESTIONS FOR REMEDIATION

The foregoing examples were not selected randomly. I hope that they served purposes of illustration and have injected a note of optimism into the discussion. But such activities are to be regarded only as a first step. Next, attention must turn to those that can further assist the utilization of the data that is accumulating.

Consequently, I conclude by attempting to answer the question: "What steps should be taken to increase use of research findings wherever there is responsibility for decisionmaking with respect to older people and social conditions affecting them?"

1. First, I hardly need mention that there is need to continue the accumulation of adequately verified findings and thus to grow increasingly more confident about them.

2. Second, more extensive contact between researchers and policymakers would further enhance the creation of a climate conducive to research dissemination and utilization. This could be accomplished through systematic seminar or workshop sessions at which researchers present and discuss findings with relevant policymakers and at which the latter could communicate their concerns. Another means of promoting contact between the research and policy communities is to increase the participation of researchers on policymaking boards and committees and to include policymakers on boards of research organizations.

3. As I suggested earlier, we need to create centers for the utilization of scientific knowledge about aging. I envision these centers staffed with individuals trained in the basics of research and willing to act as community and organizational consultants. They would interpret the significance of research data in the context of specific community and organizational problems in language appropriate to their clients.

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[7] These studies are being undertaken by Judge Sherman G. Finesilver of the University of Denver College of Law under Grant No. AA-4-67-007. On May 2, 1969, the Wall Street Journal printed an article, "Auto Insurance May Decline 5 percent for the Elderly" indicating that the insurance rating board has proposed rate structure changes to be effective as of Jan. 1, 1970. The 38 States that apply the Board's classification plans are reported to be considering approval of these changes. Judge Finesilver claims that the board's action may be a direct result of his research activities.

[8] Grant to the Division for Senior Citizens, Department of Human Resources, city of Chicago. The research component of this grant, "effects of reduced mass transit fare program on the elderly and transit system," has been subcontracted to the Illinois Institute of Technology. The second of these studies is being conducted by the Brooklyn Polytechnic Institute and the Research Foundation of the City University of New York under subcontract arrangements with the New York City Office for the Aging, a grantee of the AOA's research and development program.

These centers also should have journalistic and public relations capability, perhaps staffs of analysts whose duties would entail the interpretation of research findings in aging in the context of timely public issues. In this connection, I can't help but be reminded of two very fine magazines that serve as "public relevance" arms for the disciplines of sociology and psychology. I am referring to "Transaction" and to "Psychology Today". Perhaps the proposed centers could publish such a magazine for the educated layman so as to further assist social gerontology to its place under the sun. Finally, perhaps they could also establish information retrieval systems oriented to the needs of the policymaking layman rather than the scientific community alone.[9]

4. Moving from the general to the specific, I further suggest the necessity for increased activity in, and funding of, "research utilization demonstration projects." These would be projects to experiment with more effective ways to relate research findings to specific community problems and for the framing of policies in regard to them.

5. I suggest the creation of positions for "research utilization specialists (in aging)" in central and regional Federal offices and in State and local units on aging.

6. These last three suggestions for the creation of cadres of middlemen naturally raise questions regarding the wherewithal for implementing them. As far as personnel are concerned, research utilization skills need to be built into training programs in social gerontology and other graduate programs in the social sciences. This may require new or reorganized curriculums and new faculty attitudes and interests. Students must be trained not to say, "I am a scientist, not a propogandist." They must be trained to recognize the legitimacy and importance of interpreting and applying research findings.

Finally, the larger society needs to reinforce such a perception by rewarding efforts to use empirical knowledge in formulating policy, by allowing policy-relevant experimentation, and by supplying the wherewithal to fund the research from which the needed body of knowledge can come.

AGING—TOMORROW.—STATEMENT OF JOHN B. MARTIN, U.S. COMMISSIONER ON AGING, FLORIDA GOVERNOR'S CONFERENCE ON AGING: TAMPA, FLA., SEPTEMBER 25, 1969

The number one problem for older people in America is income—low income, John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told the Florida Governor's Conference on Aging here today.

Forty percent of those persons over 65 can be classified as poor or near poor, Martin said. The Bureau of Labor Statistics' retired couples budget is less adequately covered by social security benefits today than in 1950. In that year the average social security benefit covered one-half of the BLS budget, Martin said. Today it covers less than one-third of that budget.

The fact is, Martin said, that over the next 15 years on all projections we can make, the economic position of our older people will grow worse rather than better. Our older people will be at a growing disadvantage in the market place since annual earnings growth for the working population is steady but fixed incomes are the rule for older people.

Our older people suffer a drop of from one-half to two-thirds of their working income when they retire, and if they continue to work their earnings decrease rather sharply as age increases. Assets generally drop or are exhausted.

The home, which they own, becomes a burden because of taxes and the cost of upkeep. Medical needs rise sharply and medicare covers only 35 percent of medical costs. Finally inflation erodes their limited buying power. Even a 2-percent annual inflationary rise cuts buying power by 18 percent in 10 years.

These are the hard facts of life for America's older citizens and they pose some very tough policy problems for the future. Clearly our older people should be entitled to share in our generally increasing standard of living and should not be forced to live on the brink of economic disaster. President Nixon expressed his concern when he stated: "It is simply unacceptable in America that a large segment of older Americans have income below the poverty line. It is unacceptable that the aged should be the one group in the country where poverty is increasing today. I can promise you that the Nixon administration will change this picture,

[9] The information retrieval system for aging recently instituted by the NICHD at the National Institutes of Health, Bethesda, Md., will fill a significant gap but is oriented primarily to the scientific community.

that we will give priority attention to the problems of poverty among the aging, and that we will do everything we can to generate solutions which are thoughtful, workable, and effective."

The President has also taken a major step forward by requesting Congress to fix a Federal financial floor beneath our older people. A task force has been announced to help the President develop a legislative program for 1970 and beyond. This task force will address itself to the most critical problems which we face in the immediate future. The administration is determined to face the facts and come up with workable and effective answers.

Statement of John B. Martin, U.S. Commissioner on Aging and Special Assistant to the President for the Aging, at the American Public Welfare Seminar, Chicago, Ill., September 30

Several million unemployed older Americans have the good health and the capacity for worthwhile and constructive work, John B. Martin, U.S. Commissioner on Aging, told the American Public Welfare Association here tonight at a national conference called to consider the use of older people as subprofessionals.

"It is an unconscionable waste of our finest resources to deny the opportunity to serve to those wanting to do so," Martin said. "We know from projects we have undertaken in the last few years that satisfaction and enjoyment in the later years does not come simply from having 'something to do.' We have a work-oriented society. Constructive contribution to the society's needs is a measure of worth in the minds of most of its members. This feeling is not lost merely because people reach age 65.

"It is time we destroyed the myth that the older worker will somehow be a burden rather than an asset. On the contrary, the evidence is clear that the older worker is often more reliable, less often absent, more responsible in his job attitudes, and often more careful and precise in carrying out work assignments.

"We should be looking for new ways in which the older worker can perform. Because maximum satisfaction comes from work connected with compensation in some form, volunteer activity does not always provide a full answer for many older people.

"Our experience with foster grandparents caring for children in institutional settings has been fantastically good—good for the children and good for the older people serving in the program. Teacher aides in one of our projects in Dade County, Fla., have been such unqualified successes that other Florida schools are now interested in similar programs. The use of senior aides for person-to-person service of various kinds has proven most successful, and the green thumb program has shown what wonders in roadside beautification and park development can be brought about by older rural workers.

"Now the President has suggested that Congress adopt a national day care program. Older people can and should qualify to provide service of a high order in this program.

"There is just no excuse in a culture which values work ability and which needs talent to fail to use the talents of our older population to the fullest possible extent."

Statement by John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging,[1] October 23, 1969

"It is time that longer life is made worth living," John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told delegates to the Seventh Biennial Minnesota Governor's Conference on Aging meeting here tonight.

"American science has extended life expectancy by some 20 years in this century," Martin said, "but American genius and the American system have not yet made the older American a first-class citizen—nor used his skills and experience to national advantage.

"Millions of older people today live the barest, most degrading kinds of existence on funds wholly insufficient to permit life to go forward in decency and with dignity. The time is ripe for a national decision as to whether our older people

[1] Seventh Biennial Governor's Conference on Aging. Minneapolis, Minn., Oct. 23, 1969, Pick-Nicollet Hotel.

are to continue to be regarded as objects of charity or as first-class American citizens.

"President Nixon has already taken important corrective steps. He has recommended an increase in social security benefits, an automatic cost-of-living increase formula, a Federal financial floor of $90 for the needy older person in every State, and a prohibition of liens in connection with public assistance payments. Unfortunately, income is far from the only problem confronted by this country's older people.

"Instead of being rewarded for contributions they made in their working years toward building the tremendous productive capacity of the Nation, older Americans are, in fact, too often regarded as nuisances to be tolerated, as charity patients. They are expected to be content with such half measures as discounts, tax concessions, reduced bus fares, and charity from their children or voluntary agencies. They watch while the special needs of other segments of the population are rightfully understood and then met, but their special needs for mobility, for increased socialization, for the sense of worth that comes from productive activity, go unheeded. They ask, in truth, for little—independence, the opportunity to have options between which to choose, social services support where necessary, public transportation tailored to their needs, and social outlets. In short, they only ask for the chance to live like self-respecting human beings. Faced with this reasonable request, America has not yet given her considered answer.

"Now, we have been given a deadline. The President has called a White House Conference on Aging to meet in November 1971. In the years before that meeting we have the opportunity to develop—in the States, local communities and Federal Government—a national policy on aging. These years give us the chance to begin where we should in our planning and discussions, at the grassroots, in the home communities where the needs are and the solutions must be provided.

"There are thousands of older people who cannot wait for such a long-range program; they must have help now. So my office must be concerned with immediate help. But in order that this kind of crash survival program does not repeat itself with each generation of older people, we must establish clear and specific long- and short-range goals and a program for reaching those goals. We need to look to the future in order to have a future worth having when we reach it.

"A true national policy on aging involves four major considerations:

"1. A new role and status for older Americans and the creation of those conditions which will allow such roles to come into being.

"2. Proper definition of responsibilities between public and private sectors and between the layers of Government.

"3. Carefully stated long and short range goals and plans for achieving such goals in steps which reflect responsible estimates of available resources, and,

"4. The inclusion in the development of any national initiatives—in income maintenance, transportation, housing, nutrition, health, employment or education—of explicit knowledge and concern for the needs of older people."

The development of such a policy, Martin said, is a major aim of the Nixon administration "for without a formulated policy of this nature all efforts are bound to be fragmented and taken without adequate understanding of the impact that such efforts may have on our older citizens. A policy of this kind can offer far greater rewards for the elderly than mere establishment of isolated new programs."

Among major questions to be explored in preparation for the 1971 conference, Commissioner Martin included the possibility of using senior centers as primary "vehicles" for delivering a full range of services to older people, giving centers a role in the life of older people comparable to that of the public school in the life of children. Some 20 senior center programs in Minnesota are being supported now under the State's Older Americans Act program. Outstanding services have been made available through centers and senior clubs in rural areas.

The question of a national meals program for older people comparable to child nutrition programs, and discussions of feasible means of delivering preretirement counseling to all middle-aged Americans who wish to avail themselves of it, are also to be considered. Some Minnesota companies have been pioneering in the retirement counseling field.

Martin praised Minnesota's programs for its older people, particularly the State's unique educational television network for the elderly serving the entire State.

STATEMENT OF JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING,* OCTOBER 24, 1969

"It is time for Americans to stake their claim to the kind of individual future they want for themselves," John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told delegates to the Montana Governor's Conference on Aging meeting here today.

"For far too long," Martin said, "older Americans have been regarded as nuisances to be tolerated, as—in fact—charity patients. Millions of older people today live the barest, most degrading kinds of existence of funds wholly insufficient to permit life to go forward in decency and with dignity.

"President Nixon has already taken important corrective steps. He has recommended an increase in social security benefits, an automatic cost of living increase formula, a Federal financial floor of $90 for needy elderly persons in every State, and a prohibition of liens in connection with assistance payments. Unfortunately income is far from the only problem confronted by this country's older people.

"Instead of being rewarded for contributions they made in their working years toward building the tremendous productive capacity of the Nation, older Americans have been expected to be content with half measures—discounts, tax concessions, reduced bus fares and charity from their children or voluntary agencies. They have watched as the special needs of other segments of the population are rightfully understood and met, while their own special needs for mobility, for increased socialization, for the sense of worth that comes from productive activity, go unheeded.

"They ask, in truth, for little—independence, the opportunity to have options between which to choose, social services support where necessary, public transportation tailored to their needs, and social outlets. In short, they only ask for the chance to live like self-respecting human beings. Faced with this reasonable request, America has not yet given her considered answer.

"Now, however, a White House Conference on Aging has been called for 1971 and has set us a deadline for a decision by America as to the kind of life it really wants for its citizens in their later years and the use it will finally make of their vast reservoir of talents. The time is long overdue for development of a national policy on aging, a recognition and acknowledgement of debts owed and a national commitment to pay them.

"There are, of course, thousands of older people who cannot wait for a long-range program—for 2 years—they must have help now. So my office and the administration must be concerned with immediate help. But in order that this kind of crash survival program does not repeat itself with each generation of older people, we must establish clear and specific long and short-range goals and a program for reaching them. We need to look to the future in order to have a future worth having when we reach it.

"The 2 years before the Conference will give us time to draw upon all possible resources, so that this national policy will grow out of the grass roots; so that the answers to the hard questions will come from the home communities where the problems are and the solutions must be provided.

"A true national policy on aging involves four major considerations:

"1. A new role and status for older Americans and the creation of those conditions which will allow such roles to come into being.

"2. Proper definition of responsibilities between public and private sectors and between the layers of Government.

"3. Carefully stated long- and short-range goals and plans for achieving such goals in steps which reflect responsible estimates of available resources, and

"4. The inclusion in the development of any national initiative—in income maintenance, transportation, housing, nutrition, health, employment, or education, of explicit knowledge and concern for the needs of older people."

The development of such a policy, Martin said, is a major aim of the Nixon administration "for without a formulated policy of this nature all efforts are bound to be fragmented and taken without adequate understanding of the impact such efforts may have on our older citizens."

Martin said one of the major questions in the development of new roles and status for older people is how best to continue to use their experience and skills in volunteer and public service employment. He particularly praised Montana's Older Americans program for imaginative and effective use of active older people

* Montana Governor's Conference on Aging—Great Falls, Mont., Oct. 24, 1969, Rainbow Hotel.

in volunteer service to the less fortunate elderly in mental hospitals and nursing homes.

He said he looked to Montana for help in the discussion of possible development of a national nutrition program for the elderly. One of the Administration on Aging's 28 major experimental nutrition programs for older people is being operated in Helena by the Rocky Mountain Development Council. Another issue of particular importance in a State of great distances and rural areas is the development of transportation for older people.

REMARKS OF JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING, TO THE NATIONAL COUNCIL ON THE AGING,* OCTOBER 29

I hope you have been deciding in these few days here that there is nothing sacred about the status quo. The first order on any realistic agenda for action is a refusal to be bound by what is, if what is doesn't work. This implies an equally strong realization that any new way must also be workable, pertinent, relevant.

Represented in this room are most of the major organizations in the field of aging and much of the individual intelligence, experience, and commitment in this area. I am honored to speak with you today and sorry that I have not been able to be with you for your workshops and general sessions before now. What I want to talk about is the future of aging as a process and as a program.

Each of you I am sure has in his or her mind an agenda for action for aging—or the makings of such an agenda. Nineteen years ago there was a first Federal Conference on aging and some of you had an agenda in mind then. In 1961 you participated in major deliberations at the White House level. Two years from now, we will have a second White House Conference on Aging and some of those two original agenda of two decades ago are still pertinent—still need action. The President has asked me to take responsibility for the direction of that Conference. I am determined that it will not be just another conference of professionals and older peoples worrying about older people. It must instead concern itself with all people growing older. It should be and I believe it can be a landmark conference aimed at changing national attitudes toward the later years of life.

We have not known as a Nation and we do not know today how we want to treat our aging population—those who have retired but also those who are in the latter portion of their working years.

The 1961 White House Conference moved us in great steps forward but in fragmented ways. Now we have social security and medicare and medicaid. These are not inconsiderable accomplishments. But we have still a fragmented national program which makes of our older citizens fragmented people. Now we need to bring the pieces together. Until we provide a whole program, a coordinated and shared and mutual program, a national policy, we cannot serve whole people.

In moving forward I would like to see more scope and reach; more imagination; and a new theme. I am tired of "aging". I am concerned—and I know all of you are concerned with living—at every age.

Young people are not the only age group disenchanted today with their world. Most older people certainly can't like the condition of their lives today. They are all too often barred from the world they made—by lack of money—by lack of place—by lack of welcome and opportunity—by the attitudes of those around them who dominate and control their lives.

Something hasn't worked—somethings aren't working.

We have a patchwork of special programs for older people, put together in answer to specific problems or a special emphasis in little pockets of general programs. This patchwork is pulling apart at the seams. We need to look for new approaches.

A true national policy on aging must involve four major considerations:

1. A new role and status for older Americans and the creation of conditions which will allow such roles to come into being.
2. Proper definition of responsibilities between public and private sectors and between the layers of Government.
3. Carefully stated long- and short-range goals, and plans for achieving these goals in steps which reflect responsible estimates of available resources, and

*The National Council on the Aging Conference of National Organizations, Statler Hilton, Washington, D.C., Oct. 29, 1969.

4. The inclusion in the development of any overall national initiatives—in income maintenance, transportation, housing, nutrition, health, employment or education—of explicit knowledge and concern for the needs of older people.

The development of such a policy is even more vital to older people than the development of new programs. Without such a policy, older people will continue to be thought of as a problem group. With such a policy, society acknowledges its responsibility for including its elderly in the expanding life of America.

In reaching such a policy—we must refuse to be diverted by strawmen such as the alleged "competition" between service to the young and the old. This country can afford to do its best for both. I am convinced that we need only the will to do better than we are doing. I am convinced that we have the resources with any reasonable ordering of our priorities. But it is essential that we have the attention of those—young and old—who have responsibility for fixing those priorities, and it is a part of your responsibility to help make sure that we do have that attention.

The future envisioned for a child should encompass all the years of his life. His later years must be made worth living too. The infectious diseases we have controlled for our children are the ones that added the later years; the education we devise for them today is to grace them in maturity. These are not real successes then if those later years and that maturity, when reached, are sterile and wasted.

We must refuse to be hindered by division because of jurisdictions. I am not interested in territorial rights but in total, coherent, related services, and opportunities delivered. I have said frequently to my staff, "I am not interested in who performs these services but only in having them performed at the most effective way possible."

If we want to reach a national policy and program for the aging, the help of the national voluntary agencies is absolutely essential. I would hope that the design and delivery of services to fit the convenience of the client would outweigh any question of individual agency prerogative. One of our troubles in government and in our private agencies—and I have worked closely in and with both—is the level of concern over who has what piece of the action rather than how productive that action is.

We need the strengths of each organization in the field and we need them shared. The point of all programs in aging should be life complete—life worth living.

We face obstacles but there is tremendous talent here. And some of these obstacles we make ourselves. Those should be the easiest to overcome.

I would propose to you today that we question the present, not just how we can extend or even improve it, but how good is it and if it's not good enough how can it be reconstructed or recreated. We need not be afraid of an entirely new pattern—retaining within it the best of the past—what works and is still relevant and getting rid of what is obsolete and outworn—based on myth or mistaken judgment. Obviously we must do something drastic about income, about health, delivery of services, housing, nutrition, transportation, preretirement, and advocacy. We do not have to accept the prescriptions of yesterday or today, because we are dealing with tomorrow.

I realize I am posing questions not answers. Yet in a way, taken together, they do provide an answer of sorts. That answer—that agenda is:

Resolve to help us decide upon the framework of a national policy.

In the time before the White House Conference, work in your local communities and States to draw together the best thinking—and the hard realistic estimates of needs, possibilities, and means. Draft firm recommendations—legislatively and operationally feasible—for partnership activities starting at the local level, with the individual older person, moving up through communities to State house and Federal Government. Then at the national level we can know what you see the need to be.

The White House Conference gives us a deadline for action—it gives us a focus for the pooling of all talents, ideas, and capacities. It will give us a national basis for decisions and developments.

The date, as you know, is November 1971.

The Advisory Committee of 28 is in process of consideration—suggestions are welcome.

The major theme is toward a national policy on aging.

Major subject areas will include among others—income, health, housing, retirement roles, and activities.

Funding: There is, as you know, no appropriation specifically for the White House Conference in the present fiscal year 1970 budget. However, we plan to reprogram $250,000 of our AOA funds to assist States with their preliminary

planning this year. The balance of $1,900,000 authorized will be asked for in the 1971 budget and will be available in time for use in part to assist States to hold meetings, workshops, surveys in the spring of 1971 so that they will have recommendations ready to present for action at the Conference in November.

Final report—the recommendations of the conference are to be ready for publication and presentation to the President and the Congress within 4 months after the conference—March 1972. It should not be the 600 to 800 "recommendations" which came out of the 1961 conference. Recommendations coming in from the States and organizations to the conference will need to be concentrated on matters of major concern and assigned appropriate priorities. Then the final report, drawing upon this great preliminary work and the intensive conference period, can give us our national policy for aging or I could call it "a national policy for later living."

Needless to say we will need your help and support for a worthwhile result. I solicit that help and support and I am satisfied you will respond in the future as you have in the past.

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING, AND U.S. COMMISSIONER ON AGING,* NOVEMBER 19

Homes for the Aged view their responsibilities to the older people of their communities much too narrowly, John B. Martin, Special Assistant to the President for the Aging and Commissioner on Aging, told members of the American Association of Homes for the Aging meeting here, in a speech prepared for delivery today at the AAHA Conference luncheon.

"If properly planned and administered," Martin said, "a Home for the Aged could become a senior service center helping to meet the needs of noninstitutionalized older citizens throughout its community. It could provide such services as group meals within the home setting for older people from the neighborhood; home-delivered meals to persons temporarily or permanently immobilized in their own homes; day care for older people who have family to care for them at night but are alone during the day; and general information and referral on all community services for older people." Commissioner Martin cited individual homes which are now providing one or more of these out-reach services.

Martin called on members of AAHA to help solve the most pressing problems of the elderly in two ways, (1) though initiating action as administrators and staff members of homes to improve existing local situations of care, and (2) as leaders in the field to help fight for nationwide reforms.

Among major priority needs of older Americans, Martin listed income adequate for decent living, transportation facilities, improved nutrition, opportunities for expanded dimensions of living, and—basic to all—the establishment of a national policy on aging.

As a Nation Martin said, we are confused and contradictory in our attitudes and actions toward our older people An effective national policy must be focused over a long portion of the life span and not just a set of palliatives for the last years of life. The first absolute requirement is assurance of income sufficient for a life of comfort and dignity Such an assurance would proclaim the Nation's regard for its older people as first-class citizens worthy of all it has to offer. including a fair share of the economy they have helped to build.

Martin said the issue of more adequate income overshadows all the rest because it relates to all the other basic needs—for good health care, satisfactory housing, proper nutrition and convenient transportation. One-quarter of the aged are poor. Inflation further lowers their fixed incomes. About two-thirds of the many letters I receive are from men and women wondering how long they can hold out, trying to buy food and medicines and pay rent on small social security benefits plus, perhaps, small savings or a supplement from public assistance.

More opportunities for employment should be created for those who want to work. Private pensions should do a better job of supplementing incomes of those who retire. Pension rights ought to vest earlier than is currently now the case and such vested rights ought to be portable so that pension increments could be added together throughout a man's working life on as many jobs as he may have held for any reasonable time. Social security benefits need to be increased; old age assistance made more equitable. President Nixon has made proposals toward achieving both of these last two objectives. But both public and private sectors

*With Commissioner Martin detained in Washington to testify before the Senate on the AOA fiscal year 1970 budget, the Martin speech was read by Willis W. Atwell, Deputy Commissioner on Aging, at the luncheon meeting of the Conference in the Stouffer's Riverfront Inn, Noon, November 19, St. Louis, Mo.

have responsibility in finding solutions to these problems and other needs of our older citizens.

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING* AT THE DALLAS CONFERENCE ON AGING, DALLAS, TEX.

It is time we changed out attitude toward aging; John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told delegates to the Dallas Conference on Aging, meeting here today (November 20.)

For far too long, Martin said, older Americans have been regarded as nuisances to be tolerated or as charity patients. Millions of older people today live the barest, most degrading kinds of existence on funds wholly insufficient to permit life to go forward in decency and with dignity. Instead of being rewarded for contributions they made in their working years toward building the tremendous capacity of the Nation, older Americans have been expected to be content with half measures—discounts and token benefits. There has been no real commitment of the Nation to a coordinated and comprehensive program of services and opportunities designed to make the years of life added by science worth living.

President Nixon has already taken important corrective steps, Martin said. He has recommended an increase in social security benefits, an automatic cost-of-living increase formula, a Federal financial floor of $90 a month for needy elderly persons in every State, and a prohibition of liens in connection with assistance payments.

The administration has also set up a White House task force to develop future legislative proposals and the President has called a White House Conference on Aging for November 1971.

Now, in the period of preparation for that conference, Martin said, it is time for Americans to stake their claim to the kind of individual future they want for themselves.

The 2 years before the conference will give us an opportunity to draw upon all possible resources so that the national policy developed will grow out of the grass roots; so that the answers to the hard questions will come from the home communities where the problems are and the solutions must be provided. And many of those answers must come from older people themselves who know so poignantly the day-to-day problems of living.

Martin listed as five priorities for older people of deep concern to me and the administration, provision of: Income adequate for decent living; special transportation services; improved nutrition; opportunities for expanded dimensions of living—as volunteers, as employees, and as participating citizens; and—basic to all—the development of a national policy on aging.

Speaking specifically of the transportation needs of older people, Martin pointed out that many elderly, handicapped by low incomes, illness, inability to own or drive a car, the absence, inadequacy or expense of public transportation, are completely isolated from friends and community services and activities. Transportation is necessary for social reasons and health reasons, he said; for example, to reach a health clinic or the Dallas nutrition program. It is necessary to use in serving others. The excellent Texas road runners volunteer program serving nursing home residents could not operate without special transportation for its volunteers, and in the foster grandparent program, in Denton, where such outstanding work is being done, it is essential to provide transportation to help the grandparents reach their foster grandchildren.

Transportation is also necessary, Martin said, for fun and activities and to make it possible for older people to "keep going places." He cited a recent letter from a Dallas widow of 73 who wrote: I associate with many widows my age and older. We cannot travel. The bus is not for us with no place to put our poor tired legs; the airplanes are too high in price. We were able to travel by train and still are, but there are now no passenger trains in this part of our great country. So we stay at home wondering if you and others in Washington ever think about this one aspect of our lives. We like to go places too.

Martin praised Dallas and the State of Texas for pioneering in forward-looking programs for older people. He cited in particular, Dallas' "food and friendship" nutrition project sponsored by the Senior Citizens Foundation of Dallas and the

*Dallas Conference on Aging, cosponsored by the Community Council, Oak Cliff Chamber of Commerce, Dallas Committee on Aging, and the Governor's Committee on Aging, at the Dallas Baptist College, Nov. 20, 1969.

Salvation Army with Administration on Aging support; the Texas Foster Grandparent and volunteer programs; the Governor's Committee on Aging and its effective cooperation with the State extension service in developing local community organizations on aging in almost every county of the State.

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING AT MEETING WITH SENIOR CENTER PROJECT DIRECTORS, NORMAN, OKLA., NOVEMBER 21

The multipurpose senior center can offer every American community a most effective vehicle for the delivery of services to all its older citizens, John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told a group of Oklahoma's Older Americans Act project directors, meeting in Norman today (November 21).

In time, Martin said, the senior center could hold a place in the older persons' life equivalent to the central role now played by the school in the lives of children. It can offer a place where the community can provide major services for the elderly and a site where active older people may be recruited to serve others in community programs.

There has been a rapid increase in the development of multipurpose centers in recent years, Martin pointed out. The first publicly supported one, Hodson Day Center in New York, was established less than 30 years ago. In 1966 when the Administration on Aging published the first national directory of senior centers, it listed only 340. In the second directory, now in preparation, more than 1,200 senior centers are listed.

Not only the numbers but the kinds and quality of services provided by senior centers have grown phenomenally, Martin said. Today, most effective senior centers are no longer just places for recreation—though this is an important function; they also provide educational and cultural activities, highly individualized services such as personal counseling on many problems; nutrition programs; employment services; and—in some places—an out-reach effort to serve the homebound and to bring previously isolated older people to the centers.

"This kind of centralization, providing comprehensive and coordinated services to older people, has great value," Martin said, "obviating the difficult, tiring, inconclusive, and frightening search for help all too often experienced by the elderly.

"Isolation is one of the major problems of older Americans—transportation is difficult for them physically and financially—fragmented services are confusing and unsatisfactory. The senior center can break down isolation, drawing the older person into community participation and social activities; its one-stop coordination of services removes some of the transportation problem; and, for the community, there can be economy in the combination of many services and concentration of personnel under one roof. Above all, the senior center can provide its members with a very personal feeling of belonging, supportive and reassuring to older people."

A recent survey of senior centers showed, Martin said, that older people are attracted in large numbers to senior centers because they are more comfortable among others of their own age and don't have to compete with youth. They are able to participate in management of the programs, geared to their interests and pace, and feel, in effect, that the center belongs to them.

"We were happy to find from the survey," the Commissioner on Aging said, "that senior centers are increasingly serving the hard-to-reach older person often neglected by other social programs. These include minorities within a minority—the elderly Negro, the Spanish surnamed, and the Indian; the poor older person; those who live alone, and many who have no other major activity outlet. The physically disabled, blind, or severely visually impaired represent 11 percent of all center members reported upon in the recent survey."

Martin praised the Oklahoma State agency on aging for the effectiveness of the Oklahoma center program as a whole and the center directors for the scope of their individual programs.

He also discussed broader aspects of the needs of older people, listing as major priorities of deep concern to the Administration on Aging:

"The need for income adequate for decent and dignified living in the years added by science. The need for improved transportation facilities for older people and for improved nutrition. The need for opportunities for expanded dimensions

of living—in the labor market, as volunteers, and as citizens; and—basic to all—the great overriding need for the development of a national policy on aging."

The President has already taken a number of important corrective steps toward meeting these needs, Martin said, and in his calling of a White House Conference on Aging to be held in November 1971 has, in essence, "set a deadline for deciding and designing the kind of future older Americans should have."

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING AT THE ADULT EDUCATION ASSOCIATION GALAXY CONFERENCE, WASHINGTON, D.C., DECEMBER 8, 1969

"One of America's long-range goals must be to make lifelong education—and education for older people in particular—as freely available as it is for children and youth," John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told delegates to the Adult Education Association Galaxy Conference meeting here this morning.

"Experience of the past decade," Martin said, "has taken us beyond the question of whether older people can and will learn. We know that lifelong education is a necessity to keep pace with our rapidly changing society and to meet the special demands and problems of later years."

In discussing the implications of the forthcoming 1971 White House Conference on Aging for the field of adult education, Martin said the Adult Education Association could be effective in helping develop national policy that would bring continuing education within the reach of all older people in every community in the country.

He asked for help in achieving three specific steps toward this goal: The establishment of a unit on education for aging in every State department of education; finding ways to increase funds available for education for older people, who must spend almost their entire incomes for necessities of food, housing, clothing, and medical care; and the establishment of courses in universities and professional schools of education to train personnel specifically for educational leadership and programing for older people.

Each new generation of older people has achieved a higher level of education than its predecessor, Martin said. He predicted that adult educators would find a great number of retired persons interested in education to enable them to find new interests and satisfactions in life and to update skills if they wish to remain in the labor market.

Specialized knowledge about older people, their interests, how to reach them, and conditions essential for their best learning achievement are necessary, Martin said. He reported that such specialized preparation of adult educators and librarians for work in the field of aging has begun at the Universities of Michigan, North Carolina, North Texas State, and Oregon, with support from the Administration on Aging.

He asked the Adult Education Association in its assistance in preparing for the White House Conference on Aging, to consider compiling and publishing a new handbook on "Education and Aging," to replace a pioneering publication it sponsored 19 years ago. "Experience in the years between has given us much new knowledge about the learning patterns of older people," Commissioner Martin said, "and about their educational needs and the circumstances under which learning takes place." In addition he pointed out that there are now scores of examples of effective educational programs for older people which could be cited for the guidance of others.

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING AT JOINT HEW-HUD MODEL CITIES MEETING, RUTGERS UNIVERSITY, TRENTON, N.J., DECEMBER 10

The model cities program offers great possibilities for improving the lives of older people but only if advocates for the elderly are active in local urban planning and program operation, John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told participants in a joint AOA-MCA-sponsored meeting at Rutgers today (Dec. 10).

Support at the Federal level for services to and by older citizens in model city areas cannot take the place of local support and interest, Martin said. He reported that he came to his job in Washington last spring full of enthusiasm for the promise

the model cities program held for a better life for thousands of older people trapped in city slums. "But," he said, "at that time it was largely only a promise. The first model cities plans submitted to Washington and reviewed by AOA had little in them for the old."

Martin said that Floyd Hyde, HUD's Assistant Secretary for Model Cities and Governmental Relations, was "as much concerned as I was at the lack of content for the elderly. We talked with Secretary Romney and Secretary Finch and on August 12 the two Secretaries announced a joint effort to increase services to older people in model cities and to open up opportunities for them to participate in planning and provision of services.

"Since that time, three earlier model cities' State meetings such as today's have been held—in Connecticut, Georgia, and Michigan—bringing together representatives of the two Federal programs and State and local people involved in both aging and model cities. Some of the State and local agency people are meeting for the first time across agency lines. We find we have taken on quite a job. It is far from enough just to call attention to the needs of the elderly in the cities. We have to make certain that there is a deeply concerned advocate for older people on every layer of board and committee involved in the program or older people won't get much.

"We need three things: Visibility of needs; technical assistance; and a cooperative effort at the State and community level involving the same kind of meshing of objectives and pooling of resources as now exists at the Federal level."

Martin pointed out that older people make up a high percentage of the population of many model city areas—usually out of proportion to their numbers in the general population. They have less chance of "escaping" from the inner city than do younger residents.

In some communities, the program is fulfilling hopes of local residents for help to the elderly. In Seattle, for example—one of the first four cities to receive its development grant after planning approval, the local committee on aging worked to include five programs for the elderly in its plan. These are: Foster homes for older people; household aid (homemakers) and handyman services for the elderly; "portable parents," described as a foster grandparent-type program of employment for people over 60 in various day care programs; establishment of drop-in senior day centers; and survey of nursing homes to discover why the elderly nonwhite population is not using them, what care is being provided, and what is needed—in preparation for providing it.

Commissioner Martin also cited a cooperative project of AOA with the Social Security Administration in the Cincinnati model city area, through which senior companions—older people themselves—serve elderly residents of high-rise apartments and nursing homes by receiving their social security checks, paying their bills, shopping for them, and providing other services under supervision of a project director.

This project, Martin said, could serve as a model for other communities to improve delivery of social security benefits to aged SSA beneficiaries unable to manage for themselves and to provide supplemental income and a role in retirement to well older people.

The Commissioner urged the State and community representatives present at the meeting to provide opportunities for low-income older people in the model city neighborhoods to supplement their "tragically low" incomes in providing services to others. "Several million older people throughout the Nation," Martin said, "have the good health and capacity for worthwhile and constructive work. They offer us a real reservoir of experience and skills as aids to professionals in social and health-related services. These are their neighborhoods and their neighbors. They understand the people and the needs.

"I testified last week on the desirability of employing older people to help provide day care for the children of working mothers—or of mothers who need and wish to work. And the idea met with a warm reception in the Congress. In the model city neighborhoods, day care is a vital service and offers opportunity to help several groups of needy people in one simple, inexpensive and direct operation. It helps the elderly, who need work, income, and to be needed; helps the younger woman who also needs work and income and someone to care for her children; and helps the children who need care and attention. Everybody benefits. Our Foster Grandparent program has illustrated daily for 4 years now just how effective is the combination of the older person with love to give and the children who need it."

Martin praised the New Jersey Division on Aging (of the State's department of community affairs) for its statewide program for older people and cited in par-

ticular its effective training program in basic understanding of aging for practitioners working with older people. Mrs. Eone Harger is executive director of the New Jersey State program under the older Americans Act.

STATEMENT BY JOHN B. MARTIN, SPECIAL ASSISTANT TO THE PRESIDENT FOR THE AGING AND U.S. COMMISSIONER ON AGING AT THE ANNUAL MEETING OF THE CENTRAL BUREAU FOR THE JEWISH AGED, NEW YORK CITY, DECEMBER 11, 1969*

Money—the lack of it—is the No. 1 problem of older people in America, John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, told members of the Central Bureau for the Jewish Aged, meeting here today.

"Older Americans have many problems," Martin said, "problems of health, loneliness, isolation, housing, transportation, nutrition—but the lack of income is the greatest, contributing to all the other difficulties. Faced with a 50- to 60-percent automatic drop in income upon retirement—with retirement often mandatory—our older citizens are becoming the new poor of America."

"These are the people," Martin said, "who built the productivity of America, who worked all their long lives, saved what money they could, and maintained a reasonable standard of living during working years. Because their best earning years were in time of low wages before adequate pension systems they had no opportunity to build sizable retirement incomes. Now, they find themselves in old age suddenly impoverished with all doors shut to further opportunities for earning, often simply on the basis of calendar age. Inflation further complicates their tragedy. Something must be done. As Arthur Miller says of Willie Loman in 'Death of a Salesman'—'Attention must be paid.' "

Martin said: "We have a patchwork of special programs for older people, put together in answer to specific problems or a special emphasis in little pockets of general programs. This patchwork is pulling apart at the seams. We need to look for new approaches.

"We have not known as a Nation and we do not know today how we want to treat our aging population—those who have retired and also those who are in the latter portion of their working years.

"As should be obvious, but isn't always, whatever affirmative is accomplished for the good of today's 20 million older people will have meaning in time for every American. The very quality of life expectancy in this country is involved in our program—yours and mine.

"Each of you, I am sure, has in his or her mind an agenda for action for aging. Two years from now we will be holding a second White House Conference on Aging. The President has aksed me to take responsibility for the direction of that conference. I am determined that it will not be just another conference of professionals and older people worrying about other older people. It must instead concern itself with all people growing older. It should be, and I believe it can be, a landmark conference aimed at changing national attitudes toward the later years of life. It, in a sense, gives us a deadline for the development of a national policy on aging.

"In moving forward I would like to see more scope and reach, more imagination, and a new theme. As I have said before; I am tired of aging, I am concerned, and I know all of you are concerned, with living—at every age.

"In order to pull the pieces of what we have together and to build with what is worth saving of them and with new tools, materials, and ideas, toward a true national policy, we must involve four major considerations:

"1. A new role and status for older Americans and the creation of conditions permitting the establishment of such a role.

"2. Proper definition of responsibilities between public and private sectors and between the layers of government.

"3. Carefully stated long- and short-range goals and plans for achieving them in steps which reflect responsible estimates of available resources.

"4. The inclusion in the development of any overall national initiatives—in income maintenance, transportation, housing, nutrition, health, employment, or education—of explicit knowledge and concern for the needs of older people.

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*24th annual meeting, 120 West 106th Street, New York, Jewish Home and Hospital for the Aged.

"The development of such a policy is even more vital to older people than the development of new programs. Without such a policy, older people will continue to be thought of as a problem group. With such a policy, society acknowledges its responsibility for including its elderly in the expanding life of America.

"If we are to reach a national policy and program for the aging, the help of the national voluntary agencies is absolutely essential. I would hope that the design and delivery of services to fit the convenience of the client would outweigh any questions of individual agency prerogative. We need the strengths of each organization in the field and we need them shared. The point of all programs in aging should be life complete—life worth living.

"I would propose to you today that we question the present, not just how we can extend or even improve it, but how good is it and if it's not good enough how can it be reconstructed or recreated. There is nothing sacred about the status quo. We need not be afraid of an entirely new pattern—retaining within it the best of the past—what works and is still relevant—and getting rid of what is obsolete and outworn, based on myth or mistaken judgment. Obviously we must do something drastic about income, about health, delivery of services, housing, nutrition, transportation, preretirement, and advocacy. We do not have to accept the prescriptions of yesterday or today because we are dealing with tomorrow.

"We meet today in very stimulating surroundings. Too often nursing homes and homes for the aged take too narrow a view of their responsibilities to, and their opportunities for, service to their communities. That is certainly not true of this Jewish Home and Hospital for the Aged. Its achievements in service are widely known.

"I am particularly impressed by the training program carried on here by Dr. Zeman. And I am proud that AOA has been its sponsor. It is helping to improve the quality of life for countless older people, both resident in the home and elsewhere, as they are better served, better understood, and more warmly cherished by those serving them because of sensitive training received here.

"This administration is dedicated to the improvement also of service and understanding, to paying attention to needs, and moving forward with action. President Nixon has expressed his concern when he stated: It is simply unacceptable in America that a large segment of older Americans have income below the poverty line. It is unacceptable that the aged should be the one group in the country where poverty is increasing today. I can promise you that the Nixon administration will change this picture, that we will give priority attention to the problems of poverty among the aging, and that we will do everything we can to generate solutions which are thoughtful, workable, and effective.

"The President has also taken a major step forward by requesting Congress to fix a Federal financial floor beneath our older people. A Task Force on the Aging, headed by Garson Meyer of New York, has been meeting during the past weeks to help the President develop a legislative program for 1970 and beyond. It has addressed itself to the most critical problems and is now preparing its final report. And the White House Conference offers us further hope for progress as we enter the last years of this tumultuous century.

"The Jewish community has been pioneering in intelligent and warm concern for older people throughout the country. It has initiated many outstanding volunteer programs particularly in the recruitment and training of older people as volunteers to serve others. And has sponsored progressive homes for the aged. We need and welcome your continued commitment and help as we move forward."

MODEL CITIES AND AGING WORKSHOP, WASHINGTON PLAZA HOTEL, SEATTLE, WASH., JANUARY 14, 1970

Model cities planners from eight States are meeting in Seattle today with a large group of Seattle's older citizens in a workshop which John B. Martin, Special Assistant to the President for the Aging and U.S. Commissioner on Aging, characterizes as "vitally important to thousands of older people throughout the Nation."

Keynoting the three-day conference in company with Floyd Hyde, Model Cities Administrator and Assistant Secretary of HUD, Martin said: This workshop represents the culmination of months of cooperative effort by the Administration on Aging of HEW and the Model Cities Administration of HUD to extend the promise and reality of model cities services and opportunities to older Americans.

It is important to thousands of older people throughout the country, Martin said. If successful, we shall have taken a major step toward improving the lives

of many of today's older people and will have moved toward creation of model community life in the 21st century.

Two major grants of the Administration on Aging made the Seattle workshop possible—a research grant to the Syracuse (N.Y.) University School of Social Work to develop guidelines for inclusion of older people in the planning and initiation model cities programs and a grant to the Seattle Model Cities program. The Model Cities Administration of the Department of Housing is cosponsor of the workshop.

Last August, Secretary of Health, Education, and Welfare Robert Finch and Secretary of Housing and Urban Development George Romney announced the beginning of an intensive cooperative effort by AOA and MCA to see that increased services were provided for older people in the model cities program and that they were encouraged to take a greater role themselves in planning, developing and providing these services.

Since that time, State meetings have been held in Connecticut, Georgia, Michigan, and New Jersey, bringing together Federal, State and local representatives of agencies in aging and those primarily concerned with model city planning and implementation. The Seattle meeting will draw upon the information gathered at these State meetings, the preliminary work of the Syracuse research project, and the experience of the Seattle Model Cities program, one of the first two in the Nation to include sizable plans and programs for older people in its model cities planning and services.

Pointing out the importance of the program to the elderly, Commissioner Martin said: Older people make up a significant percentage of the populations of many model city neighborhoods—usually out of proportion to their numbers in the general population. And generally they have less opportunity to escape from the inner city than younger residents.

Therefore the model cities program offers great possibilities for improving their lives but only if advocates for the elderly are active in local urban planning and program operation. We need three things: visibility of need; technical assistance; and a cooperative effort at the State and community level involving the same kind of meshing of objectives and pooling of resources as now exists at the Federal level. We must make certain that there is a deeply concerned advocate for older people on every board and committee involved in the program.

Martin said: I am not necessarily advocating establishment of a large number of new special age-segregated services for older people only. Instead I am asking for assurance that wherever there is a program for people, older people are included in its planning, in its detailed design, and in a fair share of its services and opportunities—not the least of which is an opportunity to serve.

For example, in provision of any new housing within the neighborhood, full recognition should be given to the special safety needs of the elderly—which in fact will enhance safety for all ages. Transportation facilities should be designed with the elderly in mind. The scheduling of service in daytime hours and in centralized places will make them more accessible to the elderly. Nutrition programs should be provided wherever possible in group settings which help to provide a social exchange for older people too often isolated from their own communities.

Several million older people throughout the country have the good health and capacity for worthwhile and constructive work. They offer us a real reservoir of experience and skills as aides to professionals in social and health-related services. The employment of low-income older people in model city neighborhoods would provide an opportunity to supplement tragically low incomes while serving their own neighbors and neighborhoods.

Martin suggested, in particular, that older people could offer excellent help in providing day care for the children of working mothers—a vital service in model city neighborhoods.

Martin said that in every model city neighborhood in the country, the local program should be designed and implemented to assure that community services and opportunities are equally available to all older persons; that opportunities are available for participation in community life; that services are available to maintain independent living; that provision is made for institutional and in-home supportive services; and that older people are encouraged to participate in decisions affecting their lives.

The fact that there are not more Federal dollars available at this time, should not immobilize planning for the model cities program. We need to look closer at what each local community, public and private sector—can contribute. We ought not to assume that if it isn't available at Federal level, it isn't available elsewhere.

There are strong resources in local agencies, organizations and institutions, public and private.

Attending the workshop are representatives of Seattle, Tacoma and Olympia, Wash.; Norfolk, Va.; Salt Lake City, Utah; Minneapolis, Minn.; Kansas City, Mo.; Syracuse, N.Y.; Portland, Oreg., and Reading, Pa. Also participating will be executives and staff of community development agencies, HEW and HUD regional representatives, organizations of older people, and approximately 75 Seattle older residents of the model city neighborhood. Floyd H. Hyde, Assistant Secretary (for Model Cities and Governmental Relations) of the Department of Housing and Urban Development will open the conference.

ITEM 2: ATOMIC ENERGY COMMISSION

U.S. ATOMIC ENERGY COMMISSION,
Washington, D.C., January 23, 1970.

DEAR SENATOR WILLIAMS: We are again pleased to have the opportunity to provide information on the Atomic Energy Commission's research in aging for inclusion in the Senate Special Committee on Aging report "Developments in Aging."

With reference to your question regarding the impact of budgetary restrictions on research programs related to aging, it is noted that the AEC spent approximately $5.7 million in research programs related to an understanding of the problem of aging in fiscal year 1969. This research is conducted in approximately 11 AEC laboratories and 23 university hospital research projects. In fiscal year 1970 expenditures of $5.6 million are anticipated.

In our previous report to the committee we indicated that an important factor in aging is senescence of the immune system. In mice the immune system achieves a maximum functional capability during the latter phases of juvenility and thereafter declines steadily with advancing age. This decreased capability in aged mice could be one of the reasons why the death rate due to infectious agents is high among the aging. This study suggests a basis for investigating ways to enhance the immune competencies of older individuals and thereby possibly increase the life span. Research in the past year has indicated that removal of the spleen 6 months before the appearance of a spleen-related disease appreciably extends the lifespan in mice prone to develop this disease. Furthermore, spleen cells from young mice which have been immunized against a highly infectious bacterium protect old animals against a lethal dose of this same highly infectious bacterium. It has also been demonstrated that it is exceedingly difficult to immunize old animals against this bacterium in order to achieve protection. Since young children are immunized against many bacterial diseases it is not unreasonable to believe that it would be possible to collect certain blood cells from these immunized children and store them. In later life their own cells could then be returned to them to offer protection at a time when their own immune capabilities have diminished. The cells that would be collected from the young are programed, that is to say have the necessary information to develop rapidly and respond to a challenge by the infectious agent to which they were originally exposed; it would not be necessary to store a large quantity of these cells.

As mentioned previously, research on aging necessarily progresses slowly though we believe steadily. The continuing focus of the Atomic Energy Commission's research on aging is in determining the mechanism whereby radiation interacts at the molecular and cellular level to bring about loss of functional adaptation by the individual or species with passage of time. This includes studies that are directed to determining those parameters that are characteristic of the aging phenomenon and accelerated by irradiation; emphasis is also placed on identifying the physical and physiological phenomenon associated with the aging process and on studies on molecular and attendant cellular changes that can be used to predict the onset of an aging process.

We hope this information will be of use to the committee.

Cordially,

GLENN T. SEABORG, *Chairman.*

ITEM 3: CHIEF POSTAL INSPECTOR

POST OFFICE DEPARTMENT, CHIEF POSTAL INSPECTOR,
Washington, D.C., January 27, 1970.

DEAR MR. CHAIRMAN: In response to your request of December 17, 1969, we are pleased to furnish for your consideration in preparing your 1969 annual report "Developments in Aging," the following information which may be of special interest or help to the older consumer.

The Postal Inspector Service is responsible for the investigative enforcement of the mail fraud statute, section 1341, title 18, United States Code. It is the oldest "consumer protection law" ever enacted by the Congress. It provides felony sanctions for any use of the mails in furtherance of a scheme to obtain money or property on the basis of fraudulent representations.

Confidence in business transacted by mail is regarded as vital to the national welfare. It is the principal, if not the essential, artery of commerce and communication in this country. No elements of our society are immune to loss through mail fraud activity, and the businessman is quite as vulnerable as is the individual consumer. As in the case of all other types of criminal activity, mail fraud, the "white-collar crime" which leaves a trail of disillusionment and distrust in its wake, attacks the savings, and very frequently leaves the victim with a lengthy time payment contract to discharge, has shown a steady increase over the past several years. In fiscal year 1969, a total of 194,052 complaints were received, an increase of 23.9 percent over 1968. Arrests by postal inspectors totaled 1,061, and 767 convictions were returned; the latter representing the highest in history and 12.1 percent over 1968. Some 6,360 questionable promotions were terminated on the basis of our investigations and, although the mail fraud statute makes no specific provision for recoveries, a total of $4,833,754 was returned to victims or the Public Treasury in terms of restitution or fines.

The types of fraudulent schemes encountered in our investigations range from the fly-by-night swindles designed for a quick kill to multimillion dollar financial swindles carefully disguised behind complex corporate structures. All, of course, while they may not be specifically aimed at the elderly, affect them directly.

A typical example of the "fly-by-night" variety is that operated this past summer by two German Nationals in this country on tourist visas. Using an answering service as their business address, they coined the trade style "Deluxe Vacationer Company", Hollywood, Calif., and advertised 2,000 free vacation prizes in the April 5 "TV Guide" to be awarded in a drawing before midnight May 25. Readers were merely required to answer several simple questions. More than 57,000 persons, some in the elderly class, did so and all were notified they had won free vacations to Hawaii and/or Acapulco. A $25 "registration deposit", however, was required from each "winner". Postal inspectors moved in before the pair had an opportunity to depart with some $250,000 remitted by unsuspecting persons. Both were arrested and the funds were returned to the winners.

We have just recently mounted an intensified program to root out frauds in the health insurance field, a factor which contributes to the increasing cost of this type of insurance. As an example, a Federal Grand Jury at Detroit, Mich., on October 16, 1969, returned a 51-count mail fraud indictment against two osteopathic physicians for filing of claims against Blue Shield of Michigan for services not performed. Blue Shield estimated that during the past 3 years about $700,000 in claims were improperly filed.

In another case, seven persons, including a doctor and an attorney, collaborated during a 4-year period to defraud insurance companies of more than $3 million. Culminating an investigation of 3 years, the offenders were convicted of submitting fraudulent personal injury claims, including excessive charges for medical attention, and inflated property damage bills.

Following are summaries of several different types of mail fraud schemes which affect all segments of our society, but particularly the elderly.

MEDICAL FRAUDS

Today, despite up-to-date medical facilities in almost every community, rural and urban, some elderly people fall prey to medical quacks who depict cures for arthritis, cancer, obesity, impotency, headaches, etc., by means of carefully worded advertisements. Rapidly rising precedent-shattering medical costs and lack of proper insurance coverage tend to drive the geriatric to try such quick cures at what appear to be much lower costs.

A Federal grand jury has returned an indictment in a case currently under investigation involving the advertised treatment for diabetes allegedly based on false and fraudulent pretenses and promises. This consisted of a complete withdrawal from insulin and ingestion of white table sugar to replace same. Medical authorities who reviewed the treatment stated that a diabetic following this treatment would do so at grave peril to his health.

An investigation conducted in cooperation with State and local authorities resulted in an unlicensed physician named Wendell G. Hendricks of Los Angeles, Calif., being placed on probation for 2 years, fined $400, plus $1,500 to be paid to the California Board of Medical Examiners. Hendricks was convicted for fraud relating to worthless injections to cure multifarious ailments. In one such instance, he prepared to administer a serum to a young girl who was allegedly retarded. Fifteen such injections, at a cost of $1,000, were supposed to cure the girl.

In a cooperative investigation with officials of the State of California, Curtis H. Springer, age 72, pleaded guilty on September 17, 1969, to State charges of mislabeling of foods. Springer, whose name has been a household word since 1934 to hundreds of thousands of the ailing, the elderly, and the health food faddists throughout the Nation, reportedly maintained advertisements for various products on 50 to 60 radio stations at a cost that sometimes reached $30,000 per month. Springer, who joined commercial pitches with religious sermons and inspirational organ music, used as a theme "Eat Your Way to Health." It was reported that some products which cost as little as 50 cents to produce were sold for $10. Among the numerous complaints lodged against Springer was one relating to a $25 cure-it-yourself hemorrhoid kit.

HOME IMPROVEMENT, DEBT CONSOLIDATION, AND MORTGAGE RACKETS

These are areas which continue to be of vital concern to this Department, to your committee and to the public because they threaten the security of the home and the financial status of the citizenry. The elderly are particularly vulnerable to such threats. During the year 1969 there were four major convictions. In addition, 66 investigations are currently being conducted in which 18 persons are so far under indictment awaiting trial. In still another case, six persons have been arrested on State charges as result of investigation conducted by a Postal Inspector. The savings to the public by the termination of numerous such promotions would run into the millions of dollars.

In one recent case a defendant pleaded "nolo contendere" (no contest) at Detroit, Mich. and is awaiting sentencing. Doing business as Credit Advisors, et al., various misrepresentations were made to induce persons in financial difficulty to make payments to defendant for purpose of disbursing same to creditors, but this was not carried out. Estimated public loss in Detroit area alone is $1,900,000 and the promoter closed 56 other offices around the country as a result of his Detroit conviction.

INVESTMENT SWINDLES

This area embraces stocks, bonds, oil and gas leases, saving and loan associations and kindred activities. Attention by postal inspectors to questionable promotions in these categories is never ending as Americans—particularly the mature and elderly—are an investing, affluent people and many are susceptible to "rare opportunities for rich returns." There are currently 171 investigations in progress and 260 persons under indictment awaiting trial.

A typical case in point was recently concluded at St. Louis, Mo., when the three defendants in the Diversified Brokers, Inc., investment promotion were sentenced. The sentences handed down are perhaps the most severe in the history of the postal inspection service for this type of crime—consisting of 35 years, 20 years, and 5 years, respectively, plus fines totaling $35,000. The scheme involved the sale of promissory notes offering, falsely, a return of from 40 percent to 100 percent. The public loss is approximately $4 million.

BUSINESS OPPORTUNITIES

There are four separate, but closely related promotions falling within this category of cases. These include distributorship, franchise, vending machine, and other job opportunity frauds, which lure investors with promises of high returns and guarantees of success which later prove worthless. Retired and disabled persons lead the list of individuals who are preyed upon each year to "put their savings to work and supplement their incomes."

As of November 30, 1969, a total of 67 persons and firms were under indictment for promoting allegedly fraudulent schemes in this area. During the past 5 years, organizers and operators of "Business Opportunity" frauds that have reached our attention have cost the American public nearly $26 million.

SOLICITATION OF FUNDS

It is well known that many elderly are of a compassionate disposition and often respond to heart-rending appeals for contributions to various seemingly worthy causes. Appeals for contributions extend to many causes and include an endless variety of charities and betterment objectives, alleviation of animal suffering, religious, and political matters.

There are thousands of such organizations soliciting funds from the public. Mail fraud is indicated when funds solicited for an announced purpose are actually spent for another. The inspection service investigates when there is reasonable cause to do so. In a recent case, radio, personal, and direct mail appeals for funds were made over several years, ostensibly to enable J. Charles Jessup to carry on the religious, charitable, and missionary work of Fellowship Revival Association from Gulfport, Miss. Instead of devoting moneys received to the purposes for which solicited and given, he acquired expensive real estate, boats, airplanes, and automobiles for his personal use, and deposited large sums in his personal bank accounts. It is estimated that in 20 years of operations, he took $10 million from the public.

PUBLIC EDUCATION AND FRAUD PREVENTIVE PROGRAMS

The Department has continued to expand its program to prevent frauds through developing greater public awareness as to its danger signals. During fiscal year 1969, postal inspectors made over 1,200 speaking appearances before law enforcement, civic, educational, and consumer groups, as contrasted with approximately 1,000 the year before. Further, wide distribution was made of the mail fraud pamphlet, a copy of which was furnished you with our last statement. Then, too, we continue to maintain close liaison and exchange mutually helpful data and intelligence with numerous agencies concerned with consumer protection, which we consider to be highly beneficial.

I hope that the information contained in this summary will be helpful to you and your committee. If we can be of any further assistance, please do not hesitate to call upon us.

With kind regards,

Sincerely,

W. J. Cotter, *Chief Postal Inspector.*

ITEM 4: DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Department of Housing and Urban Development,
Washington, D.C., January 30, 1970.

Dear Senator Williams: There is attached a report on the 1969 activities of this Department with respect to the several housing programs for the elderly, and related facilities, in response to your request of December 17, 1969.

This statement and statistical data are for publication in the annual report of the Senate Special Committee on Aging entitled, "Developments in Aging."

You will note that responses to the five specific questions you pose will be found in the text covering the programs to which the questions relate.

Let us know if we can be of further assistance.

Sincerely,

George Romney.

[Attachments]

Report on Housing for Senior Citizens in 1969—Department of Housing and Urban Development

INTRODUCTION

Active interest in providing suitable housing of special design for the elderly continued and increased during 1969. As in previous years, the primary emphasis was on rental housing for the older population, including in most programs,

common activity spaces and other amenities which help assure their continued involvement in meaningful activities, as well as safe and comfortable shelter.

The several HUD programs vary on the basis of the type of financing, sponsorship and the income group which will occupy the housing. In addition to rental housing designed for independent living for the well elderly, older people are eligible to use the Federal Housing Administration (FHA) mortgage insurance programs for the purchase of individual homes, condominiums or cooperative, as well as the FHA and Renewal Assistance Administration (RAA) programs for home modernization and rehabilitation.

In the health-related field, the FHA mortgage insurance programs for nursing homes (which was expanded in the 1969 Act to include intermediate care homes); for facilities designed for the group practice of medicine, dentistry and optometry; and for nonprofit hospitals are among the sustaining aids of particular importance to the older population. In short, the Department's programs now span the age continuum by providing housing assistance for the well and active, the ill, and with the 1969 Act, the ambulatory, frail elderly.

In addition, a variety of city improvement programs have particular relevance to the older population. These include the neighborhood facilities program which can provide centers for socializing, counseling, recreation, food and health services; and the Model Cities program directed at upgrading older neighborhoods where large numbers of older people live.

These existing programs were further implemented by the 1969 Housing Act signed by President Nixon on December 24, 1969.

THE 1969 HOUSING ACT AND THE ELDERLY

The 1969 Housing Act continued to reflect congressional interest in housing and related programs for older Americans. Major housing programs such as low rent public housing, several FHA mortgage insurance programs, the direct loan program, the nursing home and nonprofit hospital programs were continued. The following new provisions or amendments to existing programs have special significance, directly or indirectly, for the older population.

Intermediate care facilities

A new section of direct importance to the elderly was the expansion of the FHA section 232 nursing home program to include funding for intermediate care facilities. Heretofore, the major resources of the Department in behalf of the elderly have been for dwellings for the well elderly who are capable of independent living and self-management, and at the other extreme, for nursing homes. A number of older people fall between these poles who cannot live independently and yet do not need skilled nursing home care.

To help finance facilities for this in-between group, section 111 of the 1969 Housing Act authorizes FHA insurance to finance new or rehabilitated intermediate care facilities, or combined nursing homes and intermediate care facilities. These can be financed under the same terms and conditions as provided for a nursing home, and the program will be administered by the nursing home section.

The mortgage is limited to a principal obligation not exceeding $12,500,000, or 90 percent of the estimated value of the property or project including major movable equipment. The Secretary must require certification by the State agency designated by the Public Health Service Act as to the need for such facilities and that there are appropriate standards for their operation. The Secretary must also consult with the Department of Health, Education, and Welfare as to the health and medical aspects of such facilities as well as the need and availability of such facilities in the area.

Rent supplements in section 236 rental housing

Section 112 of the 1969 act provides that 40 percent of the rental units in the section 236 housing projects may receive rent supplements if it is determined by the Secretary that such an increase is necessary and desirable in order to provide additional housing for those individuals and families who meet the requirements of qualified low income tenants under the rent supplement program. Formerly, only 20 percent of the units in a section 236 project could receive rent supplement assistance.

In addition to the increase in rent supplements in section 236 projects, section 107 of the 1969 act increases by $195 million the aggregate amount of contracts that the Secretary may enter into to make periodic interest reduction payments on behalf of owners of rental housing projects designed for occupancy by lower

income families. Section 108 of the act authorizes interest reduction payments with respect to part of a mortgage on a rental or cooperative housing project financed under a State or local program. Thus, we see that with the combination of interest reduction under section 236 and rent supplements, this program can reach more and more low income families, including elderly persons, and provide adequate housing within their ability to pay.

The 202 direct loan program

Section 218 of the 1969 act increased the total amount authorized to be appropriated for direct loans for housing for the elderly or handicapped by $150 million as of July 1, 1969.

Rehabilitation loans and grants

Section 207 removes the requirement limiting eligibility for residential rehabilitation loans (sec. 312) to persons whose annual income is within locally applicable income limits for the section 221(d)(3) below-market-interest-rate program. However, priority will be given to applicants whose incomes are within those limits.

Section 205 increases from $3,000 to $3,500 the maximum rehabilitation grant authorized for home rehabilitation of low-income owner-occupants under section 115. It can be expected that these two amendments will directly benefit the elderly. During 1968, about 60 percent of the low-income homeowners in urban renewal or code enforcement areas who received HUD grants for rehabilitation of their homes were elderly, and about 25 percent of the rehabilitation loans were made to those 62 years of age and over.

Public housing amendments

Several amendments in the 1969 act will benefit those eligible for occupany in public housing projects. Section 213 set ceiling rentals not to exceed one-fourth of the family's income, as defined by the Secretary. This should be of considerable benefit to the elderly, so many of whom live on fixed incomes. In addition, statutory room cost limits in public housing projects were increased, the workable program requirement for public housing was eliminated, and appropriations for upgrading management and services in public housing projects through fiscal year 1971 were extended.

Mobile homes

The 1969 act authorizes FHA to insure loans financing the retail sale of mobile homes to be used as the principal place of residence, and increases the maximum mortgage for mobile home courts from $1,800 to $2,500 per space and from $500,000 to $1 million per project. These changes should be of benefit to the increasing number of elderly who find mobile home living attractive.

Sale of land for housing

Section 414 of the 1969 act permits real property which is surplus within the meaning of the Federal Property and Administrative Services Act to be transferred to the Secretary of Housing and Urban Development at his request for sale or lease by him at its fair value for use in providing rental or cooperative housing to be occupied by families or individuals of low or moderate income.

Lower downpayments for FHA-financed sales housing

Section 102 lowers the minimum required downpayment under FHA-financed sales housing programs by reducing from 20 percent (15 percent in the case of veterans and servicemen) to 10 percent the increment of such downpayment which is attributable to the value or cost of the property in the range between $20,000 and $25,000.

Employment opportunities

Section 404 provides for increased employment opportunities for lower income persons in connection with HUD-assisted projects. This may also be of benefit to low income elderly persons.

Thus it can be seen that the 1969 Housing Act has provisions which will help more and more low income elderly persons achieve adequate housing within their ability to pay.

PROGRESS BY PROGRAMS—1969

Levels of approved housing units for the elderly and nursing home beds, primarily for the elderly, during the first three quarters of calendar year 1969 showed an increase in excess of 17,500 units over the same three quarters of 1968. Following is the comparison by program for this period:

UNITS

	1969	1968
Low-rent public housing	50,724	31,846
202 direct loan program	3,035	8,570
FHA 236 program	[1] 3,269	0
FHA 231 program	0	476
FHA 232 nursing home program	10,121	[2] 8,751

[1] This figure includes units under both formal and preliminary fund reservations. As of Dec. 31, 1969, this figure was 8,897 units.
[2] Beds.

The cumulative number of approved units from program inception through September 30, 1969:

	Units
Low-rent public housing	233,878
202 direct loan program	45,687
FHA 236 program	[1] 3,269
FHA 231 and 207 programs	43,115
FHA 232 nursing home program (beds)	62,560

[1] This figure includes units under both formal and preliminary fund reservations. As of Dec. 31, 1969, this figure was 8,897 units.

PROGRAM ACTIVITIES

Low-rent public housing for the elderly

The low-rent public housing program continues to provide more housing for senior citizens than any other housing program. As of December 31, 1968, some 183,000 units specifically disigned for elderly occupancy were under annual contribution contracts. During the first 9 months of 1969, more than 28,000 units were placed under annual contribution contracts. Construction was started on approximately 20,000, and almost 14,000 units were completed during the year. Older people also live in units which are not specifically designed for elderly families, and as of December 31, 1968, over 265,000 elderly families were living in public housing in both regular and specially designed units. With the increase in the number of elderly families living in low-rent housing, and the number of units specifically designed for their occupancy, in order to achieve a balanced program, present Housing Assistance Administration (HAA) policy emphasizes the provision of housing for families with children. While this policy may decrease the percentage of all public housing units specifically designed for elderly occupancy, the number of units for the elderly will continue to increase.

The Housing Act of 1968 limited the future use of high rise structures for family occupancy while endorsing such structures for elderly use.

Significant developments in housing for the elderly during 1969 included a trend toward conversion of family dwelling units, mostly in high rise apartments, to use by the elderly. This is happening in such places as Columbus, Ohio; Biloxi, Miss.; and Kansas City, Mo.

In Columbus, the Columbus Metropolitan Housing Authority is turning 280 three-bedroom apartments into 280 efficiencies and 280 one-bedroom units. Annual rentals from the converted units, now going into occupancy, plus the special Federal subsidy for the elderly, will bring an income of $342,000 compared with $180,000 gross income prior to the conversion. The increased income, together with anticipated cuts in maintenance costs because of the reduced wear and tear by elderly occupants, will strengthen the financial position of the housing authority.

As a part of its modernization program, the Biloxi Housing Authority has remodeled one of its family-type buildings to make eight units for elderly occupancy from four. Three similar conversions are planned for the future to meet the demand for low-income housing for senior citizens.

The Kansas City Housing Authority's conversion program, ready for implementation shortly, involves high-rise buildings and is also an element in the agency's modernization program.

Collaboration of Federal, State, and community agencies taking advantage of Federal grants aside from housing is bringing about services to the elderly in public housing and in the surrounding community.

Instances of such successful collaboration involving title III grants from the Administration on Aging in 1969 included Medford, Mass., and Joliet, Ill. In

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Medford, which has had volunteer senior citizen services in operation in the local housing authority's facilities for several years, the Leverett Saltonstall Senior Citizen Center, with joint Federal-local financing, now has a paid staff devoted to home health, information referral, recreation, and liaison for an extensive volunteer program.

The Joliet program, jointly supported by a Federal grant and the community, is conducted in a senior citizen's center in a 140-unit public housing project for the elderly. Activities include educational and home economics programs, personal counseling, information referral, and crafts. The center runs a gift shop which sells craft articles made by the elderly. A minibus donated to the center transports elderly to local stores, doctors, dentists for a small fee.

The development of house or resident councils is common in many of the public housing projects for the elderly over the country. These mutual-help organizations flourish without any particular stimulation, growing out of need or interest of the project residents. Floor monitors, garden clubs, security committees—these are among the friendly and helpful services provided as the result of formation of the resident councils.

A significant experiment in housing improvement for elderly welfare recipients is being conducted in four rural counties in Kentucky. Under a demonstration project sponsored by the Kentucky Department of Economic Security, deteriorated homes owned and occupied by aged families on public assistance, are repaired and made livable. Under section 1119 of the 1967 amendments to the Social Security Act, the Federal Government pays one-half the cost of the materials used to repair the dwelling up to a maximum of $500 per dwelling. The project employs work crews made up of older unemployed men (average age 56) under the supervision of the OEO-funded Housing Development Corporation. At the end of the first year's operation, over 500 homes had been repaired and brought up to livable condition, and between 50 and 60 unemployed men had been trained in repair and rehabilitation work. This program seems to warrant expansion and use in other States and localities as part of a housing improvement program.

The direct loan program

Section 202 of the Housing Act of 1959, as amended, authorizes HUD to make long-term, low-interest loans to nonprofit organizations, and consumer cooperatives, and certain public agencies to build rental housing for the elderly and physically handicapped. These groups are eligible for loans covering up to 100 percent of total development cost. The 1968 Housing Act added limited profit sponsors to those eligible under the program, but limited the loans to not more than 90 percent of development cost.

The maximum rate of interest is 3 percent, and loans may be made for periods of up to 50 years. The program is intended to provide assistance for housing for lower middle income elderly.

During the first 9 months of the year 1969, net applications were received for 38 projects with over 6,300 units requiring loans of about $99.5 million.

During the first 9 months of the year, 25 projects with some 3,000 units and loans of nearly $42 million were approved, bringing the cumulative total up to 338 projects with almost 45,700 units and over $571 million.

As of the end of September 1969, the pipeline of applications on hand, not yet approved, amounted to 115 projects with requests to fund 17,390 units with loans of approximately $230.4 million. In addition, it is estimated that sponsors were developing applications for loans amounting to about $300 million.

Construction starts during the first three-quarters of 1969 amounted to over 5,800 units in 37 projects with loans of over $81.5 million. This brought the cumulative totals up to 287 projects, over 39,000 units and loans of almost $487 million.

During this same 9-month period, 25 projects with about 4,400 units were completed, involving loans of almost $52.8 million. These brought the cumulative total of completed projects up to 220 projects involving some 27,800 units and loans of some $334.4 million.

Housing for senior citizens under section 236

The 1968 Housing and Urban Development Act authorized the section 236 program which may be used to assist in financing housing for all age groups, as well as housing specially designed for the elderly and handicapped. This program provides assistance in the form of periodic payments to the mortgagee financing the housing to reduce the mortgagor's interest costs on a market rate FHA-insured project mortgage.

The interest-reduction feature reduces payments on the project mortgage from that required for principal, interest, and mortgage insurance premium on a market rate mortgage to that required for principal and interest on a mortgage bearing an interest rate of 1 percent.

These payments reduce rentals to a basic charge, and a tenant either pays the basic charge or such greater amount as represents 25 percent of his income, but not in excess of the charges which would be necessary without any interest-reduction payments.

Tenants who pay less than the fair market rental charge for their units generally will have to have incomes, at the time of the initial rent-up of the projects, not in excess of 135 percent of the maximum income limits that can be established in the area for initial occupancy in public housing. However, up to 20 percent of the contract funds authorized in appropriation acts may be made available for projects in which some or all of the units will be occupied, at the time of the initial rent-up, by tenants whose incomes exceed the above limit, but do not exceed 90 percent of the income limits for occupancy of section 221(d)(3) below-market rate rental housing.

To qualify for mortgage insurance under this new program, a mortgagor must be a nonprofit organization, a cooperative, or a limited dividend entity. Mortgage limitations are the same as for mortgages insured under the section 221(d)(3) program. Interest-reduction payments also can be made with respect to part of a mortgage on a rental or cooperative housing project financed under a State or local program.

Contracts for assistance payments are authorized, subject to approval in appropriation acts, in the amount of $75 million annually, prior to July 1, 1969. The 1969 Housing Act increased this amount by $125 million on July 1, 1969, and by $125 million on July 1, 1970, and by $170 million on July 1, 1971.

A project financed under this program can include nondwelling facilities to serve the occupants of the project and the surrounding neighborhood, as long as the project is predominantly residential and any nondwelling facilities contribute to the economic feasibility of the project. Where a project is designed primarily for occupancy by the elderly or handicapped, it can include related facilities for their use, such as dining, work, recreation, and health facilities.

Projects for the elderly or handicapped approved for direct loans can be refinanced under this new interest-reduction program at any time up to, or a reasonable time after, project completion.

During the year 1969, 62 projects received preliminary or formal reservations of funds of nearly $6.9 million for a total of almost 8,900 dwelling units involving mortgage insurance of about $129 million. Nineteen of these projects were proposed originally under section 236, while 43 were proposed under the section 202 direct loan program and then modified financially for funding under the section 236 insured mortgage program with interest-reduction payments.

Status of the 202 direct loan program

All available loan funds have been committed. Section 202 proposals now are being financed under section 236.

In 1969 responsibility for the administration of the section 202 direct loan program was transferred from the Housing Assistance Administration to the Federal Housing Administration. In furtherance of this transfer of responsibility, instructions have been issued for financing unfunded section 202 proposals in the application stage and refinancing funded section 202 projects under section 236. The new special assistance program number 17, known as the tandem plan, which is characterized by joint assistance from FNMA and GNMA should, by providing for par financing, be of indispensable assistance in converting section 202 direct loan proposals to section 236 rental assistance projects.

Other steps taken to facilitate this administrative change include reconciling differences in application and processing forms, adapting FHA agreements and contract forms for use with senior citizen housing proposals eligible for conversion, and working toward standardization and decentralization of processing and approval procedures.

While these transitional actions are being taken, the objective of maintaining a clearly identifiable elderly housing program is not being obscured.

FHA section 231—Mortgage insurance for rental housing for the elderly

This program administered by FHA insures lenders against losses on mortgages for construction or rehabilitation of rental housing for the elderly. The authority contained in section 231 was added to the National Housing Act in 1959. Prior

to the enactment of section 231, FHA mortgage insurance assistance for housing for the elderly was available under the section 207 program, pursuant to legislation enacted in 1956.

This program involves market interest rates and serves a higher income group than that served by public housing or the direct loan program. It has suffered a high percentage of losses, serves only marginal purposes, and has been little used in the past 5 years.

As of the end of September 1969 cumulative commitments under this program had been issued for 281 projects, with over 43,000 units and mortgage insurance amounting to over $530 million. During the first 9 months of 1969, no new commitments were issued under the 231 program.

Rent supplements under the section 202 and section 231 program

Five percent of the rent supplement funds may be used to assist low-income elderly or handicapped occupants of section 202 and section 231 senior citizens housing projects under the experimental provisions of the rent supplement program. As of the end of September 1969 almost $2.8 million of the $3,100,000 available for these two programs had been allocated. These allocations have been made for 172 projects in 127 cities in 36 States and Puerto Rico. It is estimated that these allocations of funds will provide assistance for over 4,000 occupants of approximately 2,677 units included in these projects.

By the end of September 1969, 132 of the section 202 projects were receiving rent supplement payments, while 163 had rent supplement contracts or formal reservations for rent supplements. Eight of the nine section 231 projects participating in the program were receiving payments.

Rent supplement activity under the FHA section 221(d)(3) market rate program

In addition to the foregoing, as of the end of September 1969, a total of 39 rent supplement projects were being planned for occupancy for the elderly and handicapped under FHA's section 221(d)(3) market interest rate mortgage insurance program. These projects involve formal reservations or contracts for annual rent supplements totalling some $2.7 million and will contain about 2,730 dwelling units, practically all of which will be available for occupancy by families benefiting from assistance.

FHA mortgage insurance nursing home program

Section 232 of the National Housing Act authorizes the FHA to provide mortgage insurance for proprietary nursing homes and those sponsored by private nonprofit corporations or associations. The Housing and Urban Development Act of 1968 authorized payment of major nonrealty equipment from mortgage proceeds. There is a statutory limit of $12.5 million per project under this program. Within this limit, the maximum insurable mortgage amount is 90 percent of the FHA-estimated value of the project and equipment at completion. The maximum mortgage maturity period is 20 years and the current maximum interest rate is 8½ percent effective January 5, 1970, plus one-half of 1 percent mortgage insurance premium. Each project covered by mortgage insurance under this program must consist of not less than 20 nursing beds. A certificate of need is requested from the appropriate State agency certifying to the need for the nursing home.

Joint financing through a combination of FHA mortgage insurance and a Federal grant or loan made by the Department of Health, Education, and Welfare under the Hill-Burton Act is permissible for nonprofit nursing homes.

As of December 1969, there were at least 10 nursing home projects which involved joint FHA-Hill-Burton financing. Two (in Atlanta, Ga., and Phoenix, Ariz.) were in operation. Two more (in Denver, Colo., and Fairlea, W. Va.) were under construction. One project in Beaumont, Tex., has been approved and applications are in process for homes in Horse Cave, Ky., and Columbus, Ohio.

During the first three quarters of 1969, the FHA approved applications for 84 nursing homes planned to contain some 10,100 beds and for mortgage insurance of nearly $88 million. A total of 638 nursing homes have been insured from the beginning of the program through September 1969, with original mortgages totalling $450.9 million. They contain about 62,600 beds. Included in the foregoing figures are 82 nursing homes placed under construction during the first three quarters of 1969.

Expansion of the FHA nursing home program to include intermediate care facilities

The 1969 Housing Act expanded the FHA nursing home program to provide mortgage insurance for intermediate care facilities. The purpose of the program is to help provide facilities for persons who, while not in need of nursing home

care and treatment, nevertheless are unable to live fully independently, and who are in need of minimum, but continuous care by licensed or trained personnel.

Before this program becomes operational, HUD will consult with HEW with respect to any health or medical aspects of the program.

Supplemental loans

Supplemental loans, under section 241 of the National Housing Act, may be insured by FHA to pay for alterations, repairs, additions, or improvements to any multifamily housing project financed with an FHA-insured mortgage. These loans may also be for the purchase of equipment for operation of nursing homes or group medical practice facilities.

A loan under this section is limited to 90 percent of the FHA estimated value of the improvements, additions and equipment, except that the amount of the supplemental loan when added to the outstanding balance of the insured project mortgage shall not exceed the maximum insurable loan under the section or title by which the outstanding mortgage was insured.

The term of a loan under this section cannot exceed the remaining term of the outstanding mortgage. The interest rate, effective January 5, 1970, is 8½ percent, plus one-half of 1 percent mortgage insurance premium.

This program can be of assistance in modernizing and/or expanding an existing project or facility without the added expense of refinancing the existing insured mortgage.

Neighborhood facilities

A program of grants to local public bodies or agencies to finance neighborhood facilities projects was established by section 703 of the Housing and Urban Development Act of 1965. The program provides grants, normally two-thirds of the development cost of such facilities, except in areas designated under the Area Redevelopment Act, which may receive grants of up to three-fourths of the development cost.

A center must be multiservice by offering a wide range of health, welfare, education, social, recreational, and other similar community services. Priority is given to those projects which are designed primarily to benefit low-income families or otherwise substantially further objectives of a local community action program approved under title II of the Economic Opportunity Act of 1964.

The types of services offered to senior citizens in a neighborhood facility are varied and include health services, recreational and social activities, employment programs, welfare and social security services and legal aid. A substantial number of neighborhood facilities plan to have senior citizen components and services. Approximately 40 percent of approved projects will offer senior citizen programs.

Home rehabilitation loans and grants

Section 312 of the Housing Act of 1964, as amended, authorizes HUD to make direct Federal loans to finance the cost of rehabilitating property in federally aided urban renewal areas or concentrated code enforcement projects. Legislation was enacted in 1965 to permit HUD to make direct Federal grants under section 115 of title I of the Housing Act of 1949, as amended, to finance the rehabilitation of structures located in federally aided urban renewal areas or concentrated code enforcement projects. Both of these programs are administered by HUD's Renewal Assistance Administration. A significant difference between these two programs and most programs administered by HUD is that these loans and grants are made to individuals directly rather than through local public agencies or other private profit-motivated or nonprofit groups.

Prior to the enactment of these direct loan and grant programs, low income homeowners in blighted areas were severely limited in their ability to secure financing to rehabilitate their properties. As a result, their properties would continue to run down and eventually be subject to clearance. As a result of the rehabilitation loan and grant programs, families in federally aided urban renewal and concentrated code enforcement areas may receive direct Federal financial assistance. A substantial number of these families are elderly, and the availability of this direct assistance is of particular importance to such families, since the other deterrents which the conventional money market places on them are aggravated and compounded by their age.

Any families owning and occupying the one-to-four family dwellings in federally aided urban renewal or concentrated code enforcement areas whose incomes are $3,000 or less are eligible for a grant of $3,500 of the cost of rehabilitation, whichever is less. Families with incomes of more than $3,000 also are eligible if their

housing expense exceeds 25 percent of income. These families also are eligible for the direct 3 percent 20-year loans. These loans, not to exceed $12,000, or up to $16,400 in high-cost areas, are available primarily for rehabilitation. However, in special cases where the sum of the monthly payments on existing debt related to the property and the proposed rehabilitation loans would exceed 20 percent of the family's income, the rehabilitation loan also could be used to refinance the family's existing debt. This combination often serves not only to make the rehabilitation possible, but at the same time to reduce substantially the monthly payments which the family has to make on its property. In many cases, the owner-occupant family is able to qualify for a combination loan and grant, and this assistance is particularly meaningful to the elderly.

During the period January 1 through September 30, 1969, more than 3,100 direct loans, covering 5,200 dwelling units for about $21 million were approved. Over 6,500 loans covering 11,300 dwelling units for over $38 million had previously been made since the inception of the program through December 31, 1968. With regard to the grant program, approximately 4,500 grants were approved for over $12 million during the first 9 months of calendar 1969, as compared with cumulative approvals through December 31, 1968, of about 8,600 cases for over $13.8 million. About 60 percent of the approved grants and 20 percent of the approved loans have been in cases where the head of household was age 62 or over.

The rehabilitation workload in urban renewal and concentrated code enforcement areas continues to be very large. As indicated by the rapid expansion of grants and loans approved under these programs since their inception, they are helping to meet the need and are expected to continue expanding their roles as a major force in the rehabilitation of blighted areas.

Group practice facilities program

The Demonstration Cities and Metropolitan Development Act of 1966 authorizes HUD, under title XI of the National Housing Act, to insure mortgage loans financing the construction or rehabilitation of, and the purchase of equipment for facilities for the group practice of medicine, dentistry, or optometry. The program is administered by the FHA which receives technical guidance and assistance covering medical and health aspects of the program from the public health service of the Department of Health, Education, and Welfare.

Group practice makes possible more efficient use of scarce manpower and costly health care facilities and equipment. It can be particularly beneficial to small communities and low-income urban areas where adequate health facilities of a comprehensive nature may not otherwise be available. In addition, costly hospitalization can be significantly reduced where the group practice is combined with a comprehensive prepayment plan. This new FHA program was conceived in recognition of the potential of group practice in delivering efficient, comprehensive health services of high quality. It is intended to assure the availability of credit on reasonable terms to finance construction and equipment of medical, dental, and optometric group practice facilities.

Under the law, a group practice project may be sponsored by a group or organization which will either own and operate the proposed facility as a nonprofit unit, or will create a separate nonprofit entity to own the facility. Payment for health services provided by the group may be on either a prepayment or a fee-for-service basis.

The maximum mortgage is $5 million and a loan-to-replacement cost limitation of 90 percent of the FHA estimate of the value of the property, including equipment, covered by the mortgage. The term of the mortgage may be up to 25 years and the maximum interest rate is now 8½ percent, effective January 5, 1970, plus one-half of 1 percent mortgage insurance premium.

The Office of Economic Opportunity (OEO) can provide equity and operating funds for a group practice facility in conjunction with an FHA-insured mortgage. This is in accordance with an OEO program to provide health care for low-income people. The group practice program should be of particular benefit to senior citizens.

Nonprofit hospitals

The 1968 Housing Act authorized FHA to insure mortgage loans on nonprofit hospitals for construction or rehabilitation, including equipment to be used in the operation, under section 242.

The maximum interest rate on these loans is 8½ percent (effective January 5, 1970) plus one-half of 1 percent mortgage insurance premium and the maximum term is 25 years. The maximum insurable loan is 90 percent of the estimated replacement

cost of the building and major equipment, with the limit of $25 million for any one loan. Before insuring any mortgage under section 242, a certificate of need must be obtained from the appropriate State agency certifying that there is a need for the hospital.

A memorandum of agreement has been signed between HEW and HUD under which HEW processes hospital facility proposals under the mortgage insurance program, through its regional offices, using Hill-Burton procedures and construction and design standards. A Hill-Burton grant may be combined with an FHA-insured loan.

This program became operational in May 1969. As of October 1969, two hospital loans had been insured, and firm commitments have been given on four additional proposals. A number of hospital proposals are being processed by HEW and FHA.

Operation breakthrough

The purpose of Operation Breakthrough is to foster the development and spread of volume housing production systems which utilize innovative building materials and building techniques, imaginative site designs, and advanced systems of production, management and marketing. To initiate this program, HUD is sponsoring the construction of 10 prototype developments located at selected sites in various parts of the Nation, and utilizing approximately 20 complete building systems, competitively selected and developed by an equal number of private firms or consortia of firms.

The primary purpose of the prototype developments is to demonstrate the advantages stemming from the use of advanced volume housing production systems. Lower construction costs, to be reflected in lower sales and rental prices, as well as improved overall quality, should be among the advantages of housing produced by breakthrough housing systems producers.

Following the development of the prototype sites, and the completion of a testing and evaluation of the different volume housing production systems, the Breakthrough housing systems producers will be marketing their housing product as HUD-certified systems. The advantages in Breakthrough housing production systems will therefore be available to the public at large, which includes the aged. In addition, HUD will attach a special priority in the allocation and processing of its housing assistance subsidy funds, including those programs which are utilized primarily for housing for the elderly, for developments that will utilize Breakthrough housing production systems. Finally, elderly persons will be interested in buying or renting housing units in the 10 Breakthrough prototype demonstration developments, and some HUD housing subsidy funding will be made available where such assistance is required.

Model cities

The model cities program is a comprehensive attack on the social, economic and physical problems of selected blighted areas. It does not stop with a "job" solution, or a "housing" solution, or a "transportation" solution. Rather, it relates all of these needs to a comprehensive plan to upgrade the life of a neighborhood. For the low income aging persons in the model neighborhood, this approach is most vital. Their problems are so often multiple and interrelated. The need for health services is often vitally linked to inadequate transportation facilities to bring the person to treatment centers. Inadequate housing often contributes to the health problems of the elderly. The lack of job and recreational opportunities often contributes to the deteriorating health problems of the aging. In short, the comprehensive nature of the model cities approach can meet the most constant and justified criticisms of public and private services to the elderly—fragmentation, isolation, and intermittent attention.

It is Model Cities Administration (MCA) policy to review the submissions of cities in the light of the needs of all groups within the model neighborhood. A program would not be considered "comprehensive" if it fails to analyze and meet the needs of all significant interest groups within the neighborhood. The elderly, the low income older American, is one of the most significant of the poverty groups within our cities. It is a group that no model city can disregard if that city wishes to mount a comprehensive program.

Advocates for older persons are aware of the difficulty of serving and involving the elderly, especially the low income elderly, in publicly supported programs. Too often, health centers established to serve the "whole" community turn out to be child care and obstetric clinics, without the capacity to serve the health needs of the chronically ill. Too often, federally supported employment programs concentrate their activities on youth to the exclusion of middle aged and older

unemployed persons. Even private welfare rights efforts sometimes neglect the elderly, even though old age assistance recipients are the largest number of adults receiving welfare assistance.

The model cities program has made significant approaches to the needs of the elderly within the model neighborhoods during the past year. An analysis has identified over 50 components in the first 30 cities funded which directly or indirectly will benefit the aging. These programs deal with the problems of health, employment, transportation, housing, leisure time, consumer choices, homemaking, coordination of older persons services, and the like.

However, some of these programs do not adequately interrelate need and solution. Too often, the components in some of the earlier model cities tended to be isolated projects meeting one or more pressing needs of the aging within the neighborhood. In few cities have the programs indicated a systematic examination of the across-the-board needs of the elderly and a long-term plan to meet these needs. Too often, the plans neglected to show how existing services are being reexamined and reshaped to better serve the elderly. In too few cases did the elderly themselves and the agencies which have been serving the elderly become involved in the planning of the program. Finally, too many of the programs showed a single component for the elderly and failed to clearly show how the other components—employment, housing, legal services, health, consumer affairs, physical planning, economic development—would be certain to serve the elderly as a major interest and need group in the community.

During the past year, HUD and the Administration on Aging met to discuss their mutual concern that the model cities program effectively involve all possible resources to serve the aging. Some concrete results have been achieved.

In four States—Connecticut, Michigan, Georgia, and New Jersey—statewide meetings of cities and older persons groups and agencies have been conducted. These meetings were held under the joint sponsorship of the Administration on Aging and the Model Cities Administration at the Federal and regional levels, and the State agencies on the aging and model cities at the State level. These meetings have served to achieve an acceleration of comprehensive planning with and for the elderly and specialized agencies. The resources of the State agencies and their grantees are being linked with those of the cities.

It is hoped that out of these meetings clearer interagency guidelines and program approaches to meet the needs of the aging in model cities will be achieved. It is hoped that these kinds of meetings will be extended to all 50 States in the coming months. In cooperation with the Administration on Aging, the School of Social Work at the University of Syracuse, and the city of Seattle, HUD has collaborated on a national model cities program development conference to be held in January 1970. Staff from some 15 model cities, together with top private and governmental practitioners in the field of aging, will meet for 3 days to achieve clearer definitions of program approaches to the needs of older Americans in model cities programs.

In addition, MCA is working with the University of Syracuse and the Administration on Aging to develop program guidelines for model cities. This effort is, incidentally, being funded through a contract between the University of Syracuse and the Administration on Aging—a fine example of interagency effort.

For fiscal year 1970, MCA has tentatively allocated some $200,000 for technical assistance in the field of aging. This marks a major emphasis program in the current fiscal year.

While much of this represents substantial progress, MCA cannot, with confidence, say that it represents a full response to the need. In research developed during 1968, it was shown that in some model neighborhoods, as many as 26 percent of the population (Texarkana, Tex.) are over the age of 65, and in some cities 90 percent of the elderly are old age assistance recipients. If the age of the target population is reduced to 55, as OEO has done, we are talking about more than a third of the population in some neighborhoods. MCA believes that such concentrations of older persons in many cities requires clearer policy and guidance to the model city agencies on what they must do to show equity for the elderly in the development of their programs. MCA is developing such a policy which will be issued shortly by the Model Cities Administration to all cities participating in the program.

HUD believes that the model cities program offers a new laboratory to test out new ways to involve and serve the elderly. The program offers an effective mechanism to coordinate and consolidate Federal, State, and local services on behalf of the elderly. Through cooperation with the Administration on Aging, as well as with other public and private agencies, we can achieve the goal of a

materially secure life for older Americans, together with their full participation as members of the urban community.

CONCLUSION

HUD's contributions to the development of housing specially designed for the elderly and handicapped continued at a high level during 1969, and commitments in this field exceeded those of 1968. From program inception (1956) through the end of September 1969, the cumulative number of dwelling units for which commitments had been issued under the several senior citizens programs had risen to nearly 326,000. In terms of people, these dwellings, when completed, will house some 408,000 senior citizens. Other hundreds of thousands of elderly people live in HUD-assisted housing provided for families of all ages and in nursing homes. Commitments on nursing home beds from program inception through September 1969, amounted to almost 62,600 beds.

In addition to retaining a high level of housing commitments this year, the Department also has initiated a number of organizational changes in order to relate more closely the programs for the older population. The central office staff of the section 202 direct loan program was transferred to FHA, facilitating the phasing of the section 202 program into the section 236 program. This new office handles central office processing of all programs for the elderly except public housing. The new arrangement permits HUD to more closely relate operating experience and data between the various senior citizen housing programs, and thus, more effective assistance to sponsors interested in one or more financing mechanisms is anticipated. Responsibility for housing for the handicapped also is lodged in this new office.

Particular attention was paid to special aspects of the housing market for the elderly. This included housing in the community for former patients of mental hospitals, consideration with respect to the location, planning and design of housing for the elderly of certain ethnic groups to promote increasing utilization of programs for which they were eligible, and the special concerns of the rural nonfarm elderly.

With the passage of the intermediate care facilities program in 1969, assistance for yet another group is possible—those frail elderly who need daily services, but not the skilled and costly care of a nursing home. Vendor payments under the 1967 Social Security Amendment will make intermediate care facilities usable by recipients of old age assistance, aid to the blind and aid to the disabled.

The year 1969 also was marked by increased participation by HUD personnel in university lectures and seminars related to housing for the elderly, thus helping to increase the number of trained staff to operate housing and related facilities for the older population. Participation in international, national, and State and local meetings in great variety also brought the housing message to interested sponsoring groups, and afforded valuable opportunities for exchange of research and operating data and experience. Requests for HUD's participation in preretirement seminars increased during the year; addresses were given at numerous training sessions sponsored by both Government agencies and private groups.

The increase in housing production and variety will provide more and more choices of living arrangements, and the individual can anticipate getting closer to the right environment, the right home and in the right setting as these relate to his health, income and interests. With the continuation of the trend toward early retirement generally with decreased incomes, with the increase of life span, with the growing readiness to adjust living patterns in the later years, and because huge numbers of elderly people still occupy deficient housing, we can anticipate a continuing need to expand our efforts to reach the goal of decent and appropriate housing for all senior citizens.

ATTACHMENTS

1. Annual statistics—Cumulative through December 31, 1968—Public housing program for the elderly.
2. Statistics—Public housing program for the elderly—January 1–September 30, 1969.
3. Annual statistics—Cumulative through December 31, 1968—Section 202 direct loan program for the elderly.
4. Statistics—Section 202 direct loan program for the elderly—January 1–September 30, 1969.

5. Annual statistics—Cumulative through December 1968—Sections 207 and 231 programs for the elderly.
6. Annual statistics—Cumulative through December 31, 1968—Section 232 nursing home program.
7. Statistics—Section 232 nursing home program—January 1–September 30, 1969.
8. Highlights of nursing home survey, 1969.

FEDERALLY AIDED PUBLIC HOUSING PROJECTS WITH ALL OR SOME UNITS DESIGNED SPECIFICALLY FOR THE ELDERLY, WITH ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED, CUMULATIVE THROUGH DEC. 31, 1968

State or territory	Total public housing units for the elderly	Projects with all units for the elderly		Projects with some but not all units for the elderly	
		Number of projects	Number of units	Number of projects	Number of units
Total	183,154	1,163	112,274	1,548	70,880
Alabama	3,356	19	1,127	109	2,229
Alaska	25			1	25
Arizona	187	1	96	4	91
Arkansas	3,153	24	1,337	82	1,816
California	7,871	24	2,163	38	5,708
Colorado	903	9	803	7	100
Connecticut	3,687	43	3,345	7	342
Delaware	503	2	383	3	120
District of Columbia	1,960	6	1,085	9	875
Florida	5,439	27	3,499	31	1,940
Georgia	4,145	23	1,968	97	2,177
Hawaii	714	4	422	6	292
Idaho	170	4	170		
Illinois	14,966	98	10,601	114	4,365
Indiana	3,679	22	3,358	17	321
Iowa	848	11	777	4	71
Kansas	1,846	8	676	15	1,170
Kentucky	3,829	19	2,116	83	1,713
Louisiana	3,162	13	732	63	2,430
Maine	482	4	482		
Maryland	1,784	8	786	9	998
Massachusetts	9,360	70	6,474	19	2,886
Michigan	6,728	61	5,756	26	972
Minnesota	8,879	55	6,388	16	2,491
Mississippi	155	1	30	9	125
Missouri	3,338	15	1,216	36	2,122
Montana	16			2	16
Nebraska	4,362	68	3,411	19	951
Nevada	559	2	275	4	284
New Hampshire	1,559	16	1,205	4	354
New Jersey	12,728	80	11,027	35	1,701
New Mexico	557	4	192	17	365
New York	18,238	43	5,271	112	12,967
North Carolina	3,189	15	1,831	63	1,358
North Dakota	443	8	368	2	75
Ohio	10,083	54	6,077	27	4,006
Oklahoma	2,959	12	1,346	47	1,613
Oregon	2,419	11	871	9	1,548
Pennsylvania	10,324	67	6,311	75	4,013
Puerto Rico	170	1	50	12	120
Rhode Island	4,170	34	3,870	1	300
South Carolina	714	5	377	8	337
South Dakota	147	2	73	11	74
Tennessee	4,691	24	2,911	88	1,780
Texas	5,401	64	3,954	156	1,447
Utah					
Vermont	155	2	130	1	25
Virginia	421	1	50	7	371
Virgin Islands	159	1	85	7	74
Washington	3,726	37	3,177	12	549
West Virginia	960	5	550	14	410
Wisconsin	3,835	36	3,072	10	763
Wyoming					

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Alabama:			
Ashland [1]	60	24	1,055
Atmore [1]	100	10	1,732
Carrollton [1]	50	18	822
Clanton	50	50	675
Clayton [1]	40	8	719
Dadeville	74	24	1,271
Dothan [1]	300	75	5,157
Evergreen [1]	80	24	1,379
Fort Payne	100	50	1,646
Gordo [1]	50	26	799
Hackleburg [1]	20	8	299
Hartford [1]	36	20	544
Kinston [1]	10	2	170
Samson [1]	40	5	663
Total, Georgia	1,010	344	16,931
Arizona:			
Flagstaff [1]	197	50	4,780
Pinal County [1]	300	20	6,548
Total, Arizona	497	70	11,328
Arkansas:			
Blytheville	100	70	1,663
Camden	150	30	2,508
Coal Hill	20	12	332
Dumas	50	14	805
Howard	100	30	1,699
Mena	56	20	936
North Little Rock	221	221	3,623
Searcy [1]	50	36	830
Springdale	170	50	2,695
West Helena	100	34	1,645
West Memphis [1]	250	50	4,150
Total, Arkansas	1,267	567	20,883
California:			
Alameda [1]	350	50	7,663
Alameda County [1]	500	66	11,167
Berkeley [1]	610	10	14,288
Butte County [1]	400	160	8,915
Contra Costa County [1]	521	120	11,976
Eureka [1]	250	85	5,258
Fairfield [1]	250	30	5,401
Kern County [1]	400	80	8,525
Long Beach [1]	600	190	12,707
Los Angeles County [1]	1,000	425	21,826
Novato area	40	40	672
Pinedale	50	8	929
Riverside County [1]	1,100	200	27,280
Sacramento [1]	500	75	11,440
Sacramento County [1]	500	250	11,372
San Diego [1]	1,000	50	26,063
San Francisco	142	142	2,764
San Francisco [1]	500	300	13,698
San Jose [1]	500	75	19,140
San Luis Obispo [1]	150	35	3,268
Suisum City [1]	150	12	3,391
Tulare County [1]	200	5	4,969
Total, California	9,713	2,408	232,712
Colorado:			
Denver	200	200	3,517
Haxtun	22	18	365
Total, Colorado	222	218	3,882

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Connecticut:			
Meriden	161	161	2,803
New Haven	116	116	2,053
Norwalk	49	49	755
Norwick	29	29	511
Stamford [1]	100	40	2,083
Torrington	200	200	3,451
Total, Connecticut	655	595	11,656
Delaware: Wilmington	61	13	1,025
District of Columbia: Washington	480	388	9,148
Florida:			
Brevard County	100	100	1,203
Cocoa [1]	50	50	556
Gainesville [1]	100	100	1,151
Jacksonville [1]	450	50	11,141
Key West	200	200	3,433
Lake Butler	40	20	629
Lakeland [1]	200	200	2,302
MacClenny	80	12	1,356
Miami [1]	500	100	10,640
Orlando [1]	600	200	10,472
Springfield [1]	100	20	1,774
Tampa [1]	293	43	5,759
Total, Florida	2,713	1,095	50,416
Georgia:			
Buena Vista [1]	30	8	546
Colquitt	40	16	653
Eastman	50	10	872
Lithonia [1]	100	40	1,672
Lyerly [1]	25	6	350
Menlo [1]	50	6	791
Plains [1]	12	10	180
Quitman	60	20	999
Rome [1]	60	24	598
Thomaston	200	60	3,046
Vienna [1]	40	10	742
Total, Georgia	667	210	10,449
Hawaii: Honolulu [1]	200	50	4,252
Idaho: American Falls	40	30	639
Illinois:			
Aurora [1]	260	217	3,917
Camp Point	24	16	385
Champaign [1]	60	20	1,304
Clayton	22	16	349
De Kalb	150	150	2,228
Dix [1]	12	8	227
Elgin	150	150	2,270
Evanston [1]	100	30	2,195
Franklin County	52	52	756
Henry County	51	51	760
Jefferson County	50	50	750
Joliet	200	200	2,993
McComb	109	109	1,628
Mt. Carmel	119	119	1,803
Massac	12	6	211
Monmouth	120	120	1,791
Payson	10	10	150
Peoria	202	202	3,030
Pittsfield	72	72	1,080
Pontiac	90	90	1,344
Princeton	105	105	1,572
Randolph County [1]	46	38	855
Shelbyville	65	65	966
Springfield	111	111	1,719
Spring Valley	71	71	1,064
Sycamore	74	74	1,102
Urbana [1]	50	20	1,051
Waukegan	155	155	2,311
Total, Illinois	2,542	2,327	39,811

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Indiana:			
Elkhart	127	127	1,901
Gary [1]	75	15	1,463
Richmond	105	105	1,662
Rockport	40	40	601
Total, Indiana	347	287	5,627
Iowa:			
Cedar Rapids [1]	220	86	4,119
Iowa City [1]	250	130	4,759
Manning	30	30	447
Winterset	46	46	686
Total, Iowa	546	292	10,011
Kansas:			
Augusta	62	42	1,113
Beloit	50	50	775
Luray	12	12	207
North Newton	50	50	778
Norton	44	44	726
Parsons	100	100	1,715
Wellington	100	100	1,644
Wichita	148	148	1,612
Total, Kansas	566	546	8,570
Kentucky:			
Bowling Green [1]	200	50	3,697
Carrollton	60	20	1,073
Corbin [1]	76	76	1,188
Greenville	50	24	856
Madisonville [1]	80	50	1,238
Morganfield	66	26	1,106
Owingsville	24	12	476
Prestonburg	78	30	1,306
Richmond	200	100	3,490
Williamsburg	50	30	924
Total, Kentucky	884	418	15,354
Louisiana:			
Donaldsonville	100	30	1,755
Merryville [1]	30	10	489
Parish of Assumption [1]	180	50	2,933
St. Charles [1]	84	36	1,343
Sulphur [1]	140	40	2,259
Ville Platte	50	12	878
Vivian	30	8	483
Westwego	100	40	1,679
Total, Louisiana	734	236	12,195
Maine:			
Lewiston	153	153	2,430
Portland [1]	150	30	3,901
Waterville [1]	75	30	1,427
Total, Maine	378	213	7,758
Maryland:			
Glassmanor	123	123	1,907
St. Michaels	36	6	643
Total, Maryland	159	129	2,550
Massachusetts:			
Brockton [1]	350	50	8,844
Fall River [1]	200	100	4,424
Holyoke	200	90	4,346
Lawrence	105	105	1,745
Lawrence [1]	200	100	4,265
Lynn [1]	100	75	2,597
Malden	124	124	2,109
Malden [1]	50	30	943

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Massachusetts—Continued			
New Bedford	300	150	5,980
Quincy [1]	300	100	7,486
Somerville [1]	50	50	874
Springfield	32	32	494
Waltham [1]	50	50	850
Worcester	86	86	1,271
Total, Massachusetts	2,147	1,142	46,228
Michigan:			
Allen Park	61	61	928
Battle Creek	100	100	1,617
Big Rapids	75	66	1,200
Boyne City	40	24	713
Lansing	188	188	2,902
Menominee	128	99	2,066
Monroe	263	148	4,760
Pontiac	197	197	3,043
Rogers City	42	42	648
Saginaw	95	95	1,490
Total, Michigan	1,189	1,020	19,367
Minnesota:			
Alexandria	107	107	1,605
Aitkin	60	60	899
Bagley [1]	36	36	544
Chisholm	41	41	595
East Grand Forks	75	75	1,121
Ely	40	40	594
Grand Rapids	50	50	747
Luverne	76	76	1,134
Minneapolis [1]	1,566	1,566	23,753
Montgomery	41	41	618
Park Rapids	71	71	1,065
St. Cloud	215	215	3,322
St. Peter	71	71	1,065
Sleepy Eye	50	50	694
Tracy	60	60	881
Worthington	104	104	1,545
Total, Minnesota	2,663	2,663	40,182
Mississippi:			
Alcorn County	144	20	2,897
Brookhaven	116	30	1,894
Chickasaw County	100	20	2,012
Itawamba County	100	20	2,012
Lee County	154	20	3,098
Meridian [1]	500	125	8,653
Monroe County	100	20	2,012
Pontotoc County	60	20	1,207
Prentiss County	100	20	2,012
Tippah County	72	20	1,448
Tishomingo County	70	20	1,408
Union County	100	20	2,012
Total, Mississippi	1,616	355	30,665
Missouri:			
Bethany	80	36	1,353
Brunswick	32	20	552
Chaffee	50	16	890
Chillicothe	100	60	1,627
Excelsior Springs	120	70	2,036
Jefferson	100	100	1,817
Mexico	52	26	823
Mountain Grove	60	40	1,035
Sedalia [1]	200	50	3,517
St. Joseph [1]	300	71	5,448
St. Louis	275	275	5,024
St. Louis County [1]	100	30	2,016
Total, Missouri	1,469	794	26,138
Montana: Whitefish	50	50	835

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Nebraska:			
Cairo	18	18	273
David City	20	20	296
Hemingford	20	20	297
Sutherland	20	20	289
Tecumseh	24	24	358
Weeping Waters	20	20	291
York	82	82	1,220
Total, Nebraska	204	204	3,024
Nevada: Las Vegas	200	200	3,864
New Hampshire:			
Exeter [1]	100	100	1,826
Laconia	100	25	2,039
Manchester [1]	100	74	1,882
Somersworth [1]	20	20	353
Total, New Hampshire	320	219	6,100
New Jersey:			
Bergen County [1]	1,000	1,000	16,130
Cliffside Park	254	254	4,610
Guttenberg [1]	100	75	1,724
New Brunswick [1]	90	7	1,958
North Bergen	252	252	4,887
Total, New Jersey	1,696	1,588	29,309
New Mexico: Albuquerque [1]	200	50	3,535
New York:			
East Rochester [1]	12	7	260
Fort Edward [1]	50	25	1,098
Greenburgh	115	30	2,690
Hempstead	184	184	3,634
Hudson [1]	24	5	526
Lockport [1]	172	172	3,100
New York	733	499	14,755
New York [1]	500	215	10,383
Norwich	28	28	538
Poughkeepsie	103	59	1,983
Tupper Lake	70	32	1,415
Utica	108	108	1,829
Watertown	150	150	2,960
Yonkers [1]	50	5	1,165
Total, New York	2,299	1,519	46,336
North Carolina:			
Charlotte	298	298	4,674
Hendersonville	48	20	997
King Mountain [1]	50	10	959
Lincolnton [1]	50	10	860
Statesville [1]	100	24	1,821
Wilson	125	44	2,034
Rocky Mount	200	50	3,405
Total, North Carolina	871	456	14,750
North Dakota:			
Fargo	250	250	3,645
Mandan	86	80	1,497
Williston	49	49	725
Total, North Dakota	385	379	5,867
Ohio:			
Akron	243	243	3,745
Ashtabula	155	105	2,684
Canton-Massillon	100	100	1,515
Cleveland	708	599	12,736
Columbus [1]	400	20	10,624
Dayton	387	387	5,800
Lorain	12	12	155
Portsmouth	59	59	872
Tiltonville and Yorkville	64	55	1,108
Toledo	52	14	1,048
Willard [1]	75	35	1,468
Total, Ohio	2,255	1,629	41,755

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Oklahoma:			
Clayton	16	6	254
Hartshorne	44	28	685
Holdenville	80	54	1,338
Mangum	60	46	990
Seminole Nation [1]	200	30	3,604
Stilwell	36	24	594
Talihina [1]	32	16	460
Tishomingo	24	6	389
Wilburton	36	24	571
Total, Oklahoma	528	234	8,885
Oregon:			
Polk County [1]	300	40	6,414
Portland [1]	600	125	14,339
Salem [1]	250	65	5,747
Total, Oregon	1,150	230	26,500
Pennsylvania:			
Ambridge	25	25	455
Apollo (Armstrong Co. HA)	40	40	673
Brackenridge (Allegheny Co. HA)	63	63	1,126
Harrisburg	125	125	2,327
Lawrence	100	100	1,728
Monaca (Beaver Co. HA)	100	100	1,863
New Castle	150	150	2,693
Philadelphia	145	145	2,331
Phoenixville (Chester Co. HA)	75	50	1,373
Schuylkill	110	110	1,935
Shamokin	100	100	1,703
Swatara Township (Dauphin Co. HA)	100	100	1,739
Wilkes-Barre	200	200	3,543
Total, Pennsylvania	1,333	1,308	23,489
Puerto Rico:			
San Juan	100	100	1,403
San Juan	240	240	3,166
Total, Puerto Rico	340	340	4,569
Rhode Island:			
Bristol	150	150	2,647
Coventry	50	25	920
Pawtucket [1]	190	90	3,920
Portsmouth	40	40	761
Total, Rhode Island	430	305	8,248
South Carolina: Conway	100	10	1,948
South Dakota:			
De Smet	28	28	417
Kennebec	20	10	325
Madison	94	94	1,429
Total, South Dakota	142	132	2,171
Tennessee:			
Brownsville	70	30	1,214
Cleveland	200	120	3,056
Dyersburg	150	50	2,707
Franklin	125	12	2,355
Greeneville	100	70	1,360
Jefferson City	62	22	1,186
Lawrenceburg	24	24	362
McMinnville	150	60	2,817
Manchester	24	24	367
Mount Pleasant	48	20	742
Total, Tennessee	953	432	16,166

See footnote at end of table.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1969, THROUGH SEPT. 30, 1969 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Texas:			
Edgewood	30	18	511
El Paso	394	394	6,735
Galveston [1]	150	81	2,763
Haltom City	40	40	487
Harlingen	13	13	208
Hughes Springs	16	16	244
Kerens	32	18	515
Leonard	24	24	377
Lockhart	54	30	839
San Antonio	416	266	7,223
Santa Ana	20	20	348
Weatherford	100	44	1,707
Yorktown	52	26	878
Total, Texas	1,341	990	22,835
Vermont:			
Barre [1]	50	15	1,117
Burlington	162	162	2,562
Burlington [1]	100	25	2,358
Montpelier [1]	300	101	6,748
Winooski	53	53	871
Total, Vermont	665	356	13,656
Virginia: Fairfax County	46	46	766
Washington:			
Bremerton	150	80	3,182
King County [1]	300	50	7,334
Seattle	211	151	3,977
Seattle [1]	500	25	12,036
Total, Washington	1,161	306	26,529
West Virginia: Charleston	100	100	1,799
Wisconsin:			
Chetek	30	30	421
Cumberland	30	30	452
Frederick	21	21	315
Hudson	61	61	914
La Crosse	100	100	1,481
Merrill	101	91	1,568
New London	63	63	978
Sheboygan	210	210	3,210
Sparta	58	58	881
Stevens Point	100	100	1,539
Wausaukee	30	30	450
Woodville	26	26	358
Total, Wisconsin	830	820	12,567
Wyoming: Cheyenne [1]	360	60	7,424
Grand total	50,724	28,373	970,707

[1] Leased housing.

ELDERLY HOUSING LOANS PROGRAM, SECTION 202—SUMMARY OF APPROVED PROJECTS FROM INCEPTION OF PROGRAM THROUGH DEC. 31, 1968

State	Number of projects	Number of units	Aggregate project cost
Total	313	42,652	$529,564,165
Alabama	1	151	1,870,000
Alaska			
Arizona	2	273	3,284,550
Arkansas	1	136	1,608,000
California	39	4,895	61,693,508
Colorado	9	796	8,887,476
Connecticut	6	764	10,307,974
Delaware	1	204	2,730,000
District of Columbia	1	200	3,140,000
Florida	30	5,556	67,324,276
Georgia	7	1,274	15,397,800
Hawaii	1	111	1,455,000
Idaho			
Illinois	7	499	6,358,905
Indiana	4	290	3,680,744
Iowa	10	751	8,651,706
Kansas	3	281	3,462,000
Kentucky	1	143	1,972,900
Louisiana	3	417	5,377,220
Maine	3	123	1,459,000
Maryland	10	1,894	24,497,009
Massachusetts	10	1,585	20,214,000
Michigan	23	3,435	42,994,312
Minnesota	17	1,447	17,952,465
Mississippi	1	101	967,000
Missouri	7	1,188	14,415,300
Montana	6	462	5,697,660
Nebraska	2	176	2,160,000
Nevada			
New Hampshire			
New Jersey	12	2,253	28,036,107
New Mexico	3	274	3,281,000
New York	6	948	11,677,000
North Carolina	1	158	1,790,000
North Dakota	3	158	1,643,289
Ohio	21	3,223	40,528,500
Oklahoma	4	400	4,316,000
Oregon	3	610	7,294,000
Pennsylvania	17	3,204	41,095,000
Rhode Island	1	117	1,469,000
South Carolina			
South Dakota	4	158	1,796,745
Tennessee	4	619	7,428,657
Texas	6	843	8,937,634
Utah	2	334	4,358,000
Vermont			
Virginia	1	140	1,965,000
Washington	8	1,157	14,241,328
West Virginia	2	122	1,881,000
Wisconsin	2	145	2,136,000
Wyoming	4	276	3,329,600
Puerto Rico	4	361	4,801,500
Virgin Islands			

ELDERLY HOUSING LOANS PROGRAM, SECTION 202, APPROVED PROJECTS 9 MONTHS (JANUARY-SEPTEMBER) 1969

State and city	Name of project applicant	Aggregate project cost	Number of units
January-September 1969 program total.		$41,158,100	3,035
Alabama:			
Birmingham	Birmingham Building Trades Towers	3,200,000	243
Gadsden	Holy Comforter Housing, Inc	2,600,000	200
California:			
Belmont	The Lesley Foundation	2,427,000	166
Fresno	Twilight Haven	425,000	32
Los Angeles	East Victor Villa	595,000	46
Colorado, Boulder	First Christian Manor, Inc	1,840,000	140
District of Columbia	Second New St. Paul Housing, Inc	1,425,000	100
Florida, Bradenton	DeSota Towers, Inc	2,650,000	204
Georgia:			
Americus	South Georgia Methodist Home for Aging	820,000	78
Macon	St. Paul Apartments, Inc	2,860,000	216
Idaho, Nampa	Nampa Christian Housing	814,000	65
Illinois:			
Oak Brook (vicinity)	Franciscan Tertiary Province of Sacred Heart	2,158,000	147
Peoria	Galena Park Terrace	2,265,000	144
Indiana, Terre Haute	Wabash Senior Citizens Housing, Inc	350,000	25
Maryland, Silver Spring	United Church of Christ Home, Inc	450,000	31
Massachusetts, Boston	Jewish Community Housing for Elderly	3,286,000	243
Michigan, Detroit	Elmwood Elderly N P Housing, Corp	300,000	24
New York, Penn Yan	St. Mark's Terrace, Inc	1,428,000	102
Ohio, Mayfield Heights	Luther House	1,654,100	119
Pennsylvania:			
Allentown	Phoebe Apartments	1,680,000	131
Philadelphia	Fraternal Order of Police	1,640,000	106
South Carolina, Charleston	Episcopal Diocesan Housing, Inc	2,920,000	216
Virginia, Roanoke	Shenandoah Homes, Inc	1,960,000	151
Washington, Wenatchee	Wenatchee Immanuel Baptist Homes	1,068,000	80
Wyoming, Torrington	Golden Manor	343,000	26

MORTGAGES INSURED ON ELDERLY HOUSING PROJECTS UNDER SECTIONS 207 AND 231 THROUGH DECEMBER 1968

State	Projects	Units	Mortgage amount	State	Projects	Units	Mortgage amount
Alabama	1	80	$763,000	Nevada	2	394	$4,480,200
Alaska				New Hampshire			
Arizona	18	4,504	51,064,629	New Jersey	3	621	7,559,200
Arkansas	2	139	1,446,000	New Mexico	1	60	787,000
California	51	9,420	123,826,668	New York	4	301	3,641,009
Colorado	22	2,146	24,529,387	North Carolina	2	264	1,350,000
Connecticut	5	535	8,654,600	North Dakota	2	95	1,127,330
Delaware	1	234	3,540,300	Ohio	10	1,553	18,981,900
District of Columbia	2	659	8,666,704	Oklahoma	3	261	3,479,800
Florida	15	4,097	50,327,859	Oregon	10	1,598	18,204,500
Georgia	1	48	436,800	Pennsylvania	2	442	5,902,300
Hawaii				Rhode Island			
Idaho	1	32	311,000	South Carolina			
Illinois	7	1,067	12,525,334	South Dakota	3	122	1,030,300
Indiana	2	348	5,000,000	Tennessee	5	573	7,261,500
Iowa	5	474	4,926,100	Texas	24	3,703	44,941,784
Kansas	5	603	8,082,000	Utah	2	402	5,326,600
Kentucky	7	764	8,869,050	Vermont			
Louisiana	5	324	3,761,400	Virginia	2	384	6,358,400
Maine				Washington	9	1,685	20,653,200
Maryland				West Virginia			
Massachusetts	1	25	225,000	Wisconsin	8	524	5,424,507
Michigan	6	1,080	11,612,006	Wyoming			
Minnesota	12	748	8,874,700	Puerto Rico	2	258	3,243,400
Mississippi	2	331	3,855,100	Virgin Islands			
Missouri	5	944	12,928,769				
Montana	2	158	2,115,000	U.S. total	281	43,115	530,200,541
Nebraska	9	1,115	14,106,205				

MORTGAGES INSURED ON NURSING HOME PROJECTS UNDER SECTION 232, THROUGH DEC. 31, 1968

State	Projects	Beds	Mortgage amount	State	Projects	Beds	Mortgage amount
Alabama	9	819	$5,054,259	Nevada	3	214	$1,971,900
Alaska				New Hampshire	3	200	1,561,700
Arizona	5	350	1,825,300	New Jersey	39	4,110	37,527,770
Arkansas	2	150	965,500	New Mexico	2	100	678,500
California	43	3,700	26,336,534	New York	31	4,345	39,384,698
Colorado	7	778	4,436,500	North Carolina	2	193	1,310,800
Connecticut	14	1,347	8,848,368	North Dakota	1	71	653,500
Delaware	3	316	2,665,300	Ohio	23	2,143	14,607,363
District of Columbia	1	199	1,450,000	Oklahoma	8	548	2,812,100
Florida	32	3,044	19,530,051	Oregon	15	1,270	7,271,700
Georgia	14	1,374	8,453,100	Pennsylvania	16	1,735	12,368,243
Hawaii	2	224	1,774,200	Rhode Island	1	135	1,184,700
Idaho	6	440	1,915,543	South Carolina	11	686	4,348,800
Illinois	25	2,724	16,503,902	South Dakota	2	115	644,400
Indiana	9	756	4,636,700	Tennessee	15	1,187	7,264,500
Iowa	6	443	2,372,700	Texas	32	3,618	21,441,500
Kansas	6	420	2,515,329	Utah	7	559	3,315,600
Kentucky	8	626	3,066,049	Vermont	2	118	538,700
Louisiana	6	548	3,035,900	Virginia	6	623	4,270,900
Maine	4	252	1,384,000	Washington	14	1,421	8,465,256
Maryland	10	1,290	10,218,912	West Virginia	3	245	1,624,200
Massachusetts	12	929	7,350,963	Wisconsin	10	979	5,943,719
Michigan	41	3,339	22,669,912	Wyoming			
Minnesota	5	423	2,277,000	Puerto Rico	1	160	1,726,400
Mississippi	6	338	1,959,700	Virgin Islands			
Missouri	14	1,685	14,037,900				
Montana	4	320	2,025,500	U.S. total	554	52,439	363,056,102
Nebraska	13	830	4,830,031				

COMMITMENTS ISSUED, JANUARY THROUGH SEPTEMBER 1969, ON SECTION 232 NURSING HOME PROJECTS

City	Name of project	Number of beds	Mortgage amount
Anchorage	Glenmore Nursing Home	100	$1,601,000
Alma	Colony Manor of Alma, Inc	70	392,000
Canoga Park	Holiday Manor	92	669,700
Concord	Adobe Convalescent Hospital	98	668,300
Palos Verdes	Palos Verdes Nursing Home	120	920,800
Pomona	Pomona Convalescent and Geriatric Center	98	650,000
San Dimas	San Dimas Convalescent Center	106	711,000
Stockton	Crestwood Convalescent Center	95	877,800
Grand Junction	Colonial Manor of the West	120	498,300
Gunnison	Gunnison Nursing Home	50	325,000
Washington	National Medical Association Foundation	256	2,650,100
Jacksonville	Arlington Manor, Inc	120	782,100
Lehigh Acres	Lehigh Acres Nursing Home	50	460,000
Perry	Perry Nursing and Convalescent Center	58	386,100
Plantation	American Convalescent Center, Inc	100	667,800
St. Petersburg	Colonial Manor Nursing Home	240	1,599,500
West Palm Beach	Pinnacle Convalescent Center	120	689,400
Augusta	R. A. Robinson Nursing Home	100	828,000
Brunswick	Brunswick Nursing and Convalescent Center	162	1,280,000
Cartersville	Cartersville Nursing Home	100	746,500
Columbus	Columbus Medical Nursing Home	100	657,000
Do	Oak Manor, Inc	104	1,063,800
Decatur	Decatur Convalescent Center	100	747,400
Belvidere	Belvidere Manor Nursing Home	109	796,000
Byron	The Neighbors Nursing Home	58	420,000
Chicago	Briarwood Terrace Nursing Home	299	2,315,100
Do	Deliverance Nursing Home	199	1,349,600
Do	Michigan Terrace Nursing Home	150	1,121,000
Do	Mid-American Convalescent Centers	290	1,989,500
Do	Montrose Convalescent Home	244	1,889,900
Do	Normandy Convalescent Home	300	2,174,100
Lincoln	St. Clara's Manor	140	1,544,400
Monmouth	Applegate Inn	88	701,000
Pana	Pana Nursing Home	100	710,000
Winfield	Zace Nursing Home	100	708,100
Eagle Grove	Rotary Ann Nursing Homes	30	207,400
Metairie	Physicians E. Jefferson Convalescent Home	150	1,357,200
Brockton	Braemoor Nursing Home	120	1,460,000
Tisbury	Vinyard Haven Nursing Home	78	735,000
Detroit	Wilshire Nursing Home, Inc	476	3,302,600
Flint	Lafayette Nursing Home	226	1,550,000

COMMITMENTS ISSUED, JANUARY THROUGH SEPTEMBER 1969, ON SECTION 232 NURSING HOME PROJECTS—Cont.

City	Name of project	Number of beds	Mortgage amount
Hendricks	Hendricks Nursing Home	40	$346,600
Truman	The Lutheran Retirement Home of Southern Minnesota	63	600,000
Greenwood	Pemperton Place Nursing Home	60	388,400
Meadville	Franklin County Nursing Home	60	374,400
Meridian	Queen City Nursing Home	60	397,800
Morton	Scott County Nursing Homes	60	376,200
Newton	Newton County Medical Center, Inc	60	445,600
Portageville	Delta Stryrest Convalescent and Nursing Home	50	348,600
Kansas City	The Montabaur Club	136	2,413,800
Do	Myers Nursing and Convalescent Center	84	795,800
Liberty	Golden Age Lodge of Liberty	132	1,211,500
Libby	Libby Convalescent Center	60	312,000
Hampton	Plimpton Manor Nursing Home	75	560,000
Chatham Township	King James, Nursing Home of	106	1,211,100
Franklin Township	King James Nursing Home of Franklin	180	2,048,300
Lopatcong	Lopatcong Nursing Home	149	1,926,100
Trenton	Care Centers of America	100	1,027,100
Utica	Eden Park Nursing Home	80	962,200
Cincinnati	Vernon Convalescent Center	150	1,539,800
Cleveland	Aristocrat Nursing Home	120	1,170,000
Do	Belmore Manor	100	1,025,000
Columbus	Wesley Glen Nursing Home	42	540,000
Upper Arlington	Arlington Court Nursing Home	120	1,302,300
Easton	Northampton Nursing Home	120	1,196,100
Frackville	Broad Mountain Manor	126	1,159,000
North Strabane Township	South Hills Convalescent Center	100	1,146,900
Pittsburgh	Highland Hall Nursing Home	104	1,619,900
Cranston	Medico Nursing Facilities	118	1,348,400
Dell Rapids	Dell Rapids Nursing Home	52	390,000
Athens	Athens Convalescent Center	86	664,600
Ellendale	Tranquilaire Nursing Home	68	931,800
Austin	Austin Geriatric Center	168	2,283,800
Bonham	Seven Oaks Nursing Home	60	359,300
Mexia	Haven Nursing Home No. 2	60	389,700
Tyler	The Village East Nursing Home	120	919,400
Wichita Falls	Woods Convalescent and Nursing Home	100	535,700
Brattleboro	Eden Park Nursing Home	120	1,333,700
Spokane	Opportunity Convalescent Center	120	959,900
Do	Southcrest Convalescent Center	212	1,770,300
Milwaukee	Doctor's Hospital Nursing Home	174	1,542,000
Do	Downtown Nursing Home	260	2,536,300
Do	Hillcrest Nursing Home	50	388,100
Rice Lake	Rice Lake Convalescent Center	100	772,000
Projects		10,121	87,772,000

Highlights of Nursing Home Survey

Four hundred FHA-assisted nursing homes that had received permits for initial occupancy from the appropriate State agencies participated in a survey as of January 15, 1969, providing information on vacancy, characteristics of patients, cost per patient per day, monthly charges, and related data.

The nursing homes were located in 46 States and the District of Columbia and had 37,548 beds and 32,610 patients. Seventy percent of the projects were in metropolitan areas. Nursing homes in metropolitan areas reported an average of 102 beds—those in nonmetropolitan places, 74 beds.

OCCUPANCY-VACANCY

The overall vacancy ratio was 13.2 percent as of January 15, 1969. On a national basis, only those nursing homes receiving permits for initial occupancy during 1968 had higher-than-average vacancy rates. The ratio for projects opening in 1968 was 35 percent, compared to averages of 8 to 13 percent for projects opening in prior years.

A majority of the nursing homes reported relatively short periods of vacancy for most of their unoccupied beds. Two-fifths of the beds not in use in private rooms and one-third of those in semiprivate and ward rooms had been vacant for 15 days or less. One-half of all unoccupied beds had been vacant for less than 30 days. Longer duration of vacancy was reported primarily from homes having initial occupancy during 1968, or from a minority of the older homes that had particular problems, including projects that were Secretary-held.

The median percentage of occupancy considered necessary to break even financially was 85 percent, and the median period of operation required to break even was 18 months.

CHARACTERISTICS OF PATIENTS

The typical nursing home patient was 79 years old. Only about 5 percent were under 60 years of age, while almost 8 percent were in their nineties. About 70 percent of the total were female.

On the average, two-thirds of the patients were chronically ill, while the remainder were reported as convalescent. In nearly half of the homes, 80 percent or more of the residents were reported as being chronically ill, while in one-fourth of the homes, less than one-half of the patients were so reported. These homes undoubtedly had higher turnover rates since the average duration of residency is apt to be less for convalescent than for chronically ill patients.

One-half of the patients were reported as ambulatory and one-half as nonambulatory.

Individual nursing homes estimated the average period of residency for all patients as ranging from less than 3 months to 24 months or longer, the median period being 6.6 months. For medicare patients, the typical period of residency was considerably shorter—1.8 months. Over three-fifths of the estimates for these patients contemplated periods of less than 2 months.

Over five-sixths of the patients had come to the nursing homes from residences less than 25 miles away. Only about 11 percent had traveled 25 to 49 miles, and 6 percent 50 or more miles.

COST PER PATIENT PER DAY

The average total cost for nursing home operations was $15.78 per patient per day. Nursing care averaged $5.70 and represented 36 percent of total cost. Administrative and dietary costs averaged $2.34 and $2.40, respectively, with each accounting for 15 percent of the total. The remaining one-third of the total cost was distributed as follows: plant, $1.55; housekeeping, $0.87; interest payments, $1.02; taxes $0.70; and miscellaneous items, $1.20. Reported costs were highest in the Northeast and Middle Atlantic areas, and lowest in the southwestern region.

In contrast to the estimates from FHA nursing homes, the American Hospital Association reported that per patient day expenses incurred by hospitals in 1968 averaged $65.24.

MONTHLY CHARGES PER PATIENT

For patients in private rooms, the typical monthly charge was $650 in metropolitan places but only two-thirds as much in nonmetropolitan areas; for patients in semiprivate rooms there was a $472 median charge in metropolitan areas, and three-fourths of that amount in nonmetropolitan areas; and for those accommodated in wards, the nonmetropolitan area charge was four-fifths of the $427 median in metropolitan areas.

Private funds were the principal source of payment for 45 percent of the patients. Practically all of the remaining 55 percent of the patients received some form of public assistance. About 23 percent of the total were under the medicare program, 19 percent received welfare payments, and 12 percent were under the medicaid program.

For medicare patients the median monthly charge was $556—the highest reported for any group and $95 above the $461 median for patients supported by private funds. Welfare patients had the lowest median monthly charge of $314, and for medicaid patients it was $435.

For medicare, medicaid, and patients supported by private funds, the median monthly charges were from $92 to $94 lower in nonmetropolitan than in metropolitan areas; and for welfare patients, the median was $60 lower.

The highest typical monthly charges of $684 and $528 were in the northeast and middle Atlantic areas, respectively, and the lowest of $349 was in the southwestern region. These were the same regions with the highest and lowest average costs per patient per day.

The median monthly charge of $453 for all patients was $50, or 12.4 percent, above the $403 reported in the previous survey taken 13 months earlier as of December 15, 1967. Increases averaging 13.5 percent were reported for medicare patients, and of 10 percent under medicaid and for patients supported by private funds. The median charge for welfare patients was only $20, or 6.8 percent, higher than in the previous survey.

The number of patients covered was 15.3 percent above that in the previous survey. There was a 59 percent increase in the number of medicaid patients, reflecting the adoption of this program in additional States during the 13-month period, as well as new nursing homes opening in jurisdictions that already had active medicaid programs.

The FHA nursing homes were asked to select first, second, and third priorities among selected categories of the three leading causes for increases in charges during the 2-year period of 1967 and 1968. About 90 percent of the homes indicated wages and salaries as constituting the first priority, and most of the remaining 10 percent indicated increased staff, which would result in higher payrolls. As the second leading cause, two-fifths of the nursing homes identified increased staff and one-third cost of food. As the third most frequent cause, 39 percent designated food cost, 19 percent taxes, and 15 percent medical supplies. Other supplies, insurance, and improvements to facility were specified by a few nursing homes.

SERVICES AND FACILITIES

Hand feeding without additional cost was provided in 71 percent of the homes, and incontinence care in 61 percent. Occupational therapy was available in over one-half of the nursing homes without charge and with an extra charge in another one-fourth of the homes. In over one-half of the homes there was no charge for wheelchairs or walkers. Ninety percent of the homes imposed additional charges for oxygen and medications. Laboratory tests were available with additional charge in seven-tenths of the homes, and the same for X-rays in six-tenths; otherwise, with a few exceptions, these services had to be obtained from outside sources. Over three-fourths of the homes made an extra charge for physical therapy, while one-tenth made no charge. Personal laundry service was available in most of the nursing homes, with approximately 50 percent reporting an additional charge for this service. One-fifth of the homes provided television sets in each room, and about one-third of the homes rented sets to their residents.

Published copies of the 1969 Survey of FHA-Assisted Nursing Homes will be available at a later date, and will include a more detailed analysis as well as over 30 tables providing distributions by six regions and, when significant, by metropolitan-nonmetropolitan location.

ITEM 5: DEPARTMENT OF LABOR

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, January 27, 1970.

Hon. HARRISON A. WILLIAMS, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: Thank you for your recent letter requesting specific information on manpower activities concerned with older workers.

I am happy to be able to submit this information to you. In a short while the money figures on some of the programs may change by virtue of the beginning of contract negotiations.

Enclosed you will find the listed questions and their respective answers.

Sincerely,

GEORGE P. SHULTZ,
Secretary of Labor.

[Enclosures]

On December 4, 1969, the following change, in recordkeeping and requirements. was circulated which explains in detail the records to be made or kept relating to age; notices to be posted; and administrative exemptions. Every employment agency shall keep any records for a period of 1 year from the date of the action to which the records relate. Records must be kept also on placements, referrals, job orders, job applications, test papers, advertisements, or notices relative to job openings.

ADMINISTRATIVE EXEMPTIONS

The authority conferred on the Secretary of Labor to establish reasonable exemptions will be exercised with caution and due regard for the remedial purpose of the statute to promote employment of older persons based on their ability rather than age and to prohibit arbitrary age discrimination in employment.

DIFFERENCE IN FRINGE BENEFIT COVERAGE

An employer is not required to provide older workers who are otherwise protected by law with the same pension, retirement or insurance benefits as he provides to younger workers, provided that such a plan is bona fide and is not a subterfuge to evade the purpose of the act, except that no such employee benefit plan shall excuse the failure to hire any individual.

REFERENCE.—Part 850 (29 CFR) Records to be made or kept relating to age; notices to be posted; administrative exemptions.

(Reprinted from the Federal Register of December 4, 1969.)

Q. 1. Additional information about implementation of the Age Discrimination in Employment Act of 1967.

A. The purpose of the Age Discrimination Act is to promote employment of older persons based on their ability. The administration and enforcement of the Age Discrimination in Employment Act of 1967 was redelegated to the Administration of the Wage and House and Public Contracts Division in the Department of Labor.

This redelegation assigns authority and responsibility for (1) issuing interpretations, rules, and regulations; (2) establishing reasonable exemptions to and from any or all provisions of the Act; (3) conference and persuasion; (4) carrying on a continuing program of education and information to assist in enforcement of the law; (5) enforcement in accordance with applicable provisions of the Fair Labor Standards Act and the Age Discrimination in Employment Act; and (6) representing the Department of Labor at interagency councils or committees on matters concerning discrimination in employment on the basis of age.

When voluntary compliance cannot be obtained, the Act's provisions are enforced through legal proceedings by the Department of Labor.

Responsibilities redelegated to the Manpower Administration.—Responsibilities redelegated to the Manpower Administration include: (1) undertaking studies on the needs and abilities of older workers and their potential for continued employment and contribution to the economy; (2) promoting research to reduce barriers to employment of older workers and measures for using their skills; (3) helping employers meet problems arising from the impact of age on employment; (4) undertaking studies of institutional and other arrangements giving rise to involuntary retirement; and (5) undertaking certain reporting responsibilities. Redelegation of these activities within the Manpower Administration is still to be effected. Activities related to the promotion of employment of older workers and the expansion of opportunities for older persons have, in turn, been redelegated to the U.S. Training and Employment Service.

Action required by State ES agencies.—ES offices shall keep posted in conspicuous places the notices pertaining to the applicability of the act as prescribed by the Secretary of Labor or his delegated representative, the Wage and Hour and Public Contracts Divisions. A supply of these posters has been sent to all agencies for each office. Additional supplies can be obtained from the nearest WHPC office.

Q. 2. A report on participation by "older workers" in manpower training, Operation Mainstream, and the senior aide program.

A. The Manpower Administration has continued in its efforts to train "older workers" for jobs in industry and government when those jobs are within reach of their attainment. What has been attempted more is the use of older trained, unemployed, or retired persons to fill the positions of supervisors, counselors, and administrators in the manpower programs. It is found that older workers, especially indigenous ones, establish a rapport with the enrollee many times better than younger workers. Older workers generally establish good relationships with older enrollees or older people in the community.

Operation Mainstream has been the program which provided the vehicle for older workers. Due to the fact that Mainstream was primarily relegated to rural and semirural areas, and that the exodus of younger people from those areas has been pronounced, we find that this program has provided a surer avenue to jobs for older persons. This avenue was stimulated in December of 1968 by an administrative notice advising that the regions should work, through attrition and new opportunities, to a point where 40 percent of all Mainstream enrollees were 55 years of age or over. Information has been received from some of those regions that the greater majority of the Mainstream sponsors are well on the way to complying, if they have not already done so.

In fiscal year 1969, the Department of Labor funded 207 Operation Mainstream programs at a cost of $31 million. In addition, there are five national contracts for older workers funded for approximately $10 million. Operation Mainstream projects are administered by the Regional Manpower Administrators. The older worker programs, although funded with Mainstream funds, are administered by the national office staff.

The five projects follow the same poverty guidelines as other Mainstream programs do with one exception, the minimum age limit is 55 years. These projects are listed below.

Sponsor	Authorized funds	Slots
National Council of Senior Citizens (NCSC)	$3,200,000	1,132
National Council on the Aging (NCOA)	2,300,000	500
National Retired Teachers Association (NRTA)	738,000	313
National Farmers Union	5,200,000	2,314
(Green Thumb)	(4,700,000)	(2,044)
(Green Light)	(500,000)	(270)
Virginia State College	320,000	115

The mainstream program has the highest percentage of persons 55 years of age and over of any of the manpower programs. The programs include older workers from approximately 15 percent in the new careers program to an average of about 10 percent in other programs such as the concentrated employment program (CEP), work incentive program (WIN), job opportunities in the business sector (JOBS), and other training programs, including MDTA institutional and on-the-job training (OJT).

Older Worker Programs (National)

1. National Farmers Union—Green Thumb: In June 1969, green thumb added a new community service component to its contract, known as the green light program. Green light employs 270 enrollees, mainly women, in 11 of the 14 green thumb States. The majority of the projects are çentered in five of those States: Wisconsin, Minnesota, South Dakota, Oklahoma and Arkansas. All enrollees are over the age of 55, and are assisting local government offices and other public organizations by working as teachers' aides, homemaker aides, food stamp aides, library assistants, health aides and a variety of other service occupations.

The success of the green thumb program has inspired the Minnesota State Highway Department to propose legislation which would enable it to hire older unemployed men, who meet the poverty criteria, on a permanent part-time basis, to maintain roadside rest areas. The bill passed the State legislature in January 1969 and 40 men were employed as of early September, of which approximately half were former green thumbers. It is expected that about 180 men will be working by the end of 1970.

Through its OJT contract, green thumb has been successful in placing 421 men over the age of 45, many of whom are in their 60's, in permanent jobs in light industry.

2. National Council of Senior Citizens: In January of 1969, the Department of Labor extended and expanded the existing NCSC contract by $1.8 million. This enabled the sponsor to expand by four subcontracts and extend to March of 1970. The new subcontracts were Fairmont, W. Va.; Dayton, Ohio; St. Louis, Mo.; and Boston, Mass. This expansion also enabled an increase in each subcontract enrollment to 60 slots.

NCSC was expanded by $427,000 in June of 1969 and organized five additional cities as part of its overall contract. This brought the total number of subcontracts to 19. The new cities that were added are Newark, N.J.; Bridgeport, Conn.; Denver, Colo.; Oakland and San Diego, Calif. Their enrollment level is 60 slots each.

At the present time negotiations are beginning with reference to either a contract extension or a totally new contract.

3. The National Council on the Aging was expanded by one site in April of 1969. Hoboken, N.J. was designated as the new subcontract. In June of 1969, this contract was extended to June of 1970 with an addition of $1.2 million. The majority of this money was used to increase salary levels of the enrollees. Most of

the enrollees at that time were at the Federal minimum wage level of $1.60 per hour. In recent weeks, some unused funds were utilized to expand a working arrangement by NCOA and the Social Security Administration (SSA). This is a temporary expansion to demonstrate an activity showing the ability of senior citizens to work specific jobs of SSA.

4 and 5. Two other sponsors were added in June 1969: National Retired Teachers Association (NRTA) and Virginia State College. The NRTA contract was in the amount of $738,000 and continues to June 30, 1970. The total enrollment level is 313 with six sites having a total of 52 slots each. Those six areas are Cleveland, Ohio; Louisville, Ky.; Kansas City, Mo.; Atlanta, Ga.; Jacksonville and St. Petersburg, Fla. A contract in the amount of $320,000 was extended to Virginia State College in Petersburg, Va. This was the first antipoverty program for Petersburg and came at a time when the need for the kinds of services, extended by the senior community service program, was great. It is the hope of Virginia State College to later expand this type of program to impoverished areas surrounding other small colleges.

The impact made by the senior community service program is immeasurable in those areas where it was placed. The three purposes of the program have exceeded initial hopes. The purposes were (1) to show the need for added financial support to unemployed or retired senior citizens; (2) to prove to the community that there did exist another manpower pool that often was more dependable and reliable than those it was presently tapping and; (3) that with the knowledge that they were again needed and wanted, the senior citizen could overcome some of the aging problems such as fear, loneliness, and melancholy.

Q. 3. A summary of conclusions reached in the "Retired Couples Budgets" issued during 1969.

A. Since 1966, the Department of Labor has published three budgets; the lower and higher budgets were published during 1969. These budgets were developed to meet the needs of agencies, dealing with retired persons, such as public welfare, voluntary social and welfare agencies, and businesses, unions, and individuals concerned with retirement or retirement planning.

The retired couple was defined "as a husband, age 65 or over, and his wife, self-supporting, living independently in a separate dwelling, and enjoying reasonably good health." For this couple, total budget costs in urban United States, in the spring of 1967 averaged $2,671 at the lower level, $3,857 at the intermediate, and $6,039 at the highest level.

The style of living differs in each of these levels. The lowest level deals with the greater proportion of persons who: do not own their homes; dwell in units lacking air conditioning; put more reliance on public transportation; make greater use of free recreation facilities; and perform more services for themselves.

Housing usurps the greater proportion of this budget. Food and medical care are two and three on the list within the budget. Transportation, clothing and other consumption are fairly even with regard to the last of the expenditures.

Living cost differences among cities

The new budgets provide a wide variety of total budget costs and comparative living cost indexes (tables 1–6) for major categories of consumer goods and services.

All indexes relate to costs for families established in the areas. They do not measure differences in costs associated with moving from one area to another, or costs incurred by recent arrivals in the community.

Within each budget, the intercity indexes reflect differences among areas in price levels, climatic or regional differences in the quantities and types of items required to provide the specified level of living, and differences in State and local taxes.

The annual cost of the lower budget in spring, 1967, amounted to $3,110 in Honolulu and $2,334 in small southern cities. In relative terms, with U.S. urban average costs equal to 100, this constitutes a range of 87 to 116, or 33 percent. For the other two budgets, Hawaiian families spent $4,429 for the intermediate and $7,219 for the higher. In small southern cities, families averaged $3,222 for the middle budget and $4,827 for the higher.

Of the mainland cities, the lower and intermediate budgets total costs were highest in Hartford—$3,022 and $4,343, respectively. The highest cost mainland city for the higher budget was Boston—$7,198.

For all three budgets, food, rental shelter, and transportation were most expensive in Honolulu; medical care in Los Angeles; and clothing in Portland, Maine. The cost of homeownership was highest in New York for the lower and middle budgets, and in Boston for the higher budget.

Q. 4. A report on services offered to older workers by the U.S. Employment Service.

A. Older worker service units were established in 27 cities, through special allocations of staff made in fiscal year 1966 and fiscal year 1967, for the purpose of providing specialized and intensified employment services to middle-aged and older persons who were having difficulty in obtaining employment because of their age, or factors associated with age. In addition to providing intensified services, the units were able to develop innovative service methods and techniques for improving services to older workers. The cities in which the units were located were Baltimore, Cleveland, New Orleans, Minneapolis-St. Paul, Washington, D.C., St. Louis, Boston, Dallas, New York City, San Antonio, Detroit, Rochester, N.Y., Buffalo, Long Beach, Oakland, San Diego, Houston, Chicago, Los Angeles, Pittsburgh, Van Nuys, Kansas City, Cincinnati, Milwaukee, Philadelphia, San Francisco, and Providence.

Following is data for the period January–June 1968, summarized from reports from the 27 cities, which reflected some of the activities of the older worker service units:

Total applicant intake	33,146
New applicants	16,545
Initial counseling	8,438
Placements	8,264

Reviews made of each of the older worker service units in fiscal year 1968 showed that where the units were functioning properly they were making a significant contribution to providing appropriate employment services to older workers.

Fiscal year 1969.—Without additional staff resources for expansion of services, older worker activities continued at about the same level as in the previous fiscal year. Older worker service unit operations constituted the most significant emphasis on such services.

Fiscal year 1970.—No additional staff allocations are anticipated for fiscal year 1970. Major efforts will be directed toward qualitative as well as quantitative improvement in older worker services activities in all ES local offices, including the small offices which serve rural populations as well as the large metropolitan offices. Special attention will be given to the training of older worker specialists, using curriculum materials and training techniques developed by the National Institute of Industrial Gerontology and other ES sponsored research projects. State agencies will be encouraged and aided in efforts to effectively evaluate their services to older workers, to involve their whole community in service efforts for older workers, and to establish cooperative relationships with their universities for research activities concerning the older worker. Another area of emphasis will be meeting the employment needs of the elderly, particularly those seeking part-time employment to supplement inadequate retirement income.

A course for "training of older worker specialists" is to be conducted in Minneapolis, jointly sponsored by the Minneapolis Department of Employment Security, the University of Minnesota in Minneapolis, and the Minneapolis Rehabilitation Center. The training should result in improved interviewing and special worker services of all kinds.

Special emphasis has been given to older workers in counseling, training and placement. Community participation has resulted in improved relations with employers, has created a better understanding of the abilities of older workers, and has resulted in increased placement.

Placement of 45 and over workers for fiscal year 1969: 1,112,809 or 20.1 percent, the annual average is usually 20 percent of total. A representative is designated in each local office to be responsible for the older worker program.

Q. 5. A report on the Work of the National Institute of Industrial Gerontology.

A. On July 1, 1967, the U.S. Employment Service established in the National Council on the Aging (a nonprofit organization) the National Institute of Industrial Gerontology (NIIG).

The NIIG is an applied research program focusing on the employment and retirement of middle-aged and older workers. It was established to help improve employment services by providing specialized training in industrial gerontology to placement and counseling officers; encouraging coordinating and applying research on this subject; and developing and distributing written and audio-visual material in this field.

Industrial gerontology is the study of the employment and retirement problems of middle-aged and older workers. It begins where age "per se" becomes a handicap to employment. Industrial gerontology is concerned with aptitude testing and placement, job adjustment, retention, redesign, motivation and mobility. It is concerned with the transition from employment to retirement and with retirement itself, and retirement income with public and private pension programs.

Industrial gerontology publications to date include: "Employment of the Middle-Aged Worker", "Industrial Change and Aging in the Work Force", "Age Physical Ability and Work Potential" and "Industrial Gerontology: Introduction to New Field of Applied Research and Science".

Working papers were prepared by NIIG for the U.S. Senate Special Committee on Aging. The Senate hearings were held on December 18, 1969. The papers were: Economics of Aging: Toward a Full Share in Abundance; Health Aspects of the Economics of Aging; Social Security for the Aged; International Perspectives; Homeownership Aspects of the Economics of Aging.

A specialized body of knowledge on the middle-aged and older worker was assembled in a 773 page document entitled, Industrial Gerontology Curriculum Materials. This material, all original, was prepared by specialists in sociology, psychology, economics, medicine and other fields. It is now being tested in training situations.

A seminar, in cooperation with the W. E. Upjohn Institute for Employment Research, was held in April 1968, in Washington, D.C. which included the older worker practitioners and industrial gerontology research specialists. The group exchanged experiences, views and information regarding older workers, employment problems and techniques for handling them.

A quarterly journal, "Industrial Gerontology," has been established. It is directed to personnel administrators, vocational counselors, employment service specialists, policymakers and research scholars. There have been three issues published.

A Seminar of Industrial Gerontology for the directors of the State Employment Security agencies was held in San Juan, Puerto Rico, December 1–6, 1968. The purpose of this seminar was to encourage the State directors' involvement in solving problems of the middleaged and older workers serviced by their State agencies through the development of strong active programs in this area.

Three industrial gerontology seminars will be held prior to June 30, 1971. One will be held in September, 1970 in Minnesota; planning has started for a Pacific and a Southeastern seminar.

Four panel meetings with employers will be held to explore the scales developed by Leon F. Koyl, M.D., Toronto, Canada, for scientific matching of physical capacities of workers to physical demands of jobs. These scales are being successfully used by the de Hairiland Aircraft of Canada.

On November 6, 1969, institute staff and Mr. David Epstein of Civic Affairs Productions met in Toronto with Dr. Koyl and the staff members of de Hairiland Aircraft, to begin the development of a treatment and script for the film on the Gulhemp scales.

Mrs. Helen G. Poppelwell has done preliminary research into middle-aged and older Spanish-speaking Americans in the Bay Area of California.

Mr. Norman Sprague and Mrs. Irma Withers participated in the Organization for Economic Cooperation and Development working party on older workers in Paris, December 2–5, 1969. Prior to the meeting at OECD's request, NIIG staff sent three papers to Paris. One dealt with innovative programs in the United States. A second was an assessment of American training and employment programs for older workers. A third contained research findings on flexible retirement experiences in the United States.

Mr. Edward W. Spannaus, Research Associate of NIIG, has completed contributions to a Senate paper on private pensions. Hearing dates have not yet been set.

A study on early retirement (prior to age 65) experiences is being carried out by the NIIG through the University of Oregon. This study will take approxi-

mately a year. The findings will be reproduced in monograph form and serve as part of the industrial gerontology curriculum materials.

Q. 6. A report on experimental or demonstration projects related to older workers.

A. The experimental and demonstration projects carried on by the employment service have proved extremely beneficial in developing the senior community service program. The older worker service units have provided an older worker specialist who is fully cognizant of techniques for counseling, job development and placement of older workers.

The five prime sponsors for the senior program have had the services of the specialist and find that they have been invaluable in the recruitment, selection, continuing counseling, and job placement that is necessary in programs of this type.

ITEM 6: FEDERAL TRADE COMMISSION

FEDERAL TRADE COMMISSION,
Washington, D.C., February 9, 1970.

DEAR MR. CHAIRMAN: This is in response to your letter of December 17, 1969, requesting information on our activities related to the aging.

I am pleased to comply with your request, addressed to Chairman Dixon. In answer, I am enclosing a brief discussion of Commission activities thought to be of special significance to elderly consumers, along with a report on corrective actions taken in the past year.

I hope the enclosed information meets your request, and if I may be of further assistance, please do not hesitate to contact me.

With kind personal regards,

Sincerely,

CASPAR W. WEINBERGER, *Chairman.*

REPORT FROM THE FEDERAL TRADE COMMISSION

The Federal Trade Commission enforces laws designed to protect against unfair methods of competition and to halt in interstate commerce unfair or deceptive acts or practices. In carrying out this charge it has become apparent to the Commission that elderly consumers are among those most likely to find it hard to obtain goods and services they need and want at costs they can afford—cost in terms of money and in terms of health, safety, and convenience. The Commission is aware that the elderly make up a high proportion of the poor—the group upon which noncompetitive practices and unfair and deceptive practices in the marketplace are likely to have greatest impact.

These facts have been considered in discussing organization changes designed to expand and improve the Commission's consumer protection program. Expansion of the consumer education/information program of the Commission should bring both direct and indirect benefits to elderly consumers.

Properly informed, the elderly, as individuals, can maximize their satisfactions through their buying decisions.

Properly informed, elderly consumers, particularly in groups, can interfere directly with or at least blunt illegal conduct and persistent practices inimical to a sound market.

It is recognized that elderly consumers, particularly, need to understand their rights and responsibilities. They need this ammunition if they are to avoid the hazards of the marketplace—to avoid the buyer-seller transaction induced by unfair and deceptive practices.

A brief review of activities of the Commission of particular relevance to the elderly follows.

In recent years senior citizen groups and community organizations concerned with the elderly have been among the target groups for which both field and headquarters staff of the FTC have undertaken education/information efforts: talks and conference participation, printed consumer bulletins and press releases, for example.

CONSUMER EDUCATION/INFORMATION

Efforts at the local level are essential to deter unfair and deceptive market practices frequently confronting elderly consumers. From one FTC field office

are these examples of current activities designed to meet needs of older consumers:

The attorney in charge chaired the Mayor's Consumer Protection Committee for Senior Citizens in Los Angeles. This committee tries to coordinate and make more effective the protection and education efforts of local organizations and agencies. For example arrangements have been made for personnel in the office of the mayor to receive and distribute complaints to the proper agencies for handling.

The California Attorney General's Office and the Los Angeles FTC Field Office have worked together for the past 6 years to create interest among the black and brown people in the poverty areas. They have published pamphlets, prepared comic strips, made radio and television appearances, and designed inservice training components for social workers.

Typical subjects of talks, radio and television appearances before consumer groups included: "Five Basic Fraud Schemes (special offer, free goods, referral selling, fear selling, and bait-and-switch)"; "Federal Trade Commission and Its Role in Consumer Protection"; "The FTC and Deceptive Practices in Our Town"; "Consumer Fraud and Truth in Lending"; "Unethical Door-to-Door Salesmen".

From the headquarters staff of the Federal Trade Commission two consumer bulletins have been issued recently of special concern to the elderly. One, "Advice for Persons Who Are Considering An Investment in a Franchise Business," deals with pitfalls to watch for in purchasing franchises; the other, "Advice for Amateurs Who Expect To Breed Chinchillas for Profit," deals with pitfalls in investing in chinchilla breeding stock.

The D.C. protection program of the FTC has a consumer education component. The FTC two-man education team focuses on 16 unconscionable market practices.

FEDERAL-STATE-LOCAL COOPERATION

In the past year the Commission has pursued an aggressive program to spark State and local interest in halting deceptive and unfair competition. With limited success thus far, it has encouraged States to adopt the model "little FTC Act" which provides weapons by which State governments can put an end to unfair market practices which often plague the elderly.

The FTC tries to enlist aid of State and local officials in the enforcement of acts for which FTC is responsible, such as the Fair Packaging and Labeling Act and the Truth in Lending Act.

ACTION TO STOP UNFAIR, DECEPTIVE PRACTICES

While not a blueprint of the agency's total program, the Commission emphasizes the halt of irregular marketplace practices with particular impact on the elderly and others unable to afford to be victimized. The case-by-case approach is used in ordering individual firms to stop deceptive and unfair practices. However, the Commission cannot rely exclusively or even primarily on this approach. Nor can it rely entirely upon guidance to the industry in the form of written guides, advisory opinions or trade regulations and rules. Guidance and force both are used. Complementary education efforts are proposed as described above.

The Commission is specifically assigned responsibility for enforcing the Wool, Fur, and Textile Acts.

Older shoppers who must guard their clothing dollars carefully should be pleased at the increased activity in the recent past in FTC enforcement of laws that require truthful labeling and advertising of woolen and textile fiber products. Recently the FTC has proposed rules which would require manufacturers to put permanent labels in garments to show how to care for them.

The Commission has used its power to try to stop selling practices which misrepresent income producing business offers to the elderly. For example, sharp practices in the selling of franchises and other do-it-yourself business.

False and misleading advertising is continuing to receive special scrutiny, through the monitoring of printed and broadcast media.

Other questionable practices under study by the Commission include a study of automobile warranties, magazine sales practices, unsolicited credit cards, pricing of automobile tires, pricing practices of the automobile industry, appliance warranties, labeling and advertising of insecticides and pesticides, and retail food store advertising and marketing practices.

ITEM 7: FOOD AND DRUG ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE, CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE, FOOD AND DRUG ADMINISTRATION,
Washington, D.C., January 19, 1970.

DEAR MR. CHAIRMAN: This is in response to your request of December 17, 1969, for a report on activities of the Food and Drug Administration which protect the older generation of consumers.

I am pleased to attach a detailed statement covering these activities, which I hope will provide the information you want. Please feel free to call on me if I can be of further assistance.

Sincerely,

CHARLES C. EDWARDS, M.D.,
Commissioner of Food and Drugs.

[Enclosure]

STATEMENT ON FOOD AND DRUG ADMINISTRATION ACTIVITIES AFFECTING THE AGED

Mr. Chairman, virtually all of the FDA's many programs to enforce the Federal Food, Drug, and Cosmetic Act and related laws benefit the elderly as much, or more, than any other age group. We are protecting the health and pocketbooks of all consumers to the extent of more than $100 billion of the Nation's commerce in consumer products.

Health protection naturally comes first, leaving a fraction of our resources for matters that involve only economics. But many health problems also have an economic aspect, so there is a substantial benefit to the consumer's pocketbook in that way.

You have asked for information on four specific topics, as follows:

(1) Corrective actions of special concern to the elderly consumer during 1969

These include actions to insure the potency, purity, safety, and effectiveness of drugs. The FDA's authority and resources to deal with defective drugs have been strengthened substantially. Manufacturers recalled defective drugs from the market over 700 times during the fiscal year of 1969.

Ninety percent of these recalls were of prescription and nonprescription drugs for human use. Some of them involved large quantities of critically important items. One firm, for example, recalled millions of bottles of intravenous solutions representing some 70 different products of this type. Defects in the bottles affecting their closure had caused loss of sterility. Another company recalled all outstanding stocks of a medicated gel. The recall followed reports of eye injuries associated with use of the product.

An intensified drug inspection program has been started in which FDA inspection teams remain in a plant until all questionable manufacturing practices have been corrected. During fiscal 1969, 220 intensified inspections were started and 89 completed. The results are encouraging.

Under a contract with FDA, the National Research Council of the National Academy of Sciences completed a study of the effectiveness of some 4,000 drugs previously approved for safety alone. The foundation was thus laid for action to assure that labeling of these drugs reflects the facts with respect to their effectiveness and to remove ineffective products from the market.

Many elderly consumers, misled by lay press articles and mail order advertising about a so-called "youth drug" from Europe, called KH-3, have been attempting to import it. Hundreds of shipments have been detained at ports of entry because neither safety nor effectiveness have been established as required by U.S. law. FDA has detailed its charges against the drug in a seizure case filed in the Federal District Court at Los Angeles. (Press release enclosed, see p. 244.)

False and misleading claims for vitamin and mineral food supplements continue to be aimed particularly at the elderly consumer. A court action now underway involves mail order promotion of "Golden 50" tablets for preventing tiredness, lack of pep, worry and weakness, and increasing sexual interest, potency and activity. Illustrations and sales copy claim nutritional value of one capsule equal to that of larger quantities of expensive foods. Ads in religious and other periodicals, and mailing lists of elderly people are used to sell the product.

Regulation of therapeutic devices has been largely confined to court proceedings against defective or misbranded products. During the fiscal year, 29 new

seizure cases were started, and 90 previous actions were terminated successfully. A major court contest, still pending, involves an electrical device for "passive exercise" to reduce weight, remove wrinkles, and so forth.

An "emergency respirator" was seized on charges that it was ineffective and therefore dangerous. Recalls and multiple seizures are being carried out to halt the further distribution and use of some 40,000 of these devices.

A decision by the U.S. Supreme Court indicates that some articles regarded as "devices" are also subject to "new drug" approval under the law, but the scope of the ruling is limited (U.S. v. an article of drug . . . Bacto-Unidisk, Apr. 28, 1969).

(2) *Progress made in the study of health practices and opinions*

This project suggested by your committee and sponsored by seven Government agencies, to study the susceptibility of consumers to health fallacies and misrepresentations, is now in the final (data tabulation) phase. Interviewing of more than 2,800 randomly selected consumers was completed during the summer of 1969. Depth interviews will be conducted with selected respondents, and a report is expected to be published in the latter part of 1970. To insure coverage of elderly consumers 22.8 percent of the sample is in the 65 and older age group.

(3) *Implementation of the Fair Packaging and Labeling Act:*

It is estimated that about 85 percent of the food packages on grocery shelves are now in compliance with this law. Attached is a copy of the Secretary's report to the Congress on our administration of this statute during the 1969 fiscal year.

Regulations spelling out new labeling requirements for nonprescription drugs, devices, and cosmetics became effective December 31, 1969. Labeling of prescription drugs is not involved under the Fair Packaging and Labeling Act, being covered in much greater detail by the Federal Food, Drug, and Cosmetic Act.

Plans are being drafted for a program to obtain State assistance in developing regulations against nonfunctional slack-filling of packages.

(4) *Activities of Consumer Specialists in FDA District Offices on behalf of older consumers*

The FDA Consumer Specialists program was taken over and operated by the Consumer Protection and Environmental Health Service during the past year.

In another area of significance to the older consumer, FDA has completed and published the National Drug Code Directory. Through the assignment of code numbers to thousands of medical products the directory makes it possible for public health and welfare agencies and the drug industry to computerize drug information and recordkeeping—the payment of medicare claims, for example.

HEW News Release, November 4, 1969

The first seizure of the so-called youth drug KH-3 was announced today by the Food and Drug Administration.

A U.S. marshal seized capsules of the drug in the possession of a resident of Los Angeles at the request of FDA. Although U.S. Customs officials have been detaining and excluding mailed importations of the drug for some time, this was the first seizure from a purchaser.

KH-3 is believed to contain two basic ingredients, procaine and hematoporphyrin. Procaine is used in several kinds of anesthetics, but neither drug has any recognized use for youth restoration.

The drug was seized on September 30 because it was introduced into interstate commerce without an approved new drug application. The product was regarded as misbranded because of false and misleading statements in an accompanying pamphlet.

The capsules entering the United States generally have been mailed from a concern run by L. Peter Rothschild, Freeport, Grand Bahamas. The product also has been brought into the country by Americans returning from Europe and Latin America. Importation of the drug is illegal.

Some of the claims made for KH-3 by Mr. Rothschild include the following: "comprehensively strengthens and reactivates the entire aging organism * * * tautens the skin and improves its appearance and color as a result of improvement in circulation * * * cases of scleroderma (hardening of the skin) have been cured * * * and dry chapped and senile skin has become smooth and elastic * * * has produced a full head of new hair in cases of complete baldness."

KH-3 is manufactured by the Schwarzhaupt Chemical-Pharmaceutical Factory in Cologne, Germany, and is patterned after a drug formulated by Dr. Ana Aslan of Rumania.

ITEM 8: NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
NATIONAL INSTITUTES OF HEALTH,
Bethesda, Md., January 19, 1970.

DEAR MR. CHAIRMAN: A report on the support and conduct of research on aging by the National Institute of Child Health and Human Development is enclosed for inclusion in "Developments in Aging."

It is a pleasure to supply you with this material.

Sincerely yours,

GERALD D. LAVECK, M.D.,
Director, National Institute of Child Health and Human Development.

[Enclosure]

AGING PROGRAM—NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

Aging may represent many biological and psychological processes; it may stem from changes in individual cells or it may be a byproduct or accompaniment of disease. So many possible causes must be investigated that progress in aging research is particularly vulnearable to manpower and fund shortages. Yet everyone who lives to adulthood experiences some degree of aging. Research to unravel the complexities of the aging process and to attempt modification of aging's effects on the human mind and body is therefore of potential benefit to all people.

The National Institute of Child Health and Human Development (NICHD) is in the important business of providing support for research in the biological, medical, and behavioral aspects of aging, and for training scientists to carry forward this multifaceted and most imperative research.

THE ADULT DEVELOPMENT AND AGING BRANCH

This branch supports research at universities, medical schools, and laboratories throughout the United States in four general areas. They are aging and disease; cellular aging; intellectual changes with age; and life in the later years. It also supports training for research in aging.

Aging and disease

Experiments in aging must distinguish between aging processes and disease processes, although the two are often interrelated. Many cell and body functions decline with age, contributing to the development of disease. For example, persons become less able to utilize the sugar, glucose, as they grow older. This may represent the beginning of diabetes mellitus and it may contribute, as diabetes does, to development of atherosclerosis—a disease that reduces blood flow through the arteries and leads to strokes, heart attacks, and difficulty in walking. Appropriate diet and exercise are beneficial to diabetes; their effect on the more moderate glucose impairment in mature adults should be studied.

It takes a long time to study progressive changes with age in humans and the effects of varying life style and environmental factors on those changes. In addition, certain procedures are not suitable for human experimentation because they may have harmful effects. For these reasons, experimental animals with short lifespans are used in many aging studies. As in human studies, the disease processes that affect the experimental animals must be taken into account in studying their aging processes. Producing animals who show marked aging before they are killed by disease is of particular interest to NICHD and involves problems of disease control, genetics, and diet peculiar to various animals.

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Long-term studies in humans continue to receive NICHD support. The House Committee on Government Operations recommended that NIH, in cooperation with other involved Government agencies, review long-term medical research on aging and undertake an action program to improve this area of research. The requested review was coordinated by NICHD and completed this year. As part of the program requested by Congress, NICHD will periodically sponsor conferences to permit investigators involved in long-term studies of aging to discuss their problems. Two such conferences have already been held.

Clinical investigators will benefit from a 1970 symposium on cell and body processes that occur with age and favor the development of disease. Participants from a number of medical schools will attend the University of Washington School of Medicine for the meeting. It is hoped that a clearer idea of distinctions between aging and disease in humans will emerge from the symposium.

Cellular aging

Diseases during one's lifetime eventually causes an accumulation of damage to the body which represents one aspect of the aging process. However, the unfortunate physical changes that occur with increasing age are not all due to disease. Apparently certain changes occur because of the way the body is constructed; i.e., they are intrinsic aging processes. They occur in all persons and contribute to serious impairment in the functioning of the body with age.

Some of these changes are in molecular structure, some in the cells, and some in the organ systems. However, molecular and cellular changes are probably responsible for organ changes and are therefore the target of more research.

Some 60 trillion cells of many types form the human body. These cell types age at different rates and by different mechanisms. Studies using transplantation and tissue culture techniques are examining how aging in various cells contributes to aging of the entire man.

Transplantation studies have shown that cells from a young donor, transplanted in a series of young hosts (to keep them in a young body) will not live forever, although they will live longer than the animal they came from. This suggests that even in the best of environments, individual cells are not immortal.

For many years it was thought that some cells would live forever if removed from the body and grown in nutrient fluid, i.e. by the technique of tissue culture. Modern refinements of procedure have pointed out flaws in the experiments on which this concept was based. There is now evidence suggesting that normal human fibroblast cells grown in tissue culture will age and eventually die; these experiments can be done on other cell types, providing us with an opportunity to study aging in detail in a great variety of cells.

NICHD is building a program of research on aging of specific cell types that can be studied by transplantation and tissue culture. The program includes providing appropriate cells to interested investigators and holding meetings to discuss methods for studying those cells.

Another area of NICHD supported research deals with the cells of the body that never divide. Most of their components are periodically destroyed and recreated, just as in a dividing cell. However, deoxyribonucleic acid (DNA)—which is responsible for control of many cell activities—is formed anew only during cell division. The DNA in nondividing cells, therefore—such as in brain and muscle cells—is 80 years old in an 80-year-old man. It would not be surprising if changes had occurred in this complex molecular structure exposed for decades to its microenvironment of thermal and chemical energy. Such changes might well have led to loss of cell efficiency. In fact, alteration in the DNA of the many permanent cells in the body may be the cause of the eventual decline that we recognize as aging.

Studies are also being conducted on an abnormal material that accumulates in aging cells, particularly those of the brain and heart. This brown material, often called age pigment, may occupy as much as 25 percent of a cell's volume. It seems likely that it may cause some of the loss of function that occurs with increasing age.

In recent years advances in electron microscopy and biochemistry—such as the discovery of lysosomes—have clarified the origin of age pigment. Lysosomes are cellular vacuoles containing enzymes that can digest a variety of substances taken in by cells from the fluid surrounding them. They also appear to be involved in a continual breakdown of cellular constituents that are then replaced by new ones. Certain molecular components of the constituents broken down by lysosomes

are resistant to enzymatic destruction and accumulate as the brownish material called age pigment. This is an area of particular current interest since it is becoming apparent that lyosomes are susceptible to certain types of control with drugs.

Preparing more scientists to do research on cellular and molecular aging is vital to progress in gerontology. In the summer of 1969 NICHD initiated a program of instruction in the biology of aging for young scientists from various fields. The 3-week course was offered to 20 students who convened at the University of California, San Diego, with a faculty of aging experts from around the country. Many of the students are now doing research on aging. The summer course will be condensed to 2 weeks in 1970 and will be held at Stanford University.

Intellectual changes with age

Modern man is at least as dependent on his mental processes as on his physical well-being, and he experiences profound changes in mental function with increasing age. Understanding and perhaps learning to modify these changes would be a significant contribution of research.

Many investigators are examining the problems a person faces in performing complex tasks, many of them posed by technological advances requiring rapid detection, storage, retrieval, and processing of information by the brain. The modern air pilot faces this type of problem in the safe guidance of his aircraft from takeoff to landing. The age of the pilot is one of the factors that affects his performance, positively in some ways, negatively in others.

This type of research needs to be expanded to cover a larger range of psychological functions. Research is needed on thinking, learning, remembering, and creativity, with regard to the processes themselves and to the effect of aging on each of them.

Recent work on cell chemistry and drugs may lead to understanding the biological processes responsible for changes in psychological functioning with age.

Each postdoctoral trainee carries out research in aging under the direction of a senior investigator. Fifteen disciplines are represented by the present trainees: Sociology, 46 trainees; psychology, 40; human development, 27; social work, six; anthropology, four; architecture, two; public administration, four; biology and cell biology, 20; biochemistry, 13; physiology, 13; anatomy, five; microbiology, four; physical education, four; and biophysics, one.

The support of training in aging has increased from $301,747 in fiscal year 1964 (when the NICHD training program started) to $2,284,988 in fiscal year 1969. There have been 145 graduates from the program in that time. They hold jobs in universities, Government agencies, hospitals, and industrial research laboratories. The majority of the graduates are in universities teaching and conducting research.

THE ADULT DEVELOPMENT AND AGING INFORMATION CENTER

Four issues of the Adult Development and Aging Abstracts—representing screening of 300,000 articles in 3,200 journals—were published in 1969 to aid investigators in keeping abreast of developments in aging research. The Abstracts have been favorably received by the 1,000 American and 200 foreign investigators and the 400 medical libraries that received copies.

Expanding the coverage of this service and updating another information center publication—the International Directory of Gerontology—will not be possible without additional funds.

THE GERONTOLOGY RESEARCH CENTER

The new $7.5 million gerontology research building located on the grounds of the Baltimore City hospitals was formally dedicated in June 1968. Here NICHD conducts its direct intramural studies of aging. Current operations were moved into the building but expansions in program originally planned for the new facility have not been initiated because of Government-wide restrictions in hiring personnel. These programs include studies on aging in normal women, studies on the genetic bases of aging, the effects of chemical and nutritional factors on lengthening lifespan, studies on the mechanisms of DNA damage and repair, studies on the physical-chemical organization of biomembranes, the role of immunity and immunological phenomena in senescence, age differences in response to drugs, and the relationship between life stresses, such as retirement, death of spouse, et cetera, to aging and disease.

In January 1969 the total staff of the Gerontology Research Center was 125. By September 1969 the staff was reduced to 116.

During the year, laboratory facilities of the Gerontology Research Center have been provided to eight non-Government scientific groups from the Baltimore City hospitals and Johns Hopkins School of Medicine in support of projects pertinent to the field of aging. Operating expenses for these projects come from research grants made to the investigator. Applications from additional guest scientists are pending.

By December 1969 approximately 75 percent of the space in the GRC was assigned and occupied; complete occupancy will depend upon availability of funds and authorized positions. As soon as hiring authority is granted to the GRC the remaining space will be fully utilized.

Biological research

Since loss of functioning cells from various organs is associated with aging, determination of the mechanisms involved in cell death is an important problem for gerontology. One possible model for this process is the involution of certain organs, such as the uterus, thymus, and sex target organs, which occurs normally, during different phases of the life cycle. The progressive accumulation of lysosomes and the release of their enzymes within a cell has been observed during physiologic involution of the uterus and mammary gland of the rat.

Studies of DNA have given clues to how cell functioning is affected by age. The specific interactions of nucleic acids, polypeptides and metals have been examined in detail to explain how different protein components can block different portions of the DNA, thus controlling the synthesis of specific proteins and enzymes.

Investigation of the mechanisms by which hormones regulate metabolism and homeostasis has focused on the mode of action of thyroid hormone in inducing the synthesis of a specific enzyme. With this model system it was demonstrated that old animals are capable of responding to thyroxine in the same manner as do young animals. Thus, when old rats are exposed to maximal levels and durations of hormone the cellular machinery for protein synthesis is intact and competent.

In a study of why muscular work performance declines with age, investigators found a decline in rates of oxidation and a lowered capacity to respond to the physiological respiratory stimulant ADP with an enhanced oxygen uptake. Other enzyme systems which regulate metabolism during muscular activity have been identified and investigators are studying how they are controlled.

Previous methods used for culturing rotifers gave mean lifespans ranging from 15 to 29 days in different experiments from animals obtained from the same clone (generally identical). In order to use the rotifer as a model system to test the effects of various environmental factors on lifespan it was essential to reduce this variance. During the past year a culture system free of microbial contamination has been developed which involves manual transfer and feeding of the rotifer aseptically daily for its entire lifespan. The average lifespan has been increased from 22 to 27 days and the percentage of eggs hatched increased from 60 percent to 95 percent.

It has been postulated that age pigment accumulates in cells because of age dependent impairments in cellular oxidation. In support of this hypothesis it was found that young vitamin E deficient rats (aged 4 months) showed a marked accumulation of age pigment in the adrenal gland whereas rats fed normal diets showed no age pigment.

It has also been shown that cells maintained in tissue culture accumulate age pigment at a much greater rate than do similar cells maintained in vivo. Hence age pigment accumulation may be accelerated when the cellular environment is less than optimal.

The influence of age on the major structural proteins, collagen and elastin, in skin, blood vessels, heart, lungs, and connective tissues and on the elastolytic enzymes and their inhibitors has been determined. Results of this study include the findings that it is insoluble collagen which increases in the lungs and heart of old rats with age, whereas soluble collagen remains constant throughout the lifespan. Tendons were also found to be strengthened by calcium, complexed with the protein material. These findings indicate the biochemical basis of the increased rigidity of skin and connective tissue associated with aging.

The longitudinal study of aging in normal male subjects has continued. Computer techniques for the analysis of aging changes in individual subjects have been developed and applied to selected measurements on 250 of the 600 male

subjects who have been examined five times over an interval of 4.5 to 6 years. In some variables (serum cholesterol, vital capacity, and 24-hour creatinine excretion) there was fairly close agreement between the cross-sectional age differences (comparisons of same-age individuals) and longitudinal age changes (in an individual). However, in other variables, such as kidney function and basal metabolic rate, longitudinal observations showed that age changes in the individual did not follow the same pattern as that shown in averages based on cross-sectional observations. Instead of a gradual reduction over the total age span, kidney function in individuals showed fairly stable values up to the age of 65–70. After the age of 70 function declined. It is apparent that for some variables the longitudinal approach is essential for the estimation of age changes.

The longitudinal study has provided statistical evidence that cigarette smokers have poorer lung function than nonsmokers and that when cigarette smoking is stopped there is an improvement in lung function even in adults who have been heavy smokers.

Studies on decreased glucose tolerance with age have shown that the phenomenon is related to a reduced sensitivity of the pancreas to respond to an increased blood sugar level by releasing insulin. Followup studies on the longitudinal volunteers will have important clinical implications for the detection and treatment of diabetes in middle-aged people.

Psychological research

Studies on problem solving have shown that old men require more information to reach or accept a solution to an experimental problem than do young men. Furthermore, when a great deal of information pertinent to the solution of a problem is presented at one time, old men make less effective use of the information than do young. These findings have an important bearing on the hypothesis that information channels are more readily overloaded in the old than in the young. Whether this is associated with a loss of channels or an increase in "noise" level in the elderly remains to be determined.

It has also been shown that learning performance improved most in old persons who responded frequently during the learning situation. The possibility that overt responses serve as auditory stimuli which improve the likelihood of the response being retained was tested. It was found that adding an auditory input to the visual input did facilitate short-term retention for the old. There appeared to be some small additional effect of actively responding during the learning process.

Why should learning and short-term retention improve for the old person when he says the material aloud or when the material is presented aloud? Evidence from several psychology laboratories indicates that material presented visually in short-term retention is converted to an auditory storage, and if auditory storage does not occur, at least under some conditions, all the material is forgotten in a very short time. The old may have difficulty converting visual input to auditory storage. Therefore, any aspect of the learning situation that facilitates this conversion to auditory storage, such as active responding or auditory presentation, should be particularly beneficial to the old person's learning and retention.

In summary, it may be seen that progress has been made in understanding the basic biological mechanisms involved in aging at the cellular and molecular level as well as quantitative estimates on age changes in the individual.

STATISTICS ON THE NICHD AGING PROGRAM

The expenditures for research and training in aging by NICHD in fiscal year 1969 were:

Adult development and aging branch (ADAB)

Item	Amount
Research grants	$3,485,047
Training grants	1,976,642
Fellowships	133,527
Research career development awards	174,819
Contracts	167,955
Subtotal, ADAB [1]	5,937,990
Gerontology research center	1,700,000
Adult development and aging information center	86,000
Total	7,723,990

[1] An additional $852,904 was approved by the Institute Advisory Council for use in funding research and training projects, but was unavailable due to budgetary cutbacks.

ITEM 9: NATIONAL INSTITUTE OF MENTAL HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Chevy Chase, Md., February 6, 1970.

DEAR MR. CHAIRMAN: In reply to your request of December 17, 1969, we enclose a report summarizing the activities of the National Institute of Mental Health in the field of aging during 1969, together with a statement of the effects of recent cutbacks in funds on research activities related to aging. If I can be of further assistance, please let me know.

Sincerely yours,

STANLEY F. YOLLES, M.D., *Director.*

[Enclosure]

REPORT OF ACTIVITIES, NATIONAL INSTITUTE OF MENTAL HEALTH, DURING FISCAL YEAR 1969 IN THE FIELD OF AGING

The National Institute of Mental Health has a special interest in the aging population in view of the fact that elderly persons are particularly vulnerable to mental impairment. Often in the processes of aging, great losses are suffered which may mean the old person loses the ability to control his life situation in terms of obtaining the basic necessities of food, shelter, and clothing and of being with those persons who could be concerned for or interact with him. The actual decrements may include less physical mobility, possible organic deterioration which may affect the degree of his clarity of thought, bereavement through death of important relatives or friends, retirement from lifelong occupations and concomitantly a decrease in financial income and the loss of roles that were meaningful. Each of these losses can contribute to a feeling of insecurity in the life situation of the aged person and, therefore, to the status of his mental health.

Imposed on these losses, which differ in the degree of seriousness for each aging person, is his overall image to other adults in our youth and work-oriented society. Rejection that even the physically healthy aged person faces and to which he brings his own earlier feelings about "old people" will have impact on his adjustment to aging and, therefore, to his mental health. This, too, is an area which must be taken into account in an overall consideration of the mental health problems of the aging, but it is increasingly apparent that this particular issue has to be handled at an earlier period in the life span.

Evidence of the problem in mental health for many aged persons is indicated in the knowledge that though in 1967, persons aged 65 and over comprised about 9.5 percent of the population, 30 percent of the patients in mental hospitals were within this age group, and approximately 18 percent of the first admissions to these hospitals were aged persons. It is estimated, and probably conservatively, that 55 percent of the patients in nursing homes and other facilities serving the chronically ill are mentally impaired. Various studies have estimated that anywhere from 10 to 25 percent of the aged persons living in the community have some degree of mental impairment.

Within NIMH's goal of improving the mental health of the people of the United States, it is presently attempting to meet the mental health needs of the aged through programs which seek knowledge about mental health and mental illness through research, the training of professional manpower to perform services which will sustain and improve the mental health of older persons, demonstrations in State mental hospitals of ways to improve the mental health care of aged persons, and the development of community mental health centers both to treat and improve the mental health of aged persons. The Division of Special Mental Health Programs is responsible for coordinating the NIMH's efforts for the aging and stands in the role of advocate for programs for improving and sustaining the mental health of the aging both within and outside the Institute. Various techniques have been used to promote the development of programs to prevent mental health problems in the aging, including staff participation in conferences, meetings, institutes, and workshops, and consultation with grantees and prospective grantees. These, plus liaison with other Federal agencies and other Divisions within NIMH, have proved to be useful methods of stimulating increasing interest and activities in the area. A number of papers have been

given by the staff at conferences throughout the country concerning the mental health of the aging. Among these conferences was the Summer Institute for Advanced Study in Gerontology held at the University of Southern California which focused on community mental health and the aging. Summaries have also been made of past and present NIMH research which have proven to be effective in explicating and disseminating information and furthering the findings of our research.

RESEARCH

The research grants concerning the aging funded by NIMH in 1969 totaled approximately $2.2 million. Our studies can be divided into: (1) Those concerned with the development of knowledge about human behavior and adjustment to promote mental health in the aged and about treatment and rehabilitation of the already mentally impaired aged; and (2) those studies concerned with the delivery of services to prevent mental impairment and the delivery of new kinds of services to the already mentally impaired aged in the community and in the institution.

Research to develop knowledge concerning the mental health and mental illness of aged persons

The Institute's recognition that no one solution can be offered to help the aged to sustain their mental health and, in the event of mental impairment, to treat them, has meant that a variety of investigations are carried out in applied, behavioral, clinical, and psychopharmacological research. Among these studies are those concerned with environmental factors which may have an effect on the mental health of aged persons, the effect of retirement and withdrawal from lifelong occupations, other psychosocial studies of adjustment of the aged, as well as studies of the terminal stage of life, and studies of persons already impaired living in the community and in institutions.

Among our studes of environmental conditions and their effect on the aging is being carried out at the Philadelphia Geriatric Center. It is examining the effect of group housing and the provision of other services for aged tenants upon their medical, social, and psychological status. Preliminary findings indicate that medical services are desired by a majority of older persons, and that the decision to include medical services within housing units may affect the characteristics of the aged population who apply for such units. An investigator at the University of Southern California is exploring what the aged perceive as ideal housing. A sample of 1,700 elderly persons now residing in various types of housing is being interviewed. Preliminary findings indicate that aged persons prefer to be with good people of their own kind, including those of similar age. Another study at the Philadelphia Home for the Jewish Aged is examining the effect of architecture on the behavior of mentally impaired aged persons. The study will take place within a building which has been specifically designed for the mentally impaired aged. The study will explore and evaluate the therapeutic effect of experimentally changing the structure of the building components and furnishings on its mentally impaired residents.

Other studies are concerned with what may be called the life crisis of retirement, a time when great changes take place to which adjustments must be made by the individual involved. One study at Harvard Medical School aims to identify recognizable patterns of behavioral response to loss of occupation through retirement and to develop and test a number of questions relating to the quality of the individual's response to retirement.

Several studies are concerned with the psychosocial adjustment of the individual to the aging process. One followup study of a research project at the Philadelphia Geriatric Center by an interdisciplinary team, originally carried out between 1955 and 1957 on 47 healthy men aged 69 to 91 and followed up in 1962 and later in 1968, has shown some interesting results. In 1968, 25 survivors of the original group were examined on their social-personal situation, medical and mental status, and psychological functioning. One of the investigators found that the survival of the 25 out of the 47 appeared to be associated with the retention of intellectual vigor and capabilities.

An investigator at Senior Citizens, Inc., in Nashville, Tenn., made a study of racial attitude changes in older adults. This study was carried out through assessing attitude and personality variables of older white and Negro participants in an integrated senior citizens' center and comparing them with a control group of

older whites and Negroes active in other groups. It specifically explored whether, as social integration proceeds, the changing social attitudes of the community at large are reflected in the observable changes in the older population. It also examined whether interracial social participation under favorable conditions facilitated attitude change. A book published as a result of this study indicates that both white and Negro adults are relatively accepting of racial integration when in a social situation where little personal contact is involved. However, when integration moves into increasingly personal areas, there is a corresponding shift toward an increase in the expression of racial prejudice. This investigator is now aiming to measure interracial prejudice as a function of age and race to determine what effect periodical racial violence has upon interracial prejudices and to measure the course of long term friendships in racial prejudice. This research could be of importance to those engaged in community planning and policy.

Another research project being carried out at Duke University is focused on the roles and resources of older urban Negroes in the area of kinship relations, health, welfare, and housing for the purpose of determining the social and psychological characteristics of those who are effective and ineffective users of available resources. This research, too, can be of significance in determining what factors tend to prohibit or reduce the adequate use of health resources for preventive early diagnostic and treatment purposes of older Negroes.

Other investigators in behavioral and clinical research are including in their overall projects specific studies which are of importance to our understanding of the processes of aging. One investigator who is examining variations in subject conditionability and the contribution of different factors in conditionability has made one experiment with 25 aged men, 26 young men, and 17 young women to test the relationship of the different autonomic, nervous, and central nervous system responses. He has found that adrenaline excretion rates were higher both before and after the test for aged men than for the other subjects, which may mean that the aged organism reacts to a novel and possibly stressful situation with total mobilization of its biochemical defenses, whereas young men react more economically. Another investigator is engaged in a series of experiments aimed at understanding immediate memory. Impairment of immediate memory functions characteristically occurs in the aged and brain damaged. Preliminary results indicate that short-term storage and a distinct learning process may be differentially impaired, both contribute to short-term retention.

Another study being carried out in the Mount Carmel Guild in Newark, N.J., is examining the use of magnesium pemoline to enhance the memory of normal aged persons. This study will involve three groups of 25 subjects each aged 60 and over, matched for socioeconomic level, age, sex, intellectual and memory impairment. This study may be of great significance to aged persons who usually with increasing age suffer some memory loss.

Some clinical research projects which are concerned with sleep and dreaming have included specific studies which are of great relevance to aging persons. One study being carried out at the University of Florida is exploring nocturnal angina pectoris (chest pain) which is associated with coronary artery disease. It has been thought a possibility that these attacks occur during dreaming and that the emotional content of the dream may be a precipitating factor in the episode. The investigator will test this hypothesis and evaluate physiological pathways by which dreams may induce angina pectoris.

Another investigator is studying sleep patterns in mental illness. In one study, normal subjects ranging in age from 5 to 96, 15 of whom were between the ages of 65 and 96, were compared with 15 persons suffering from chronic brain syn drome aged 64 to 92. In the comparison of the normal aged sample with those with chronic brain syndrome, it appeared that the degree to which sleep was reduced paralleled the degree to which intelligence was impaired. From this finding, the investigator is now hypothesizing that sleep involves brain function vital for intelligence and cognition.

Research into the development of new kinds of delivery of services to improve or sustain mental health status of aged persons

The whole problem of finding ways of helping support the mental health of aged persons and helping those aged persons already impaired has been difficult to solve because of our lack of knowledge of exactly how to prevent mental health problems and how to make up for certain internal and external losses taking place in the aging process. NIMH, through various studies, has attempted to find

some solutions. One study carried out at the Harris Diagnostic Center in Houston, Tex., was undertaken to find out how comprehensive services could be provided by the community, thus preventing mental hospitalization of older people. One hundred consecutive applicants aged 65 or over were studied by an interdisciplinary geriatric diagnostic team. Existing community resources plus services of members of the team were utilized for rehabilitation and treatment. Preliminary reports indicate quite striking differences between the physical living arrangements of the group studied and a comparison group, who were not offered the service, after discharge from the diagnostic center. For example, only 41 patients who had the benefit of the geriatric team services went to a mental hospital, as contrasted with 72 members of the comparison group.

Another study presently being conducted by the Welfare Council of Chicago is concerned with developing and demonstrating improved methods of finding and reaching impaired older people and of serving them. The funds from NIMH are for the coordination and evaluation of the demonstration which will be carried out in seven established social agencies. It will promote utilization of already existing resources and encourage development and expansion of services where indicated. This project has significance because it focuses upon an increasingly serious problem in urban areas and may provide answers as to types of services to be offered the impaired older person in the community as well as make use of agencies that have already been established.

A workshop demonstration program for mentally impaired aged persons is being carried out at the Hebrew Home for the Aged in Riverdale, N.Y. Preliminary impressions are that the introduction of this workshop into the lives of the impaired aged has resulted in the enrichment of the patients' lives and in an increased amount of purposeful activity rather than being a simple substitution of one activity, such as occupational therapy, for another.

Another study carried out by the Family Services Association of America in five member agencies in Baltimore, Chicago, Cincinnati, Cleveland, and Philadelphia, has the goal of learning whether the aged client can sustain his functioning in the community more effectively through the enhancement of services by the social work team. Teams consist of a trained caseworker and an agency-trained social work assistant. The demonstration was found to be so successful that though NIMH is no longer funding the demonstration as such and evaluation is now in progress, four out of five of the agencies have retained their assistants and are adding more assistants to their staffs to help enhance their services.

HOSPITAL IMPROVEMENT PROGRAM

The hospital improvement program was established in 1963 in order to help the States improve their hospital services to the mentally ill. In fiscal year 1969, 20 HIP grants, focused on the aged persons, and totaling more than $1.6 million were given to mental institutions.

Most of these projects aimed at reducing the length of stay for aged patients in mental hospitals through placement in the community, and/or to restore a greater degree of social functioning, and/or to provide physical rehabilitation services, and/or to develop more adequate means of screening the aged inpatient population. One project at the Oregon State Hospital in Salem is designed to activate infirm patients and to provide a corps of personnel to take care of their psychiatric needs. This project is carried out on three wards containing 150 beds. It is of particular interest because of its aim to help and rehabilitate the hospital's most physically and mentally deteriorated patients. During an 11-month period, 80 patients left the program. Of these, 12 went to nursing homes, four returned to their psychiatric units as improved, 27 patients (most very aged persons) expired, and 37 were transferred to the medical or surgical services for acute conditions.

A project at the Western State Hospital in Staunton, Va., aims to return a greater number of geriatric patients to the community. As a means of reaching this aim, the project works with the community developing and making maximum use of community resources, educating the community, and establishing more adequate and intensive treatment programs in the hospital. This project is being carried out in three wards of 30 beds each. Progress reports indicate that 23 patients have been discharged or furloughed as of the end of 1968. Approximately two-thirds of the unit's patients have been able to care for themselves fully. Efforts have been made to prevent admission to the hospital where appropriate by attempts to work with patients to utilize other resources or ways of caring for the patient.

Another program is being carried out at the Peoria State Hospital in Illinois. This is a hospital in which 60 percent of the population are geriatric patients. Their plan includes hospital involvement in pre and posthospital phases of treatment. The treatment program within the hospital will focus on the patient's physical condition, manifestation of chronic brain impairment, and psychological needs. Various treatment modalities will be used, including physical rehabilitation and systematic memory training. The program will be carried out on two remodeled wards housing 76 patients. The pre and posthospital phases will include consultation and screening before admission, discharge planning, and consultation after discharge.

TRAINING

The development of manpower to meet the needs of the aged to prevent, or to help those persons already suffering, mental health problems is of critical importance. Unfortunately for our concerns for the aged, the majority of persons interested in further professional training have not chosen to work with the aging. In fiscal year 1969, more than $630,000 was spent by NIMH for training for those persons working with the aging. Of 16 grants made for this purpose, 14 went to schools of social work where 74 students received stipends and worked in various agencies where the focus was on helping the aging. One grant was given for geropsychiatry and one for geropsychiatric nursing.

Two grants have been given for continuing education in gerontology. One was made to the Gerontological Society. They propose to develop a meaningful continuing education program for individuals working in the field of gerontology. Their primary purpose is to improve and increase mental health services to the psychiatrically ill elderly; apply the most recent research data to practice; stimulate interest and involve more professionals in conscious innovation of mental health services to the aged.

NIMH has attempted to stimulate training of new types of paraprofessionals to work with the aging in light of the results of some of our applied research studies which indicate that certain very important functions can be performed by nonprofessionals which will prevent institutionalization of the aged and help enhance the terminal years.

COMMUNITY MENTAL HEALTH CENTERS

In view of the high vulnerability of the aged to mental impairment, much hope had been expressed that the community mental health centers would be of assistance in helping the aged sustain themselves in the community. However, with the myriad problems that the centers face in staffing and serving those who, in cost benefit terms, may yield a higher return; e.g., the man who can go back to work with psychiatric help and thereby support himself and family; as compared with the aged person who may continue to need supportive help and care for the rest of his life, the actual investment of resources in staff has been limited. The aged have obviously not been of priority to the centers as can be seen from the following report for 1968 from a representative selection of community mental health center admissions. Seven and one-half percent of those persons receiving 24-hour care, nearly 4 percent of patients receiving partial care, and over 3 percent in outpatient care, were 65 or older. In view of the figures given on the first page of this report, one can see that the aged are seriously underrepresented in use of community mental health centers. There are a few programs in the centers which give special attention to the aged. The section on mental health of the aging in the division of special mental health programs has made itself available for consultation to community mental health centers through the regional offices in order to attempt to raise the priority for care of the aged in the centers.

HEALTH INSURANCE AND MEDICAL ASSISTANCE

NIMH is concerned with the development and extension of mental health services through the health insurance and medical assistance programs, titles XVIII and XIX, Public Law 89–97. The primary goal is to make benefits for the mentally ill comparable to those available to persons who experience other kinds of illness. Implementation of standards for delivery of quality care, encouragement of additional resources, and new approaches to service delivery are major concerns.

In order to assess the effects of the recent Federal legislation on the care of the mentally ill, a study was done of the utilization of mental health facilities by the

aged. Length of stay and other factors affecting utilization were reviewed to determine if the patterns of care are undergoing change. A study is underway of the types and availability of alternative methods of care for the geriatric long-term patient usually found living in public psychiatric institutions. The study includes an exploration of the element of care that must be available to assist patients to remain in their home community.

NIMH participated with Community Health Service and the Bureau of Health Insurance in pilot studies of the enforcement of standards and the evaluation of the quality of care being provided mental patients in both public and private mental institutions. In cooperation with the Bureau of Health, Social Security Administration, and the Community Health Service, NIMH undertook a thorough review of the certification of the psychiatric hospitals under Medicare. This has resulted in the involvement in planning for changes in the special psychiatric requirements as well as planning for in-depth training programs for the State survey personnel.

Three workshops have been held for NIMH regional office staff members who are specifically concerned with health insurance and medicaid. Also participating in these sessions were other NIMH personnel, community mental health service personnel, and the social and rehabilitation service staff interested in titles XVIII and XIX. Resource materials have been distributed to both regional offices and State mental health authorities concerning policies and standards of care.

EFFECTS OF RECENT CUTBACKS IN FUNDS ON RESEARCH ACTIVITIES RELATED TO AGING

The information provided in response to your question on NIMH studies related to aging was for fiscal year 1969. The cutbacks in research grants occurred in fiscal year 1970. As a result of these cutbacks, the program level for agency research grants will decline from 37 grants and $2,202,000 in 1969 to an estimated $1,934,000 in 1970. Current estimates indicate that a minimum of 3 grants totaling $168,000 will be approved but unfunded in fiscal year 1970.

ITEM 10: OFFICE OF ECONOMIC OPPORTUNITY

OFFICE OF ECONOMIC OPPORTUNITY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., February 3, 1970.

DEAR MR. CHAIRMAN: I am pleased to submit at your request the Office of Economic Opportunity's third annual calendar year report to the U.S. Senate Special Committee on Aging.

In the enclosed statement you will find a description of the numerous projects and activities of the Office of Economic Opportunity program areas as they relate to the problems of the low-income elderly. It also includes the activities, during 1969, of the Office of Economic Opportunity regional older persons specialists and a summary of the 217 senior opportunities and services program which were funded and operational at the end of this past year.

The reorganization of the Office of Economic Opportunity is nearing completion and will, when completed, result in the following changes with respect to the older persons program responsibilities of this Agency:

The commitment of the Office of Economic Opportunity to the problems of older living in poverty will be emphasized by the establishment of a new Office of Special Programs. The new office will be headed by a Presidential appointee. He will hold the titles of Assistant Director for Special Programs and Assistant Director for Older Persons. This office will have the responsibility for coordinating all of the Agency's activities for the elderly.

The management responsibility for handling grants or contracts for operational programs dealing with the problems of poverty among the elderly will be located as appropriate in the Office of Operations, Office of Health Affairs, the Office of Legal Services, and Volunteers in Service to America.

Developmental projects will be located in the Office of Program Development or when appropriate, in the Office of Health Affairs. Research and evaluation on the problems and impact of poverty on the elderly poor will be provided by the Office of Plans, Research, and Evaluation.

Thank you for your continuing interest in and support of the Office of Economic Opportunity programs.

Sincerely,

DONALD RUMSFELD, *Director*.

[Enclosure]

THE OFFICE OF ECONOMIC OPPORTUNITY 1969 ANNUAL REPORT FOR OLDER PERSONS ACTIVITIES AND PROGRAMS

INTRODUCTION

Of the 25.4 million impoverished Americans, it is estimated that 5 million are age 65 and over and that an additional 2 million are 55 to 64 years of age and also living on incomes under the poverty level.

Studies indicate that the number of poor in general has declined in recent years; however, the number of elderly poor has been reduced little. In fact, the number of older women living alone and in poverty has actually increased.

For youth, the major goal is to break the cycle of poverty from generation to generation. Measures undertaken and programs designed to break the linkages of poverty may be long range, beginning even in infancy. For the old who are poor however, efforts must be directed toward results in the immediate or near future. Many will have to continue to live on very meager and limited moneys, but they should be able to live out their lives in greater decency and dignity than most of them do at the present time.

The Office of Economic Opportunity is endeavoring to help low-income older Americans by putting their energies and skills to work, to update or improve skills, and/or teach new skills to better their situation insofar as this is possible.

Community action agencies throughout the country are providing many employment opportunities as well as many services for older Americans with low incomes. These include senior centers, employment counseling and referral, food service for shut-ins, home health, homemaking, home repair services, transportation aid, recreational, educational, and vocational programs. Hundreds of thousands of older people are also being served through such programs as neighborhood health and legal service centers, although these programs are not specifically directed to older people.

The Office of Economic Opportunity has been able to demonstrate through a number of developmental type programs that through adequate training many unemployed and underemployed can be placed in job opportunities in the private and public sectors. These programs include national demonstration and research projects such as Foster Grandparents, Green Thumb, Green Light, Project FIND, and local research and demonstration programs such as the home repairs for the elderly in Letcher, Knott, Leslie, and Perry Counties, Ky. Additionally, a number of senior opportunities and services programs have trained and placed many older poor in local, private business enterprises.

THE ELDERLY CONCEPT OF OLDER PERSONS PROGRAMS

The early OEO concept of older persons programs was that, while desirable and needed, such programs would have to wait until programs for the younger poor were satisfactorily launched. In part this attitude was caused by the youth orientation of our entire culture in general and of the administration's plans and goals in particular. Largely, however, it came about because funds were limited from the beginning so that it was obvious that no full scale effort would be waged, and it was thought that first emphasis ought to be given to the possibility of saving as many children and young people from the irreparable scars of poverty as possible.

THE PRESENT OEO EMPHASIS ON OLDER PERSONS PROGRAMS

The 1966 amendments to the Economic Opportunity Act required that greater emphasis be given to serving the older poor and the 1967 amendments were much more detailed in scope and not only amended many sections of the act to insert specific references to the necessity for serving the older poor in various programs. but also set up a special national emphasis program in section 222 of the title dealing with community action programs, and removed all legislative earmarks, thus giving older persons programs—referred to as senior opportunities and services programs—equal status with such previously emphasized programs as Headstart, legal services, health services, and so forth.

Moreover, within the OEO itself, during 1969, there has been a continuing study of how the needs of the older poor might be met, and one staff member was assigned in every program area to give at least part time to the consideration of ways and means of serving the older poor better in the particular program area concerned.

THE EMPHASIS ON SERVING THE OLDER POOR THROUGH GENERAL PROGRAMS

The emphasis, largely because adequate funds are still not available for special programs, continues to be on working to involve the older poor to a greater degree in all existing programs. To this end, VISTA has deliberately attempted to recruit more older volunteers and to assign more volunteers of all ages in serving the older poor in projects specifically sponsored for that purpose. The Job Corps has attempted to hire more older people on its staff as instructors, counselors and otherwise, and to provide more opportunities for trainees to serve the needs of the older poor in the districts close to the various training centers.

In the community action program, of course, the most involvement has been possible. In the special emphasis programs such as Headstart, legal services, health services, and so forth, efforts have been made to employ more older persons as staff member and, where possible, to involve more of them as participants. Reports have been encouraging about the services of older women as teacher aides in Headstart, for example, and many older aides have been very useful in various health and legal service centers. The number of older people availing themselves of the services in these centers has been small, but efforts have been made to bring these services to the attention of the older poor in a more effective manner than has been done previously. A special effort has been launched to acquaint the older poor with methods for protecting their legal rights in their relations with governmental and private agencies and with individuals. The National Council of Senior Citizens is sponsoring this demonstration project.

In the general programs sponsored by the local community-action agencies, there has been increased involvement of the older poor as staff members and participants, but efforts in this regard have not yet been either universal or uniformly successful.

The same can be said of the delegated or jointly operated OEO programs which are handled through the Department of Labor, the Department of Health, Education, and Welfare, and the Department of Agriculture.

THE ROLE OF THE OLDER PERSONS PROGRAMS LIAISONS IN THE REGIONAL OFFICES

Each region during 1969, had a part-time older persons programs liaison person, whose role was to assist headquarters in its efforts for the older poor.

To the greatest extent possible, the regional older persons programs liaison have worked not only with the community action program in the region, but with the VISTA and the Job Corps as well, and to make certain that regional OEO programs involve the older poor to the greatest extent possible. They have also kept in close contact with other Federal, State, local, and private agencies in the regions, which are concerned with programs affecting the older poor, and to cooperate with them where possible. They collect reports from the CAA's in the regions regarding their activities in behalf of the older poor, to advise with them about the development of further activities, and make periodic reports to the national office.

TITLE I PROGRAMS

Foster grandparent program

The first national demonstration program to be implemented was the foster grandparent program. The program recruits, trains, and employs persons age 60 and over with low incomes to serve neglected, deprived, maladjusted, and sick children and young teenagers who lack close personal relationships with their peers, parents, or adults. The children and teenagers may be in institutions, clinics, special schools or classes, sheltered workshops, or other settings.

In fiscal year 1965, 1,006 low-income elderly men and women were trained and assigned as foster grandparents to work with about 1,300 children. The fiscal year 1965 foster grandparent budget of $2.5 million provided the initial funding for 21 pilot projects to demonstrate the feasibility and value of the program concepts to both the children, teenagers, and the employed elderly.

In fiscal year 1969, more than 4,100 low-income older poor persons were employed in the program and served more than 8,100 children and teenagers at a cost of $9 million.

The foster grandparent program having demonstrated its worth to both children and the elderly was continued by the Office of Economic Opportunity through fiscal year 1969 at which time the program was transferred from the Office of Economic Opportunity to the Administration on Aging of the Department of Health, Education, and Welfare.

Mainstream programs

The most recent guidelines published by the Department of Labor state Operation Mainstream's purpose to be the provision of work-training and employment projects, augmented by necessary supportive services designed to provide permanent jobs at decent wages for adults with a history of chronic unemployment: "Designed for rural areas and towns, projects concentrated on work experience and training activities that will improve communities and those low-income areas where the projects may take place. Such projects may seek to decrease air and water pollution, improve parks, protect wildlife, rehabilitate slum housing or extend education, health, and social services."

Preferred projects lead to opportunities for permanent employment; provide services or employment for older persons in rural areas, and improve the social or physical environment of the area.

To be eligible an individual must come from a family whose income is below poverty level, be at least 22 years old, with the stipulation that at least 40 percent of the enrollees be age 55 or over. Priority is given to those who have been chronically unemployed (defined as unemployed for more than 15 consecutive weeks, repeatedly employed during the past 2 years, or employed less than 20 hours a week for more than 26 consecutive weeks); have completed some training but remain employed; lack current prospects for training or employment because of age or some other factor. In fiscal 1969, the obligation for Mainstream was $41 million.

Regular and older persons projects

Older persons.—The special component of Operation Mainstream dealing with older persons concentrates on those over age 55 who meet the previously stated qualifications. The largest of these programs is sponsored by the National Farmers Union (under national contract) entitled "Green Thumb," now operating in Arkansas, Indiana, Kentucky, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Virginia, and Wisconsin. Total authorized enrollment under the most recent contract was 2,073 for green thumb and 270 for the female division of green light, which has recently been established. As of the end of July 1969, there were 2,100 male and 10 female enrollees on duty. For the most part green thumb enrollees work on beautification and conservation projects and are provided with limited training for 20 hours a week. The total Federal share of green thumb is $4,653,050; for green light, $598,670.

Green thumb enrollees are generally lower income retired farmers. Although the lower age limit is 55, the average age of an enrollee is around 68; the oldest individual at the moment is 94. Enrollees work approximately 3 days per week and are offered some on-the-job training.

For the younger participants, the major focus is on securing permanent employment, and incidence of placement is fairly high. While in green thumb, enrollees' salaries are paid through the Federal grant to the National Farmers Union, salary is restricted to $1,500 per year so as not to interfere with social security benefits, etc. The participating agency for which the enrollee is working provides only the materials necessary for the job and in-kind contributions. Once an enrollee is placed in a permanent position, total salary is assumed by the employer.

The green light program for women age 55 and over is presently operating in 10 States. The enrollees are involved in community service positions for 2 days a week and the third day is spent doing outreach work aiding people who are not otherwise served by community programs.

Other older persons programs have been funded during 1969. These contracts have gone to Virginia State College with authorized enrollment of 115 persons, Federal share $319,955; National Council on the Aging which operates 11 projects, total authorized enrollment of 500 at $2,232,028; seven projects operating under a contract with the National Retired Teachers Association for $738,805, authorized enrollment of 313; and a contract with the National Council of Senior Citizens encompassing 19 projects at the Federal share of $3,321,591, enrollment authorized for 1,132.

These other "senior aides" programs offer human service types of employment to enrollees. Job titles (all aide positions) are as follows: administrative, job development, nutrition, surplus food, instruction (both in day care centers and public schools), homemaker, home repair (specifically in the Kentucky project), and survey (in Burlington, Vt., to determine need for community services). The enrollees in these projects ranged in age from 55 to 85. Other job responsibilities obtained from the Department of Labor were as follows: visiting the elderly helpless; delivering meals and aiding in shopping, housework, and chores; escorting elderly to doctor's offices or welfare agencies; teaching in Headstart; etc.

TITLE II PROGRAMS AND DEMONSTRATION PROJECTS

Senior opportunities and services programs

Objectives.—The 1967 amendments to the Economic Opportunity Act established Senior Opportunities and Services (SOS) as a special emphasis program. Amendment 222(a)(7) delineated a wide range of programs and goals for meeting the needs of the older poor and assuring them an opportunity of greater self-sufficiency and fulfillment. Project goals and programs range from highly specialized ones providing job training and placement or home health care and nutritional guidance to very generalized community outreach and referral programs or community centers where the elderly poor may engage in recreational activities or participate in community organizations or action.

Program performance and expansion during 1969

During 1968, the SOS programs were funded at national level of $2.5 million which in turn was complemented by $1.8 million of local initiative moneys allocated to begin new or expand ongoing programs for the older poor.

In 1969, 217 SOS programs in 45 States were funded to help communities identify and meet the needs of older poor persons above the age of 60. These projects employ, serve, or involve older persons as the predominent employee or beneficiary group, $6.4 million of national and local funds were spent to strengthen and refund the projects begun in 1968 and to begin 32 new programs. More than 670,000 older poor were served by these SOS projects during 1969 at a unit cost of less than $10 per beneficiary.

Additionally, a joint Operation/VISTA experimental program was begun in three regions with nearly 100 VISTA volunteers specially selected and trained to be assigned to areas having large concentrations of older poor or to CAPS with sizable numbers of older persons and no programs to serve their special needs.

The SOS projects have been placed in a variety of urban and rural settings to test the viability and applicability in differing locales with divergent or different admixtures of needs and problems.

Some projects seek to develop and provide new types of training and employment for older poor persons without usable skills, out-of-date skills or persons whose advancement is blocked because their usable skills need to be updated. Other projects seek to stimulate and create needed additional services and assistance to remedy gaps and deficiencies in existing local social services and welfare programs. One of the more necessary and successful types of projects for helping the older poor feel that he has not been shunted aside or left out is the all-season recreation and service center controlled by the older poor themselves.

SOS program evaluation

During 1969 a contract was let for an evaluation of a score of SOS projects which had been in operation about 1 year. The evaluations were completed in December and the preliminary findings indicate: (1) They are low in unit-cost per beneficiary. (2) In many instances the elderly poor not only improve their own financial and psychological status, but do so while serving other elderly poor. (3) The programs have attracted a large measure of local and other financial support such as joint funding by other agencies. (4) They have demonstrated success in effecting change in other institutions such as increasing use of elderly nonprofessional aides by health, social, and educational institutions. (5) They have performed a useful service through outreach and referral to other agencies as well as to poor people who were unaware of existing services.

SOS programs and fundings for fiscal year 1970

In 1970, $7.6 million is budgeted to be used to continue funding of the senior opportunities and services program currently in operation, including those programs originally supported by local initiative funds. New projects will be focused on the poorest rural areas having high concentrations of elderly poor, and in urban areas where the existing resource base can be tapped at a minimal incremental cost.

Health and legal services programs

Efforts will continue to make OEO's programs focus on the special needs of the older poor, to be more responsive to their immediate and acute problems, and to increase participation by the elderly in such programs.

During 1969, the Office of Health Affairs, through its emergency food and medical program channeled $8.4 million (slightly more than one-third of its funds) into emergency medical services and food for the older poor.

Likewise, the legal services programs are studying the special legal needs and problems of the older poor to prevent continuing exploitation of their number and to seek redress of the private and public policies which severely limit the ability of the older poor to secure employment, to be protected from fraudulent business promotions, etc.

Innovative and demonstration programs in 1969

Lacking adequate resources for massive employment, income maintenance and service programs for the older poor, the OEO has had to plan its research and demonstration projects so that the knowledge and experience gained from them could be channeled not only to local community action agencies, but to many other public, private, and volunteer agencies who increasingly are concerning themselves with the problems of the older poor.

A wide variety of R. & D. projects which were begun, continued or completed during 1969 are described below.

Project FIND (friendless, isolated, needy, and disabled).—A national demonstration project which was concluded in November 1968. In 12 different communities throughout the country, Project FIND reached approximately 25,000 older poor Americans in their homes and noted their unmet needs. Many local CAA's now conduct a project FIND as a senior opportunities and services program funded under title II, section 222(a)(7) of the Economic Opportunity Act. During 1969 the research component of Project FIND was continued to tabulate and analyze the data compiled during the 18 months of operation. These findings and research data provided background materials and the major focus for an OEO national Voluntary Organization Conference in Washington, D.C., in November 1969 as well as the basis for seven OEO regional training institutes.

Project Late Start.—A research and demonstration grant was made to the National Retired Teachers Association and the American Association of Retired Persons to conduct a research project to test the hypotheses that the aged can have their life pattern and problems altered and/or ameliorated through a group experience which seeks to be educational and informative in nature. It assumes that intervention can alter the life experience of later years. Late Start provides a 10-week learning experience during which the aged are given a chance to assess their situation, get a new start—a Late Start—and are made aware of agencies and services that are in existence to assist them in making the latter years of life not a period to simply endure, but rather to enjoy. The gap between services available and the older persons needs, will hopefully be bridged through this demonstration project. Four cities held 10-week training sessions with 38 participants in each group, 19 of which were hard-core cases.

Housing repair for elderly poor.—A pilot project to repair the substandard homes of elderly poor persons in a four-county area of eastern Kentucky, it trains older persons as construction workers to repair homes owned by elderly, blind, or disabled recipients of public assistance. The project involves 100 participants, most of them 65 and older at a cost of $355,875 in Leslie, Knott, Letcher, and Perry Counties. In the first 9 months after work began in September 1968, 230 homes were repaired. It is anticipated that an additional 700 homes will be repaired.

Housing assistance project

A research and demonstration project conducted by the Cambridge (Mass.) Economic Opportunity Committee has mobilized the elderly poor into eight neigh-

borhood housing groups which bridge ethnic and racial barriers. They established priority needs for 2,000 elderly poor including location of housing units, rentals, rehabilitation of homes, and providing outreach services.

Home repair

A demonstration project conducted in eight northern pueblos of New Mexico to provide for employment of the elderly in repairing homes of older Pueblo residents.

Legal research and services for the elderly.—A national demonstration program was initiated in fiscal year 1968 at a cost of $510,793. The program is sponsored by the National Council of Senior Citizens under an Office of Economic Opportunity grant. The aim is to identify the legal problems of the elderly poor and demonstrate better methods of bringing resources of the legal profession to bear on these problems. There are eleven different project sites to reflect geographic, ethnic, and problem diversity. Ten of the projects will conduct research and provide services in specific problem areas. In addition, one project will act as an overall research and technical assistance arm and a force for generating law reform. In fiscal year 1969 the program received $741,346 for its continuation.

Specifically, the pilot programs are as follows:

1. *Research and services for the elderly, Legal Aid Society of Albuquerque, N. Mex.*—In conjunction with the University of New Mexico Law School and the university's political science department, the Legal Aid Society of Albuquerque is concentrating on economic development programs for the senior citizens in Albuquerque and Bernalillo Counties. The program is conducted with Coordinated Action for Senior Adults, Inc. Among the most promising projects to emerge are a grocery buying club and a preschool day care center.

2. *Golden age legal aid, Atlanta (Ga.) Legal Aid Society.*—This is located in a predominantly Negro area of the city with a high concentration of elderly poor. The project is focusing on group representation. Its aim is to obtain reduced transportation fare for senior citizens, solve housing problems and generate economic development enterprises. After 1 year's training in this office, attorneys will rotate to other neighborhood offices, thereby sharing and spreading expertise on the problems of aging.

3. *Senior citizens project, California rural legal assistance, San Francisco, Calif.*—There are two lawyers, a community worker coordinator, and approximately five senior lay advocates to assist in handling legal problems of the elderly. At the conclusion of the program, it is planned to produce a training manual for national use based upon the experience gained in this project. The lay advocates will concentrate on representing the elderly poor on health rights in connection with the welfare department and the Social Security Administration. It also is planned to provide legal services to groups of senior citizens and develop a group legal capacity similar to group medical practices.

4. *Fordham University School of Law, South Bronx, N.Y.*—This project involves a comprehensive study of legal problems associated with death of the elderly poor. The first stage involves a community project using senior aides trained at Fordham. They will educate the elderly poor in probate matters. The second stage will focus on the need for change and reform of applicable laws. As a result, educational material will be produced.

5. *Council of Elders, Roxbury, Mass.*—The Boston project is focusing its work in the model cities area. Under contract to the Council of Elders, a Boston law firm provides advice, handles test cases, assists in training lay advocates, recommends new and/or amendments to legislation and refers cases to the Boston legal assistance project. Work has started toward pressing for a separate State department of elderly affairs, achieving representation before the public utilities commission and improving protective services procedures. The group testified before the Senate Special Committee on Aging on "the Usefulness of the Model Cities Program to the Elderly." As a result, Senator Frank Moss, who conducted the hearings, stated the Council of Elders was unique in the Nation and requested the group to submit a detailed plan in order that other communities might be able to develop similar councils. He also requested that the council submit recommendations on changes in the model cities legislation or policy.

6. *Legal Services Senior Citizens Center, economic opportunity legal services program, Miami, Fla.*—Under the guidance of a strong advisory board, the Miami effort is focusing on the major problem in that area: The escalation of rents. A city conference was requested to deal with issues, requesting emer-

gency rent supplements, rent control and an increase in the number of units in public and low-cost housing. The program also is operating a drug-reimbursement project, assisting the elderly to file claims for which they are eligible.

7. *Legal research for Appalachian elderly, Mercer and Summers County community action programs, Bluefield, W. Va.*—Through the auspices of the two community action agencies, it is concentrating on pension and health rights of the elderly, The project involves delegation, representation, drafting of legislation, and dissemination of reports and information to other agencies and organizations.

8. *San Francisco Local Development Corp.* is endeavoring to generate economic development projects and techniques for older persons in the ghettoes. In order to assist a 69-year-old man to obtain a loan, to establish a business as a meat jobber, the corporation worked out a complicated and unusual insurance policy.

9. *Housing opportunities for west side elderly, Western Center on Law and Poverty, Santa Monica, Calif.*—This project addresses itself to senior citizen housing problems in the Venice and Santa Monica areas such as zoning, taxation, public housing, urban renewal, relocation, and building standard violations. The attorneys represent both individuals and organized groups before administrative bodies and government agencies. This housing oriented project has been christened "HOWSE" (Housing Opportunities for West Side Elderly). Housing aides are running a rental registry and are deep in the efforts to insure places for elderly persons in the urban renewal areas that are uprooting them.

10. *Legal research and services for the elderly, Northeastern Kentucky Area Development Council, Morehead State University, Morehead, Ky.*—This project will concentrate on resolving land ownership which has been confused by generations of partitions and leases of mineral rights. A strong outreach effort is well underway providing community education, administration of benefits under social security, public assistance, veterans programs, consumer problems, and domestic relations.

11. *Center on Social Welfare Policy and Law, Columbia University, New York, N.Y.*—The center has agreed to establish a law reform unit concentrating on legal problems of the aged poor and to provide research and technical assistance to this center and the others under contract to the National Council of Senior Citizens. Its efforts will concentrate on old age assistance, social security, medicare, health problems and public housing. The center has also taken some independent action against the medicaid cutbacks in New York State and is exploring the possibility of challenging the 1-year limit on retroactive social security payments.

Home education livelihood program, Albuquerque, N. Mex.—This is a demonstration project to provide legal services for elderly migrant workers.

Community action migrant program in Fort Lauderdale, Fla.—This also is a demonstration project to provide legal services for elderly migrant workers.

ACTIVITIES BY OEO REGIONAL REPRESENTATIVES ON AGING

OEO established a "voice" for the older poor by appointing a person in each of the seven regions to serve as older persons programs liaison. These representatives collaborate with their National Council on Aging counterparts in each region in the development of programs, review of proposals and conduct State and local training sessions.

Stimulated by four regional conferences held in 1967–68, and by a series of 11 additional regional training institutes held in 1968–69, local CAA's or other agencies, governmental and private, have now launched older persons program in many communities. Many State and local conferences have likewise stimulated this development.

Training and technical assistance

From April 1967 through March 1969, the National Council on Aging (NCOA) under contract to OEO, conducted 167 training programs for 14,352 trainees. The following is a breakdown of the sessions:

	Sessions	Number of trainees
National level	14	1,684
Regional	40	5,016
State	55	4,122
Local	58	3,530
Total	167	14,352

The theme of the workshops covered a wide range of subjects as follows:

Employment institute

1. How to develop an employment program for the older person.
2. Job preparation for the older worker.
3. Resources for employment programs.

Senior center institute

1. Operation of a senior center.
2. Senior center programing.
3. Changing concept of the senior center.

Health and community planning

1. Supportive services (transportation, mobile units, homemaker service).
2. How to get supportive services.
3. Health maintenance.
4. Organizing the older poor.
5. Community planning.
6. Effective social action (tax relief, welfare rights, co-ops).

Community planning and senior opportunities and services projects

1. Organization of senior opportunities services project.
2. New concepts.
3. Community planning and program techniques.
4. Organizing the older poor.
5. Mobilizing the community.
6. Effective social action.

Training at the State level included information on OEO policies and programs for older persons, funding sources, technical assistance resources, creation of closer cooperation between State representatives of OEO and the Administration on Aging.

Local level training encompassed techniques for community action to reach and maintain contact with elderly poor members of the center and vice versa.

Special emphasis was given to training VISTA planners in order to direct the VISTA program into giving more attention to developing programs and services to the elderly under the CAP/VISTA agreement.

Training and technical assistance materials

The second edition of the Resources for Aging—An Action Handbook was printed in the amount of 50,000 copies. It was updated by the National Council on Aging and printed at headquarters OEO. To date, 45,000 copies have been distributed to community action agencies, other Federal, State, and local agencies as well as colleges and universities throughout the Nation.

In addition to the handbook, the participants in training sessions are provided with kits containing materials from other agencies as appropriate to the theme of the institute. Other training and technical assistance materials such as models of various programs, library loan folders and bibliographies are provided by the National Council on Aging.

TITLE VI, SECTION 610

Programs for the elderly poor

The reorganization of the Office of Economic Opportunity is nearing completion and will, when completed, result in the following changes with respect to the older persons program responsibilities of this Agency:

The commitment of the Office of Economic Opportunity to the problems of older persons living in poverty will be emphasized by the establishment of a new Office of Special Programs. The new office will be headed by a Presidential appointee. He will hold the titles of Assistant Director for Special Programs and Older Persons. This Office will have the responsibility for coordinating all of the Agency's activities for the elderly.

The management responsibility for handling grants or contracts for operative programs dealing with the problems of poverty among the elderly will be located in the Office of Operations, Office of Health Affairs, the Office of Legal Services, and Volunteers in Service to America, as appropriate.

Developmental projects will be located in the Office of Program Development or, where appropriate, in the Office of Health Affairs. Research and evaluation on the problems and impact of poverty on the elderly poor will be provided by the Office of Plans, Research, and Evaluation.

TITLE VIII, PART C, SECTION 832

In addition to the special VISTA project described in the title III section of this report, Volunteers in Service to America has made special efforts to recruit older poor persons as volunteers in the Southwest and other regions—385 persons above age 50 were assigned to 144 projects as VISTA volunteers at the end of 1969, while more than 50 completed their service and were terminated during the year.

More than 8 percent of VISTA volunteers are over age 50. Due to their lifetime of experiences, they are among the most successful VISTAs.

More than 100 VISTA projects are designed as older persons projects or have an older persons component.

ITEM 11: OFFICE OF EDUCATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., January 9, 1970.

DEAR MR. CHAIRMAN: Thank you for your letter of December 17 requesting information describing activities in 1969 affecting the aging, to include in the Report of the Senate Special Committee on Aging.

Enclosed are statements with respect to the following programs administered in the U.S. Office of Education:

Adult basic education.
Public library services.
Community services and continuing education.
Manpower development and training.

If I can be of further assistance, please let me know.

Sincerely,

JAMES E. ALLEN, Jr.,
Assistant Secretary for Education and
U.S. Commissioner of Education.

[4 Enclosures]

ADULT BASIC EDUCATION

The adult basic education program authorized under the Adult Education Act of 1966, as amended, provides instruction in basic skills—reading, writing, speech, comprehension, computation—up to and including the eighth-grade level for persons 16 years of age and older who need and desire such skills. Adults enroll because they want to prepare for a job or job promotion, they want to be able to follow their children's progress in school, or they want to be more functioning citizens. The program is administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. Facilities and resources of local public school systems are utilized where available.

During fiscal year 1969, the reports of age distribution in appropriate adult basic education activities indicated the approximate extent to which persons over 45 years of age participated in the program:

State grant program [1]

	Number of enrollees
45 to 54	83,700
55 to 64	41,850
65 and over	20,925

Teacher training program [1]

Age:	*Number of participants*
40 to 49	1,119
50 to 59	589
60 and over	241

[1] All figures based on fiscal year 1968 percentages as applied to estimated or adjusted fiscal year 1969 enrollment and participant reports.

PUBLIC LIBRARY SERVICES

The Division of Library Programs during the past year has maintained liaison with the Administration on Aging. Staff have been particularly concerned with the public library's role as part of the total community effort in the field of aging. With increased free time, older adults are now making greater use of their public libraries—for information, inspiration, and leisure-time reading. Many kinds of library-sponsored adult education programs are in evidence. These include film series, lectures, forums, television programs, and discussion groups.

The following are examples of the programs under titles I, IV–A, and IV–B of the Library Services and Construction Act:

California—Los Angeles Public Library—Service to Shut-ins

Demonstration of service to shut-ins, LSCA title I project. (Many of the shut-ins are older persons.) The original project was started and is continuing in the "Core City." It includes publicizing the service as well as serving the shut-ins in their homes and in institutions. A bookmobile travels a different route each day. Recently a books-by-mail service was added.

In the West Valley region of the Los Angeles library system, a pilot program, "Book-Ins for Shut-Ins" was begun using volunteers for delivering books (and librarians at branch libraries for selecting material for the shut-ins).

A booklet entitled, "Service to Shut-ins, Report of the Library Services and Construction Act, Project No. 2843" has been prepared by the Los Angeles Public Library. In addition to describing the project, it includes pictures of patrons, "A Day in Service to Shut-ins," a section on volunteers and other pertinent information.

Florida—Tampa Public Library—Extension. LSCA title I project

Bookmobile service to nursing homes.

Missouri—Service to the aged—St. Louis Public Library. LSCA title I

This project aims at serving some 85,000 persons over 65, the chronically ill, and disabled shut-ins. Under the program, book carts are taken into 30 nursing and retirement homes and hospitals twice a month. Specially equipped vans are used to bring the 1,000-book collection, including many large-print books, to those people who cannot visit the library themselves.

New York—New York Public Library—Large print book project. LSCA title I

The final report entitled, "Large Print Book Project," was published by the New York Public Library in 1969.

The implications for the elderly of the availability of books in large print run throughout the report.

South Dakota—LSCA title IV–B

A report in the South Dakota Library Bulletin, January–March 1969, pages 13 and 14, describes the use of reading materials and reading aids by residents in retirement homes, nursing homes, hospitals, and other institutions served by the public library in Mitchell. The article ends with these words: "Every aspect of this program is useful and appreciated by those who use it."

The aging in all parts of the Nation benefit from the materials and services being provided under title IV–B and by the Regional Libraries for the Blind and Physically Handicapped in cooperation with the Library of Congress.

The aging in State institutions of all types also receive special services under title IV–A.

LSCA title IV–A: State institutional library services

A large number of people who reside in State institutions can be categorized as "the aging"—especially if the institution is for the chronically ill, the insane, or for those needing custodial care.

Under title IV–A of the Library Services and Construction Act, States and territories administer programs to establish and improve State institutional library services.

In institutions with older residents, programs include acquisition of books, magazines and news in large type for those whose vision is poor; books and magazines on records and tape for those who cannot read ordinary printed material; simply written books of high interest for those of low reading ability; reading aids, such as magnifiers, reading stands, and automatic page turners; films and

filmstrips; and the development of programs such as reading-discussion groups; story hours; recording of reminiscences; choral reading; and creative writing groups.

LSCA title IV–B: Library services to the physically handicapped

The physically handicapped eligible for specialized library services are defined by the act as those "certified by competent authority as unable to read or to use conventional printed materials as a result of physical limitations."

Materials such as talking book records and machines, books on tape and braille books are provided through a network of some 43 regional libraries for the blind and physically handicapped in cooperation with the Library of Congress.

Under title IV–B, large print books and magazines, recordings, tapes, and many kinds of reading aids are provided. Many of the recipients of these services are elderly people in institutions or living in their community. A number of libraries provide mobile library service to shutins and books-by-mail service.

COMMUNITY SERVICES AND CONTINUING EDUCATION

Community service and continuing education programs, authorized by title I of the Higher Education Act of 1965, have established a number of programs designed to assist the older American. In 1969, a total of 8,550 persons participated in 18 programs developed for the older Americans in 12 States.

Recognizing that early retirement and advances in medical science have afforded the senior citizen many years for useful activities, the title I program is attempting to find solutions to the problems which confront the older adult and to increase the possibilities for effective utilization of this potential reservoir of knowledge, manpower, and experience. Programs with these objectives include—

- Consumer education for the elderly through telecasts and counseling services;
- Training programs for administrators of care facilities for the elderly;
- Interdisciplinary courses in social gerontology, home nursing, health, recreation, and employment for professionals, volunteers, and community leaders to aid them in working with the aged;
- Job counseling, retirement counseling, educational programs, and discussion groups for the elderly to enable them to be more productive and useful citizens of the community;
- Training programs for volunteers who counsel the aging and who supervise leisuretime programs for the elderly in nursing homes and homes for the elderly;
- Educational programs for senior citizens designed to help them adjust mentally and physically to a new "style of life," to enable them to qualify for leadership roles in community service projects.

Mature women face problems similar to the retiree due to their changing status in the economic, political, sociological, psychological, and intellectual milieu of our society. There is a need to enlarge their horizons, to help them assess their capabilities and define new goals, and to reorient themselves to the needs of the labor market and the community. The title I programs directed to meeting these needs include counseling for individual development and self-improvement; programs designed to help women assess their present status and their potential; programs to assist women in securing gainful employment, more education, and satisfying participation in civil affairs; and courses to prepare women for leadership roles as volunteers.

MANPOWER DEVELOPMENT AND TRAINING PROGRAM

(Public Law 87–415, as amended)

Although the Manpower Development and Training Act (MDTA) since its inception has afforded opportunities for training to persons 45 years of age and older, the 1966 amendments recognized the special training and employment needs of this age group and gave impetus to programs meeting these special needs.

In fiscal year 1969, the participation of older workers in the program continued at about the same level as the previous year, with persons 45 years of age and older representing about 10 percent of the enrollments both in institutional and

on-the-job training. Cumulatively (fiscal years 1963–69), however, the participation is slightly higher, at 11 percent of the total enrollment. Following is the participation for both institutional training and on-the-job training for fiscal year 1969:

	Total MDTA	Institutional	OJT
Total enrolled	220,000	135,000	85,000.
45 and older	22,000	13,500 (10 percent)	8,500 (10 percent).

A number of training programs have been developed which meet the special training needs of the older group. The manpower training skills centers operated by the public school system with their open-ended, open-entry scheduling and remedial and support services represent a valuable resource for the training and retraining of older workers. Broader occupational choice is available in the cluster or galaxy concept in which a group of similar occupations is combined into a basic component. Training is offered in a broad basic occupational area with the opportunity to proceed into a specific phase of training which an individual finds he is most qualified to perform. The participation of older workers in skills center programs, although not identified separately, is assumed to be at a rate similar to the whole institutional program or about 10 percent.

Two successful national contracts have also afforded unique opportunities to older workers this year. A second contract with the Board for Fundamental Education and the Office of Education provides a continuation of the basic education training for workers in the steel industry with training opportunities extended to some 1,600 workers. Building on the experience in the steel industry contract, another contract with the Board for Fundamental Education was let to provide similar opportunities for some 2,000 workers in the rail industry. Both of these contracts are based on the premise that lack of an adequate basic education impedes upward job mobility. And they both represent a unique relationship wherein unions, management and Federal and private agencies are cooperating in an educational endeavor. Experience in the contracts to date indicates that the greatest impact has been on workers 45 years of age and older. It has been found, too, that with the educational barriers removed to promotion and transfer, it now remains for labor to look closely at seniority systems.

MDTA has also provided training in new and emerging occupations particularly suited to the older worker. At the Newark Manpower Training Skills Center both teenagers and adults are being trained for 30 weeks to qualify for jobs as brokerage clerks on Wall Street. Arranged in cooperation with the Association of Stock Exchange Firms, training is provided in securities nomenclature, order processing, and recordkeeping, along with the basic education the trainees need to qualify for high school equivalency certificates. Some of the workers trained in this course are over 50 years of age. This is a relatively new and prestigious occupation and one particularly suited to older workers.

The AMIDS (Area Manpower Institutes for the Development of Staff) are providing training, staff development and technical assistance to all manpower personnel working with the disadvantaged (and by definition, this includes persons 45 years of age and older). AMIDS were developed by the Office of Education in response to the need for counselors and instructional personnel in MDTA programs who possessed a unique understanding of the special learning and human needs of persons enrolled in MDTA programs. The AMIDS programs have been extended to all manpower personnel working with the disadvantaged whether in the MDTA program, State agencies such as the employment service and private industry.

ITEM 12: PRESIDENT'S COUNCIL ON AGING

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 20, 1970.

DEAR MR. CHAIRMAN: As requested in your letter of December 17, enclosed is a report of activities by the President's Council on Aging during 1969. Please let us know if you would like additional information.

Sincerely,

BOB FINCH, *Secretary.*

[Enclosure]

THE PRESIDENT'S COUNCIL ON AGING—1969

The President's Council on Aging is composed of the Secretary of Health, Education, and Welfare, its Chairman; the Secretaries of Agriculture, Commerce, Housing and Urban Development, Labor, Transportation, and Treasury; the Chairman of the Civil Service Commission; the Administrator of Veterans' Affairs; and the Director of the Office of Economic Opportunity. It is the principal mechanism established to assure interdepartmental communication on the various aspects of Federal aging policy, and interdepartmental cooperation on concerns of the Nation's elderly.

The Department and agency heads who are members of the Council are represented in its work by the Executive Committee, which is composed of representatives of each department or agency on the Council. Usually, members of the Executive Committee are the individuals in each member department or agency who have most direct responsibility for its work in aging. The Chairman of the Executive Committee is the Commissioner on Aging.

As one of the Council's activities during 1969, a report on "Federal Outlays in Aging" for the fiscal years 1964, 1966, 1968, 1969, and 1970 was prepared by Herman B. Brotman, Chief, Research and Statistics of the Administration on Aging. The report was based on information from various Federal agencies, which had been requested by the Secretary of Health, Education, and Welfare as Chairman of the Council. A copy of this report is attached hereto and is made a part hereof.

There were three meetings during 1969 of the Executive Committee's Subcommittee on Transportation Problems of the Elderly, attended by representatives of the Department of Transportation, the Administration on Aging, the Department of Housing and Urban Development, the Department of Agriculture, and the Office of Economic Opportunity. Those attending described programs of their respective departments and agencies affecting the mobility of the aged, and plans were made for publicizing the contribution made by each Federal department or agency toward solving transportation problems of the elderly.

The Executive Committee's Subcommittee on Group Services reviewed and assisted in the National Study of Senior Centers, which was conducted under a title IV contract between the Administration on Aging and the American Rehabilitation Foundation. This study resulted in a report entitled, "Senior Centers: Information From a National Survey" by Nancy N. Anderson, Ph. D., published during June 1969.

During the final weeks of 1969, plans were being made for concentration by the Council during 1970 on preparations for the White House Conference on Aging, called by President Nixon for November 1971.

Federal Government outlays in all programs of special benefit to the older (65 and over) population for the fiscal year ending June 30, 1970, are expected to total about $35.7 billion. This is just over double the $17.7 billion spent in the fiscal year ending June 30, 1964 (an increase of 102 percent) but does not take into account the fact that the older population will have increased about 13 percent during this 6-year period.

On a per-older-person basis, Federal spending will average out at about $1,785 for each of the 20 million older people in fiscal year 1970, an increase of less than 80 percent over the $1,000 average for each of the 17.7 million elderly in fiscal year 1964. In terms of per capita cost to the total population for providing all of these programs for older people, the average will be $173 for the 206.8 million people in the United States in fiscal year 1970. This represents an 86 percent increase over the per capita figure of $93 for each of the 190.8 million people in the United States in fiscal year 1964 since the older population grew faster than the total population.

Of the $1,785 per older person to be spent in 1970, $1,485 or 83 percent will come from trust funds previously established and to most of which the beneficiary has made a major contribution. Only $300 will be appropriated from general funds. In fiscal year 1964, before medicare and other improvements in social security, the portion of expenditures coming from trust funds was still 78 percent ($774 of $999).

	Fiscal year 1964	Fiscal year 1970
PER PERSON 65 PLUS		
Total	$998.53	$1,785.38
Trust funds	774.18	1,484.56
General funds	224.35	300.82
Program outlays:		
Federally operated	873.47	1,573.76
Non-Federally operated	110.09	173.77
Administrative costs	14.97	37.84
PERCENT DISTRIBUTION		
Total	100.0	100.0
Trust funds	77.5	83.2
General funds	22.5	16.8
Program outlays:		
Federally operated	87.5	88.1
Non-Federally operated	11.0	9.7
Administrative costs	1.5	2.1

These increases in the social security program also increased the amount of the Federal dollar spent in the programs operated directly by the Federal Government from 87.5 to 88.1 cents and in administrative costs from 1.5 to 2.1 cents in the 6-year period. Meanwhile, the proportion made available to other public and private agencies as Federal support fell from 11 to 9.7 cents. In total dollars, however, Federal support for nonfederally operated programs increased from $1.9 billion in fiscal year 1964 to $3.5 billion in fiscal year 1970.

COMPARISON OF FEDERAL OUTLAYS IN AGING FOR FISCAL YEARS 1964 AND 1970 [1]

Purpose	Percent distribution		Percent change 1964–70	Outlay per person aged 65 or over [2]	
	Fiscal year 1964	Fiscal year 1970		Fiscal year 1964	Fiscal year 1970
Total	100.0	100.0	+101.9	$998.50	$1,785.38
Income maintenance	94.0	73.6	+58.1	938.96	1,314.72
Retirement	65.8	53.4	+64.0	657.19	954.45
Disability	7.4	3.5	−4.0	73.85	62.78
Survivor	13.9	12.6	+82.5	138.92	224.54
Unemployment compensation	.6	.4	+9.5	6.49	6.30
Public assistance	6.2	3.7	+20.1	61.57	65.47
Other	.1	.1	+44.2	.92	1.18
Health and related services	4.7	24.8	+954.1	47.35	442.00
Provision of health services	4.0	24.2	+1,130.0	39.59	431.24
Medical care in Federal facility	1.2	1.0	+73.5	12.22	18.78
Payment for medical care	2.7	23.1	+1,601.9	27.37	412.46
Increasing health resources	.8	.6	+53.4	7.54	10.24
Construction (facilities and equipment)	.3	.2	+36.9	2.87	3.48
Direct construction (Federal facility)			+300.0	.03	.10
Federal support of construction	.3	.2	+39.3	2.74	3.38
Federal mortgage programs (insurance)				.10	
Health research (knowledge)	.2	.2	+78.7	2.31	3.66
Training and education (manpower)			+206.7	.07	.20
Organization and delivery	.2	.2	+43.4	2.29	2.90
Prevention and control of health problems			+171.0	.21	.52
Food and drug protection			+50.0	.01	.02
Other			+177.8	.20	.50

See footnotes at end of table.

COMPARISON OF FEDERAL OUTLAYS IN AGING FOR FISCAL YEARS 1964 AND 1970[1]—Continued

Purpose	Percent distribution		Percent change 1964–70	Outlay per person aged 65 or over[2]	
	Fiscal year 1964	Fiscal year 1970		Fiscal year 1964	Fiscal year 1970
Housing	.5	.7	+156.7	$5.26	$11.95
Rent supplements					.19
Low rent public housing	.3	.5	+229.1	2.96	8.64
Direct loans	.2	.2	+52.7	2.21	2.98
Mortgage insurance				.08	.04
Other					.10
Employment		.1	+779.3	.16	1.28
Services			+100.0	.16	.29
Training					.01
Work programs		.1			.98
Other					
Social and Rehabilitation Services	.4	.5	+132.9	4.17	8.60
Rehabilitation			+592.3	.07	.45
Social services	.4	.4	+97.3	3.96	6.92
Research (knowledge)			+187.5	.09	.23
Training (manpower)			+4,900.0	.01	.25
Other AoA programs			+1,842.8	.04	.68
Other OEO programs					.07
Education					.14
Consumer food programs	.3	.3	+120.4	2.60	5.07
Other		.1			1.62

[1] See following tables for dollar amounts, etc.
[2] Based on estimated average of 17,710,000 older persons for fiscal year 1964 and 20,000,000 for fiscal year 1970.

FEDERAL OUTLAYS IN AGING, FISCAL YEARS 1964, 1966, 1968, 1969, AND 1970

[In millions of dollars]

PT. A. SUMMARY: BY PURPOSE AND TYPE OF FUNDING

Purpose	1964	1966	1968	1969	1970
ALL FUNDS					
Total	[1] 17,683.9	[1] 20,999.6	29,695.2	[2] 33,393.7	[3] 35,707.5
Income maintenance	16,629.4	19,628.2	22,527.6	25,216.1	26,294.3
Retirement	11,639.2	13,991.9	16,181.8	18,283.4	19,089.0
Disability	1,308.0	1,385.0	1,334.1	1,335.2	1,255.6
Survivor	2,460.4	3,038.5	3,746.7	4,251.2	4,490.9
Unemployment compensation	115.0	92.3	105.7	118.8	125.9
Public assistance	1,090.5	1,101.3	1,138.2	1,205.3	1,309.4
Other	16.3	19.2	21.1	22.2	23.5
Health and related services	[4] 838.6	[4] 1,076.9	6,745.5	[5] 7,680.6	[5] 8,840.1
Provision of health services	701.2	904.4	6,550.1	7,477.5	8,624.9
Medical care in Federal facility	216.5	249.1	304.3	341.7	375.7
Payment for medical care	484.7	655.3	6,245.8	7,135.8	8,249.2
Increasing health resources	[4] 133.6	[4] 167.5	186.4	[5] 193.3	[5] 204.9
Construction (facilities and equipment)	[4] 50.9	[4] 52.9	65.2	[5] 64.2	[5] 69.7
Direct construction (Federal facility)	.5	.8	1.0	2.0	2.0
Federal support of construction	48.6	50.3	61.1	62.2	67.7
Federal mortgage programs (insurance)	[4] 1.8	[4] 1.8	3.1	([5])	([5])
Health research (knowledge)	40.9	49.1	58.5	63.8	73.1
Training and education (manpower)	1.3	3.0	3.7	4.0	4.0
Organization and delivery	40.5	62.5	59.0	61.3	58.1
Prevention and control of health problems	3.8	5.0	9.0	9.8	10.3
Food and drug protection	.2	.2	.2	.3	.3
Other	3.6	4.8	8.8	9.5	10.0

FEDERAL OUTLAYS IN AGING, FISCAL YEARS 1964, 1966, 1968, 1969, AND 1970—Continued

PT. A. SUMMARY: BY PURPOSE AND TYPE OF FUNDING—Continued

Purpose	1964	1966	1968	1969	1970
Housing	[6] 93.1	[6] 153.8	209.5	[7] 202.8	[8] 239.0
Rent supplements			.9	2.2	3.8
Low rent public housing	52.5	80.8	111.1	116.7	[9] 172.8
Direct loans	39.1	71.2	88.5	82.2	59.7
Mortgage insurance	[6] 1.5	[6] 1.8	8.3	[7] .4	[7] .7
Other			.7	1.3	2.0
Employment	2.9	3.8	16.2	19.5	25.5
Services	2.9	3.7	4.5	5.1	5.8
Training			.2	.2	.2
Work programs			11.5	14.2	19.5
Other		.1			
Social and rehabilitation services	73.9	103.8	123.5	159.9	172.1
Rehabilitation	1.3	2.6	5.1	7.1	9.0
Social services	70.2	92.4	98.6	125.2	138.5
Research (knowledge)	1.6	1.9	4.6	5.2	4.6
Training (manpower)	.1	1.0	3.2	4.3	5.0
Other AoA programs	.7	5.9	10.3	16.2	13.6
Other OEO programs			1.7	1.9	1.4
Education		1.3	2.3	2.6	2.7
Consumer food programs	46.0	31.8	47.0	83.5	101.4
Other			23.6	28.7	32.4
TRUST FUNDS					
Total	13,710.7	16,577.9	24,619.1	28,069.3	29,691.1
Income maintenance	13,707.7	16,574.1	19,267.3	21,842.3	22,834.3
Retirement	11,514.3	13,837.2	15,989.8	18,061.8	18,841.7
Disability	98.2	113.9	135.2	148.3	163.5
Survivor	1,966.3	2,513.7	3,017.9	3,493.9	3,682.5
Unemployment compensation	113.0	90.5	103.7	116.5	123.5
Other	15.9	18.8	20.7	21.8	23.1
Health and related services	.1	.1	5,347.3	6,221.9	6,851.0
Provision of health services: Payment for medical care			5,347.2	6,221.8	6,850.9
Increasing health resources: Construction (facilities and equipment), direct construction (Federal facility)	.1	.1	.1	.1	.1
Employment services	2.9	3.7	4.5	5.1	5.8
GENERAL FUNDS					
Total	[1] 3,973.2	[1] 4,421.7	5,076.1	[2] 5,324.4	[3] 6,016.4
Income maintenance	2,921.7	3,054.1	3,260.3	3,373.8	3,460.0
Retirement	124.9	154.7	192.0	221.6	247.3
Disability	1,209.8	1,271.1	1,198.9	1,186.9	1,092.1
Survivor	494.1	524.8	728.8	757.3	808.4
Unemployment compensation	2.0	1.8	2.0	2.3	2.4
Public assistance	1,090.5	1,101.3	1,138.2	1,205.3	1,309.4
Other	.4	.4	.4	.4	.4

FEDERAL OUTLAYS IN AGING, FISCAL YEARS 1964, 1966, 1968, 1969, AND 1970—Continued

PT. A. SUMMARY: BY PURPOSE AND TYPE OF FUNDING—Continued

Purpose	1964	1966	1968	1969	1970
Health and related services	[4] 838.5	[4] 1,076.8	1,389.2	[5] 1,458.7	[5] 1,989.1
Provision of health services	701.2	904.4	1,202.9	1,255.7	1,774.0
Medical care in Federal facility	216.5	249.1	304.3	341.7	375.7
Payment for medical care	484.7	655.3	898.6	914.0	1,398.3
Increasing health resources	[4] 137.3	[4] 172.4	195.3	[5] 203.0	[5] 215.1
Construction (facilities and equipment)	[4] 50.8	[4] 52.8	65.1	[5] 64.1	[5] 69.6
Direct construction (Federal facility)	.4	.7	.9	1.9	1.9
Federal support of construction	48.6	50.3	61.1	62.2	67.7
Federal mortgage programs (insurance)	[4] 1.8	[4] 1.8	3.1	([5])	([5])
Health research (knowledge)	40.9	49.1	58.5	63.8	73.1
Training and education (manpower)	1.3	3.0	3.7	4.0	4.0
Organization and delivery	40.5	62.5	59.0	61.3	58.1
Prevention and control of health problems	3.8	5.0	9.0	9.8	10.3
Food and drug protection	.2	.2	.2	.3	.3
Other	3.6	4.8	8.8	9.5	10.0
Housing	[6] 93.1	[6] 153.8	209.5	[7] 202.8	[8] 239.0
Rent supplements			.9	2.2	3.8
Low rent public housing	52.5	80.8	111.1	116.7	[9] 172.8
Direct loans	39.1	71.2	88.5	82.2	59.7
Mortgage insurance	[6] 1.5	[6] 1.8	8.3	[7] .4	[7] .7
Other			.7	1.3	2.0
Employment		.1	11.7	14.4	19.7
Training			.2	.2	.2
Work programs			11.5	14.2	19.5
Other		.1			
Social and rehabilitation services	73.9	103.8	123.5	159.9	172.1
Rehabilitation	1.3	2.6	5.1	7.1	9.0
Social services	70.2	92.4	98.6	125.2	138.5
Research (knowledge)	1.6	1.9	4.6	5.2	4.6
Training (manpower)	.1	1.0	3.2	4.3	5.0
Other AOA programs	.7	5.9	10.3	16.2	13.6
Other OEO programs			1.7	1.9	1.4
Education		1.3	2.3	2.6	2.7
Consumer food programs	46.0	31.8	47.0	83.5	101.4
Other			23.6	28.7	32.4

Note: See footnotes at end of table, pt. D.

PT. B. DETAIL: BY PURPOSE, TYPE OF FUNDING, AND LEVEL OF OPERATION

[In millions of dollars]

Purpose	Program outlays: Federally operated					Program outlays: Nonfederally operated					Federal administrative costs				
	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970
ALL FUNDS															
Total	15,469.1	18,488.4	26,447.0	29,896.4	31,475.2	[1] 1,949.7	[1] 2,188.7	2,627.4	[1] 2,798.4	[10] 3,475.4	265.1	322.5	620.8	[11] 698.9	[11] 756.9
Income maintenance	15,178.6	18,134.3	20,908.7	23,505.4	24,442.1	1,200.9	1,190.3	1,241.2	1,321.5	1,432.6	249.9	303.6	377.7	389.2	419.6
Retirement	11,434.9	13,744.4	15,874.2	17,967.8	18,749.6						204.3	247.5	307.6	315.6	339.4
Disability	1,301.1	1,378.1	1,327.9	1,329.0	1,249.0						6.9	6.9	6.2	6.2	6.6
Survivor	2,423.0	2,990.7	3,684.3	4,185.4	4,419.0						37.4	17.8	62.4	65.8	71.9
Unemployment compensation	3.7	2.3	1.6	1.4	1.4	111.0	89.8	104.0	117.3	124.4	.3	.2	.1	.1	.1
Public assistance						1,089.9	1,100.5	1,137.2	1,204.2	1,308.2	.6	.8	1.0	1.1	1.2
Other	15.9	18.8	20.7	21.8	23.1						.4	.4	.4	.4	.4
Health and related services	290.5	354.1	5,538.3	6,391.0	7,033.1	[4] 541.1	[4] 715.0	976.9	[4] 993.8	[4] 1,485.2	7.0	7.8	230.3	[12] 295.8	[12] 321.8
Provision of health services	214.6	247.4	5,428.4	6,273.6	6,911.0	483.0	653.1	895.9	911.0	1,395.2	3.6	3.9	225.8	292.9	318.7
Medical care in Federal facility	213.7	246.4	301.3	338.3	371.6						2.8	2.7	3.0	3.4	4.1
Payment for medical care	.9	1.0	5,127.1	5,935.3	6,539.4	483.0	653.1	895.9	911.0	1,395.2	.8	1.2	222.8	289.5	314.6
Increasing health resources	74.2	104.1	105.1	112.2	116.6	[4] 56.5	[4] 60.0	77.4	[4] 79.0	[4] 86.0	2.9	3.4	3.9	[12] 2.1	[12] 2.3
Construction (facilities and equipment)	.5	.8	1.0	2.0	2.0	[4] 48.1	[4] 49.5	61.4	[4] 61.3	[4] 66.7	2.3	2.6	2.8	[12] .9	[12] 1.0
Direct construction (Federal facility)	.5	.8	1.0	2.0	2.0										
Federal support of construction						48.1	49.5	60.2	61.3	66.7	.5	.8	.9	.9	1.0
Federal mortgage programs (insurance)						(4)	(4)	1.2	(4)	(4)	1.8	1.8	1.9	(12)	(12)
Health research (knowledge)	33.1	40.6	48.7	53.8	62.9	7.2	7.7	8.8	8.9	9.0	.6	.8	1.0	1.1	1.2
Training and education (manpower)	.1	.2	.2	.3	.4	1.2	2.8	3.4	3.6	3.5			.1	.1	.1
Organization and delivery	40.5	62.5	55.2	56.1	51.3			3.8	5.2	6.8					
Prevention and control of health problems	1.7	2.6	4.8	5.2	5.5	1.6	1.9	3.6	3.8	4.0	.5	.5	.6	.8	.8
Food and drug protection											.2	.2	.2	.3	.3
Other	1.7	2.6	4.8	5.2	5.5	1.6	1.9	3.6	3.8	4.0	.3	.3	.4	.5	.5
Housing						[6] 86.6	[6] 145.0	200.2	[6] 193.7	[13] 229.2	6.5	8.8	9.3	[14] 9.1	[14] 9.8
Rent supplements								.8	2.1	3.7			.1	.1	.1
Low rent public housing						48.6	75.4	105.0	110.0	[9] 165.7	3.9	5.4	6.1	6.7	7.1
Direct loans						38.0	69.6	86.7	80.3	57.8	1.1	1.6	1.8	1.9	1.9
Mortgage insurance						(6)	(6)	7.0	(6)	(6)	1.5	1.8	1.3	[14] .4	[14] .7
Other								.7	1.3	2.0					

See footnotes at end of table, pt. D.

PT. B. DETAIL: BY PURPOSE, TYPE OF FUNDING, AND LEVEL OF OPERATION—Continued

[In millions of dollars]

Purpose	Program outlays: Federally operated					Program outlays: Nonfederally operated					Federal administrative costs				
	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970
Employment						2.9	3.8	16.2	19.5	25.5					
Services						2.9	3.7	4.5	5.1	5.8					
Training								.2	.2	.2					
Work programs								11.5	14.2	19.5					
Other							.1								
Social and rehabilitation services						72.9	102.2	121.1	156.9	168.7	1.0	1.6	2.4	3.0	3.4
Rehabilitation						1.3	2.6	5.1	7.1	9.0					
Social services						70.1	92.2	98.4	124.9	138.2	.1	.2	.2	.3	.3
Research (knowledge)						1.5	1.7	4.4	4.9	4.3	.1	.2	.2	.3	.3
Training (manpower)							.8	3.0	4.0	4.7	.1	.2	.2	.3	.3
Other AoA programs							4.9	9.1	14.8	11.8	.7	1.0	1.2	1.4	1.8
Other OEO programs								1.1	1.2	.7			.6	.7	.7
Education							1.3	2.3	2.6	2.7					
Consumer food programs						45.3	31.1	45.9	81.7	99.1	.7	.7	1.1	1.8	2.3
Other								23.6	28.7	32.4					
TRUST FUNDS															
Total	13,358.9	16,193.2	23,924.8	27,283.7	28,843.5	111.9	91.7	106.5	120.1	127.8	239.9	293.0	587.8	665.5	719.8
Income maintenance	13,358.8	16,193.1	18,798.8	21,349.6	22,305.4	109.0	88.0	102.0	115.0	122.0	239.9	293.0	366.5	377.7	406.9
Retirement	11,310.0	13,589.7	15,682.2	17,746.2	18,502.3						204.3	247.5	307.6	315.6	339.4
Disability	97.4	113.1	134.5	147.5	162.7						.8	.8	.7	.8	.8
Survivor	1,931.8	2,469.2	2,959.8	3,432.7	3,615.9						34.5	44.5	58.1	61.2	66.6
Unemployment compensation	3.7	2.3	1.6	1.4	1.4	109.0	88.0	102.0	115.0	122.0	.3	.2	.1	.1	.1
Other	15.9	18.8	20.7	21.8	23.1										
Health and related services	.1	.1	5,126.0	5,934.1	6,538.1								221.3	287.8	312.9
Provision of health services: Payment for medical care			5,125.9	5,934.0	6,538.0								221.3	287.8	312.9
Increasing health resources: Construction (facilities and equipment), direct construction (Federal facility)	.1	.1	.1	.1	.1										
Employment services						2.9	3.7	4.5	5.1	5.8					

GENERAL FUNDS															
Total	2,110.2	2,295.2	2,522.2	2,612.7	2,631.7	[1]1,837.8	[1]2,097.0	2,520.9	[1]2,678.3	[10]3,347.6	25.2	29.5	33.0	[11]33.4	[11]37.1
Income maintenance	1,819.8	1,941.2	2,109.9	2,155.8	2,136.7	1,091.9	1,102.3	1,139.2	1,206.5	1,310.6	10.0	10.6	11.2	11.5	12.7
Retirement	124.9	154.7	192.0	221.6	247.3										
Disability	1,203.7	1,265.0	1,193.4	1,181.5	1,086.3						6.1	6.1	5.5	5.4	5.8
Survivor	491.2	521.5	724.5	752.7	803.1						2.9	3.3	4.3	4.6	5.3
Unemployment compensation						2.0	1.8	2.0	2.3	2.4					
Public assistance						1,089.9	1,100.5	1,137.2	1,204.2	1,308.2	.6	.8	1.0	1.1	1.2
Other											.4	.4	.4	.4	.4
Health and related services	290.4	354.0	412.3	456.9	495.0	[4]541.1	[4]715.0	976.9	[4]993.8	[4]1,485.2	7.0	7.8	9.0	[12]8.0	[12]8.9
Provision of health services	214.6	247.4	302.5	339.6	373.0	483.0	653.1	895.9	911.0	1,395.2	3.6	3.9	4.5	5.1	5.8
Medical care in Federal facility	213.7	246.4	301.3	338.3	371.6						2.8	2.7	3.0	3.4	4.1
Payment for medical care	.9	1.0	1.2	1.3	1.4	483.0	653.1	895.9	911.0	1,395.2	.8	1.2	1.5	1.7	1.7
Increasing health resources	74.1	104.0	105.0	112.1	116.5	[4]56.5	[4]60.0	77.4	[4]79.0	[4]86.0	2.9	3.4	3.9	[12]2.1	[12]2.3
Construction (facilities and equipment)	.4	.7	.9	1.9	1.9	[4]48.1	[4]49.5	61.4	[4]61.3	[4]66.7	2.3	2.6	2.8	[12].9	[12]1.0
Direct construction (Federal facility)	.4	.7	.9	1.9	1.9										
Federal support of construction						48.1	49.5	60.2	61.3	66.7	.5	.8	.9	.9	1.0
Federal mortgage programs (insurance)						(4)	(4)	1.2	(4)	(4)	1.8	1.8	1.9	(12)	(12)
Health research (knowledge)	33.1	40.6	48.7	53.8	62.9	7.2	7.7	8.8	8.9	9.0	.6	.8	1.0	1.1	1.2
Training and education (manpower)	.1	.2	.2	.3	.4	1.2	2.8	3.4	3.6	3.5			.1	.1	.1
Organization and delivery	40.5	62.5	55.2	56.1	51.3			3.8	5.2	6.8					
Prevention and control of health problems	1.7	2.6	4.8	5.2	5.5	1.6	1.9	3.6	3.8	4.0	.5	.5	.6	.8	.8
Food and drug protection											.2	.2	.2	.3	.3
Other	1.7	2.6	4.8	5.2	5.5	1.6	1.9	3.6	3.8	4.0	.3	.3	.4	.5	.5
Housing						[6]86.6	[6]145.0	200.2	[6]193.7	[13]229.2	6.5	8.8	9.3	[14]9.1	[14]9.8
Rent supplements								.8	2.1	3.7			.1	.1	.1
Low rent public housing						48.6	75.4	105.0	110.0	[9]165.7	3.9	5.4	6.1	6.7	7.1
Direct loans						38.0	69.6	86.7	80.3	57.8	1.1	1.6	1.8	1.9	1.9
Mortgage insurance						(6)	(6)	7.0	(6)	(6)	1.5	1.8	1.3	[14].4	[14].7
Other								.7	1.3	2.0					
Employment							.1	11.7	14.4	19.7					
Training								.2	.2	.2					
Work programs								11.5	14.2	19.5					
Other							.1								

Note: See footnotes at end of table, pt. D.

PT. B. DETAIL: BY PURPOSE, TYPE OF FUNDING, AND LEVEL OF OPERATION—Continued

[In millions of dollars]

Purpose	Program outlays: Federally operated					Program outlays: Nonfederally operated					Federal administrative costs				
	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970
Social and rehabilitation services						72.9	102.2	121.1	156.9	168.7	1.0	1.6	2.4	3.0	3.4
Rehabilitation						1.3	2.6	5.1	7.1	9.0					
Social services						70.1	92.2	98.4	124.9	138.2	.1	.2	.2	.3	.3
Research (knowledge)						1.5	1.7	4.4	4.9	4.3	.1	.2	.2	.3	.3
Training (manpower)							.8	3.0	4.0	4.7	.1	.2	.2	.3	.3
Other AoA programs							4.9	9.1	14.8	11.8	.7	1.0	1.2	1.4	1.8
Other OEO programs								1.1	1.2	.7			.6	.7	.7
Education							1.3	2.3	2.6	2.7					
Consumer food programs						45.3	31.1	45.9	81.7	99.1	.7	.7	1.1	1.8	2.3
Other								23.6	28.7	32.4					

PART C. SUMMARY: BY AGENCY AND TYPE OF FUNDING

[In millions of dollars]

Agency	1964	1966	1968	1969	1970
ALL FUNDS					
Total	[1] 17,683.9	[1] 20,999.6	29,695.2	[2] 33,393.7	[3] 35,707.5
Departments:					
Agriculture	55.1	49.6	52.9	91.8	110.8
Defense	181.2	220.9	271.7	309.6	341.0
Health, Education, and Welfare	13,537.1	16,391.8	24,292.4	27,589.5	29,647.5
Office of Education		1.3	1.6	1.8	1.9
Public Health Service	103.4	132.0	142.9	146.9	148.7
Social and Rehabilitation Service	1,632.6	1,840.7	2,126.7	2,242.4	2,853.4
Social Security Administration	11,801.1	14,417.8	22,021.2	25,198.4	26,643.5
Housing and Urban Development	[1] 85.8	[1] 137.8	205.7	[2] 189.2	[3] 221.6
Labor	113.9	93.6	108.5	122.4	130.2
Transportation	4.0	5.0	5.6	6.2	6.5

Independent agencies:					
Atomic Energy Commission	4.4	4.5	5.3	5.6	5.7
Civil Service Commission	809.0	995.2	1,268.9	1,397.0	1,540.9
Office of Economic Opportunity			47.1	63.8	66.3
Railroad Retirement Board	911.7	995.9	1,167.5	1,287.0	1,307.1
Veterans' Administration	1,981.7	2,105.3	2,269.6	2,331.6	2,329.9
TRUST FUNDS					
Total	13,710.7	16,577.9	24,619.1	28,069.3	29,691.1
Departments:					
Health, Education, and Welfare	11,801.2	14,417.9	22,021.3	25,198.5	26,643.6
Public Health Service	.1	.1	.1	.1	.1
Social Security Administration	11,801.1	14,417.8	22,021.2	25,198.4	26,643.5
Labor	111.9	91.7	106.5	120.1	127.8
Independent agencies:					
Civil Service Commission	793.4	976.5	1,242.8	1,370.9	1,514.5
Railroad Retirement Board	911.7	995.9	1,167.5	1,287.0	1,307.1
Veterans' Administration	92.5	95.9	81.0	92.8	98.1
GENERAL FUNDS					
Total	[1] 3,973.2	[1] 4,421.7	5,076.1	[2] 5,324.4	[3] 6,016.4
Departments:					
Agriculture	55.1	49.6	52.9	91.8	110.8
Defense	181.2	220.9	271.7	309.6	341.0
Health, Education, and Welfare	1,735.9	1,973.9	2,271.1	2,391.0	3,003.9
Office of Education		1.3	1.6	1.8	1.9
Public Health Service	103.3	131.9	142.8	146.8	148.6
Social and Rehabilitation Service	1,632.6	1,840.7	2,126.7	2,242.4	2,853.4
Housing and Urban Development	[1] 85.8	[1] 137.8	205.7	[2] 189.2	[3] 221.6
Labor	2.0	1.9	2.0	2.3	2.4
Transportation	4.0	5.0	5.6	6.2	6.5
Independent agencies:					
Atomic Energy Commission	4.4	4.5	5.3	5.6	5.7
Civil Service Commission	15.6	18.7	26.1	26.1	26.4
Office of Economic Opportunity			47.1	63.8	66.3
Veterans' Administration	1,889.2	2,009.4	2,188.6	2,238.8	2,231.8

See footnotes at end of table, pt. D.

PART. D. DETAIL: BY AGENCY, TYPE OF FUNDING, AND LEVEL OF OPERATION

[In millions of dollars]

Agency	Program outlays: Federally operated					Program outlays: Nonfederally operated					Federal administrative costs				
	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970	1964	1966	1968	1969	1970
ALL FUNDS															
Total	15,469.1	18,488.4	26,447.0	29,896.4	31,475.2	[1] 1,949.7	[1] 2,188.7	2,627.4	[1] 2,798.4	[10] 3,475.4	265.1	322.5	620.8	[11] 698.9	[11] 756.9
Departments:															
Agriculture						54.1	48.2	51.0	89.0	107.1	1.0	1.4	1.9	2.8	3.7
Defense	181.2	220.9	271.7	309.6	341.0										
Health, Education, and Welfare	11,621.6	14,210.1	21,518.3	24,621.9	26,009.1	1,683.9	1,895.8	2,194.7	2,311.1	2,927.2	231.6	285.9	579.4	656.5	711.2
Office of Education							1.3	1.6	1.8	1.9					
Public Health Service	48.6	73.1	70.4	72.9	69.1	53.7	57.4	70.7	72.0	77.5	1.1	1.5	1.8	2.0	2.1
Social and Rehabilitation Service						1,630.2	1,837.1	2,122.4	2,237.3	2,847.8	2.4	3.6	4.3	5.1	5.6
Social Security Administration	11,573.0	14,137.0	21,447.9	24,549.0	25,940.0						228.1	280.8	573.3	649.4	703.5
Housing and Urban Development						[1] 77.8	[1] 127.9	195.3	[1] 181.1	[10] 213.2	8.0	9.9	10.4	[11] 8.1	[11] 8.4
Labor						113.9	93.6	108.5	122.4	130.2					
Transportation	4.0	5.0	5.6	6.2	6.5										
Independent agencies:															
Atomic Energy Commission						4.4	4.5	5.3	5.6	5.7					
Civil Service Commission	791.4	974.4	1,240.4	1,368.0	1,511.5	15.6	18.7	26.1	26.1	26.4	2.0	2.1	2.4	2.9	3.0
Office of Economic Opportunity								46.5	63.1	65.6			.6	.7	.7
Railroad Retirement Board	901.9	985.8	1,155.4	1,273.8	1,293.8						9.8	10.1	12.1	13.2	13.3
Veterans Administration	1,969.0	2,092.2	2,255.6	2,316.9	2,313.3						12.7	13.1	14.0	14.7	16.6
TRUST FUNDS															
Total	13,358.9	16,193.2	23,924.8	27,283.7	28,843.5	111.9	91.7	106.5	120.1	127.8	239.9	293.0	587.8	665.5	719.8
Departments:															
Health, Education, and Welfare	11,573.1	14,137.1	21,448.0	24,549.1	25,940.1						228.1	280.8	573.3	649.4	703.5
Public Health Service	.1	.1	.1	.1	.1										
Social Security Administration	11,573.0	14,137.0	21,447.9	24,549.0	25,940.0						228.1	280.8	573.3	649.4	703.5
Labor						111.9	91.7	106.5	120.1	127.8					
Independent agencies:															
Civil Service Commission	791.4	974.4	1,240.4	1,368.0	1,511.5						2.0	2.1	2.4	2.9	3.0
Railroad Retirement Board	901.9	985.8	1,155.4	1,273.8	1,293.8						9.8	10.1	12.1	13.2	13.3
Veterans Administration	92.5	95.9	81.0	92.8	98.1										

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
GENERAL FUNDS															
Total	2,110.2	2,295.2	2,522.2	2,612.7	2,631.7	[1] 1,837.8	[1] 2,097.0	2,520.9	[1] 2,678.3	[10] 3,347.6	25.2	29.5	33.0	[11] 33.4	[11] 37.1
Departments:															
Agriculture						54.1	48.2	51.0	89.0	107.1	1.0	1.4	1.9	2.8	3.7
Defense	181.2	220.9	271.7	309.6	341.0										
Health, Education, and Welfare	48.5	73.0	70.3	72.8	69.0	1,683.9	1,895.8	2,194.7	2,311.1	2,927.2	3.5	5.1	6.1	7.1	7.7
Office of Education							1.3	1.6	1.8	1.9					
Public Health Service	48.5	73.0	70.3	72.8	69.0	53.7	57.4	70.7	72.0	77.5	1.1	1.5	1.8	2.0	2.1
Social and Rehabilitation Service						1,630.2	1,837.1	2,122.4	2,237.3	2,847.8	2.4	3.6	4.3	5.1	5.6
Housing and Urban Development						[1] 77.8	[1] 127.9	195.3	[1] 181.1	[10] 213.2	8.0	9.9	10.4	[11] 8.1	[11] 8.4
Labor						2.0	1.9	2.0	2.3	2.4					
Transportation	4.0	5.0	5.6	6.2	6.5										
Independent Agencies:															
Atomic Energy Commission						4.4	4.5	5.3	5.6	5.7					
Civil Service Commission						15.6	18.7	26.1	26.1	26.4					
Office of Economic Opportunity								46.5	63.1	65.6			.6	.7	.7
Veterans Administration	1,876.5	1,996.3	2,174.6	2,224.1	2,215.2						12.7	13.1	14.0	14.7	16.6

[1] See footnotes 4 and 6.
[2] See footnotes 4, 6, 12, and 14.
[3] See footnotes 4, 6, 9, 12, and 14.
[4] Data not available for program costs, nursing home mortgage guarantees.
[5] See footnotes 4 and 12.
[6] Data not available for program costs, rental housing mortgage guarantees.
[7] See footnotes 6 and 14.
[8] See footnotes 6, 9, and 14.
[9] Includes fiscal year 1969 supplementary.
[10] See footnotes 4, 6, and 9.
[11] See footnotes 12 and 14.
[12] Data not available for administrative costs, nursing home mortgage guarantees.
[13] See footnotes 6 and 9.
[14] Data not available for administrative costs, rental housing mortgage guarantees.

ITEM 13: REGIONAL MEDICAL PROGRAMS SERVICE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Bethesda, Md., January 19, 1970.

DEAR SENATOR WILLIAMS: In response to your letter of December 17, 1969 we are herewith submitting a report on the Regional Medical Programs Service activities relating to aging and to the elderly.

I hope the enclosed statement will be useful to the Senate Special Committee on Aging in its preparation of the 1969 annual report on the "Developments in Aging."

If we can be of further assistance, please let me know.

Sincerely yours,

STANLEY W. OLSON, M.D.,
Director, Regional Medical Programs Service.

[Enclosure]

REGIONAL MEDICAL PROGRAMS

Regional medical programs, through grants, assist the Nation's health institutions and professions in putting into widespread practice the most recent and effective advances of scientific medicine in the prevention, diagnosis, treatment, and rehabilitation of heart disease, cancer, stroke, and related diseases, including emphysema, diabetes, and kidney and nutrition disorders; and thereby to improve the quality of care provided to patients suffering from, or those threatened by, these diseases. The enabling legislation (Public Law 89–239) requires that this be accomplished through a process of voluntary regional cooperative arrangements among medical schools, hospitals, practitioners, and other health resources.

The efforts of regional medical programs to improve health care in the areas of heart disease, cancer, stroke, and related diseases include prevention as well as treatment and rehabilitation. The activities include continuing education and training programs for health professionals in prevention and screening methods, multiphasic screening programs, and detection for specific diseases and public education programs.

By the end of calendar year 1969, 44 of the 55 regional medical programs were engaged in "operational" activities. Half of the programs had become operational in 1969 and are still in the developmental phase.

The majority of disease oriented activities are not directed solely at the aging or aged population. Nevertheless, efforts aimed at the improvement of care for the aging and lessening the impact of chronic long-term illnesses are beginning to emerge in activities such as disease detection and prevention (screening activities), public education, followup, rehabilitation and improved care for the ambulatory, as well as demonstrations in the care of persons suffering from or susceptible to the threat of cardiovascular disease including hypertension, cerebrovascular disease, diabetes, pulmonary (emphysema) and nutritional problems and malignant neoplasms.

Typical activities underway in regions which suggest direct or indirect impact on the improvement of health and quality of medical care for the aging and aged are found in projects in the areas of stroke and rehabilitation, nutrition, diabetes, cardiovascular and pulmonary diseases, multiple screening services, follow up and long-term care for the chronically ill.

The following highlights the elements of some of the activities involving the aged currently being supported in selected regions.

CEREBROVASCULAR DISEASE AND STROKE—REHABILITATION

Development of a comprehensive statewide stroke program.—Each of the five subregions of the State will be responsible for developing a stroke program related to and in cooperation with existing facilities and services. The coordination of the program will be through select community hospitals identified as capable of providing comprehensive services to surrounding communities through cooperative arrangements with other institutions and agencies.

Training program in reality orientation technique.—To improve care and rehabilitation of older patients with cerebrovascular disease and stroke. Training will be directed toward a broad spectrum of health service personnel, with special attention to lower echelon personnel in nursing homes that therapeutic patient environment will replace custodial environment.

A comprehensive stroke program.—Based at Orange County and Long Beach. Would encompass prevention, diagnosis, treatment, rehabilitation, and long-term care of stroke patients throughout the area. Besides enhancing patient care, project seeks to assist in the process of regionalization. Every acute care hospital in area was contacted, as were representatives from extended area facilities, and many health service agencies, with "unanimous" support from all. The community would support the program at some unspecified future time.

Rehabilitation consultation service.—This project would focus on stroke using a mobile team which would provide consultation, service, and educational programs in peripheral hospitals and other health care facilities in the region. The proposed team would be under the direction of a physician and be composed of physical and occupational therapists, speech pathologists, and orthotists. Additional consultative services would be available from other departments of the Upstate Medical Center which has an established rehabilitation program and is designated as a primary rehabilitation facility by the State.

Training in rehabilitation in catastrophic diseases.—The Rehabilitation Center in Honolulu will collaborate with the Hawaii regional medical program in providing training for medical and paramedical personnel in the execution of planned rehabilitation programs. Formal courses will be held in Honolulu every 3 months. Lectures and demonstrations will be held at already identified auxiliary centers on each of the neighboring islands, at monthly or quarterly intervals.

Stroke and related neurologic disease.—To establish visiting consultant and teaching clinics that will bring expert consultation service in stroke and related neurological diseases to local communities and provide continuing education to local nurses and physicians; and to collect data about the type of patients seen with these diseases and the problems they present to the practitioner. To establish an information library and telephone consultation service to keep the practitioner abreast of knowledge about the care of stroke victims; to provide him with advice at the moment he needs it. A 24-hour telephone consultation service and information library service will be maintained at the University of Utah Medical Center.

Model demonstration acute stroke care and rehabilitation unit.—To provide a model unit for research, education and demonstration of exemplary care in cerebrovascular disease. Information obtained on stroke patients in this unit will be used to define what is necessary and feasible to provide "optimum" management.

A comprehensive program in stroke management.—Stroke teams in 16 communities will be responsible for educational programs for health personnel concerned with the total management of the stroke patient; consultation to physicians; strengthening arrangements in the community for continuity of care; and supervising nursing rehabilitation services.

Cerebrovascular and neurological nurse training.—To increase: (1) Understanding and participation in the multidisciplinary approach to patient care; (2) understanding of the interrelatedness of patient, family and community; (3) ability to assess and analyze nursing problems peculiar to patients with cerebrovascular and neurological disease; (4) knowledge and skills necessary to give direct care to patients with cerebrovascular and neurological conditions; (5) skills in preventive measures of complications from prolonged bed rest; and (6) ability to help patient move from dependence to independence, i.e. activities of daily living.

Acute and chronic stroke units.—A four-bed acute stroke unit will be established at Johns Hopkins to provide initial diagnosis and intensive care of patients with acute cerebral vascular episodes.

Acute intermediate and long-term stroke care program.—The York Hospital, a 530-bed acute general hospital, would establish a four-bed acute stroke unit, an 18-bed intermediate care unit, and a three-bed special evaluation and post-intermediate care unit for the complete care and rehabilitation of patients with stroke.

Proposal on stroke.—The University of Maryland would expand the services of its functioning outpatient stroke clinic, to establish a four-bed acute stroke unit, and augment an existing cooperative arrangement with Montebello State Hospital for care of patients with rehabilitation potential.

Establishment of a stroke center in the Memphis region.—A "model center" for management of stroke, including a special unit for the intensive care of stroke, would be developed in the University of Tennessee—City of Memphis Medical Center. The center would be used for development of a training program to provide special nursing skills, dissemination of new information techniques and therapeutic approaches, expansion of physical therapy training facilities, and development of continuing education programs for stroke management. The facility would be available for complex diagnostic problems referred from all medical institutions in the region.

The Freedman's Hospital Stroke Station for the diagnosis, treatment, and investigation of cerebral vascular disease.—To establish a stroke station in which the latest methods for the diagnosis and treatment of cerebral vascular disease will be carried out and taught to medical personnel, students, and paramedical and allied personnel. A team of physicians, social workers, psychologist, occupational therapist, etc. will be involved.

Northeast Missouri cooperative stroke pilot project, Kirksville Clinic of Osteopathy and Surgery.—To study and demonstrate how physicians, clinics, and hospitals can cooperate to improve stroke detection, care, and rehabilitation in a rural five-county area. Cooperative arrangements in the subregion are being developed between M.D.'s and D.O.'s, local hospitals, and community leaders.

Comprehensive stroke program.—Community development of comprehensive stroke programs will be encouraged through a central coordinating unit at Bowman Gray School of Medicine. Activities will be: Publication of guidelines for community stroke programs, arranging educational activities such as training programs for nurses, conducting an annual stroke workshop, and developing a family-patient education unit. The latter is a demonstration project to show the usefulness of modern teaching devices in helping patients and their families learn to cope with the long-term effects of stroke disability.

Diagnosis and treatment of cerebrovascular disease and the influence of a stroke clinic on stroke care.—The purpose of this project will be to study the natural history of disease; to establish a demonstration clinic which will apply model current methods of therapy in order to determine if the presence of such a clinic in a community hospital will improve stroke-patient care; and to disseminate pertinent information to medical and paramedical personnel concerned in the care of stroke patients.

Guiding adult patients with aphasia.—This project will provide an 8-day instructional and clinical course to increase the ability of health professionals to handle the patient whose communication skills have been impaired following a stroke. Personnel and facilities in Oregon are not adequate to aid these patients. This project would pool the resources of physicians and allied health workers who work with stroke patients so that this important phase of rehabilitation will not be overlooked. Five training courses will be given each year, with 15 students per course.

Acute stroke demonstration project.—To establish in the central region of South Carolina a hospital-based acute stroke service for the purpose of offering a comprehensive medical program for the management of acute stroke patients, keeping physicians abreast of current diagnostic and management techniques, training interns and residents, establishing teaching programs for related paramedical personnel, soliciting involvement and support of the public, and, ultimately, demonstrating to this and other areas of the State the value and feasibility of a coordinated team approach to stroke management.

Stroke rehabilitation project.—The gradual conversion of an existing health facility into a facility for the extended care and rehabilitation of stroke patients in the central region of South Carolina with the related objective of demonstrating the feasibility and advantages of such an undertaking to other areas of the State.

Stroke demonstration unit for progressive patient care.—To establish and staff an intensive stroke demonstration unit at Presbyterian Hospital, Dallas, under the supervision of the University of Texas Southwestern Medical School, has been funded under an earmarked supplement to the planning grant. The unit will serve the metropolitan area of Dallas and Tarrent Counties, Hillsboro, and Kilgore.

Specialized training programs will be developed and new methods of communication with the practicing physicians will be explored.

Regional rehabilitation program, part A: Baylor University.—Baylor has selected the community of Wharton, which has two hospitals, the Caney Valley Memorial Hospital, and the Gulf Coast Medical Center, which need rehabilitation services for their patients. This project will develop a shared core rehabilitation staff for both hospitals and a program for home health care.

Regional rehabilitation program, part B: University of Texas Medical School at San Antonio.—The San Antonio Medical School will work in the new Braunfels community which has a new rehabilitation center under construction adjacent to a home for the aged. The school will provide professional guidance in the initiation and development of a rehabilitation program for the community.

Regional rehabilitation program, part C: University of Texas School of Medicine at Dallas.—The Dallas School of Medicine will assist the community of Kilgore which has an on-going East Texas Rehabilitation Center interested in refining and improving rehabilitation techniques. In addition, the school of medicine will assist the Caruth Rehabilitation Center in Dallas in training home rehabilitation aides and in establishing a program to assess and evaluate the potential and capacity of the stroke patient for vocational endeavor.

Stroke rehabilitation nursing program.—This proposal would expand a training program in stroke rehabilitation nursing initiated in September 1967 by the Washington State Heart Association at Good Samaritan Hospital in Puyallup, Wash., a 154-bed general hospital, and only comprehensive rehabilitation center outside of university-affiliated hospitals. The present program of five 2-week courses a year would be expanded to six courses per year, training 50 plus nurses as teachers, hiring of one additional instructor, and would provide follow-up by course instructors to the home hospitals of the trainees.

Community-oriented continuing education in stroke rehabilitation for physicians and allied health personnel.—This proposal is sponsored by the division of health of the Wisconsin Department of Health and Social Services. It is one phase in a comprehensive stroke program. Primary emphasis is given consultation services and postgraduate education programs for physicians, nurses, and allied health personnel in from five to seven nonurban areas. A major "aim of this project is to improve the rehabilitative care of stroke patients" who are in small hospitals, their own homes, or extended care settings, or who otherwise reside distant from established rehabilitation facilities or services.

Regional comprehensive neurology clinics.—Hold clinics in six cities, covering all neurologic disease with emphasis on stroke. Clinics are viewed as an extension of the training programs and patient services available through the Mississippi regional medical program demonstration stroke unit. They are to be correlated with existing and proposed cardiovascular clinics.

CARDIOVASCULAR DISEASE

Improvement and coordination of facilities for cardiovascular diagnostic services.—Facilities of highest quality for cardiac catheterization, angiocardiography, and coronary angiography at several medical centers will enable the centers to provide these services for other hospitals in the region. A major portion of support would be for equipping cardiovascular laboratories in the Emory University Hospital and the Grady Memorial Hospital.

Cardiovascular clinics.—Strengthen an existing network of 39 diagnostic and consultative heart clinics operated by the heart disease control unit of the State Board of Health in association with the Mississippi Heart Association, University Medical Center, and private physicians, and related to an additional seven clinics operated in association with the University of Tennessee Medical School. Improvement in diagnosis and treatment capabilities of practicing physicians is expected to result so that more efficient use can be made of consultant time and of referral opportunity.

Comprehensive cardiovascular care units.—To develop a comprehensive care unit for grouping patients with heart or circulatory disease or who have been admitted for other purposes but require close cardiac observation. The program will be conducted where a house staff is nonexistent. It is hoped that this grouping of patients relieves the workload for nurses on general medical and surgical wards and improves the quality and efficiency of care.

Programed comprehensive cardiovascular care.—To develop, demonstrate, and train in new methodologies of cardiovascular care, stressing the continuity of care planning from outset of a cardiovascular crisis through recovery and rehabilitation.

Evaluation of the status of implanted pacemakers.—The purpose of this project is to develop improved methods for the evaluation of implanted pacemakers. Facilities of the pacemaker clinic at the Newark Beth Israel Hospital Institute will be extended to an estimated 1,000 patients with implanted pacemakers in New Jersey. Each patient referred by his physician will be examined every 2 months for possible pacemaker failure. The recordkeeping system utilizing the digital computer of Newark Beth Israel will be expanded to handle the increased patient load.

Establishment of a comprehensive interuniversity cardiovascular program in the department of health and hospitals in the city of Boston.—To establish a clinical-cardiovascular program to provide comprehensive in- and outpatient care for indigent patients with heart disease in the primary service area, to make this level of care available to patients referred by physicians throughout the region, and to insure continuity of medical care and followup in Boston City Hospital.

Development of a cardiovascular center (Mercy Hospital, Benton Harbor).—Applicant states that the development and establishment of a modern catheterization and angiography laboratory would assist and benefit both the area hospitals and the medical community by: (1) Providing for the early identification of patients having coronary artery and vascular disease; (2) establishing a cardiovascular teaching program which would serve the physicians of a three-county area; and (3) providing assistance in the development of a communications system between Wayne County General Hospital, University of Michigan, Mercy Hospital, other area hospitals, and the physicians within the three-county area in order to reduce the time lag in the use of new heart disease procedures.

HYPERTENSION AND NEPHROLOGY

A teaching, training, and demonstration program in hypertension and nephrology.—To be located in Emory University School of Medicine for physicians, nurses and allied health personel to work in the field of diagnosis, prevention and treatment of hypertension and kidney disease throughout the State. Funds will be used to employ teachers and trainers, prepare materials, set up practice facilities and mockup of equipment, evaluate performance of trainees, and encourage the establishment of hypertension-nephrology programs in smaller cities. Goal is to produce the team a nephrologist would use in a combination office and hospital practice in a community of 75,000 and a hospital of 200 beds.

Laboratory evaluation of renal and adrenal hypertension.—This proposal would offer a new laboratory test for renin and aldosterone in the region that previously has been difficult to obtain. The tests would be made available on a regionwide basis and evaluated by a hypertension study group which also advises the regional medical program concerning this disease process. The physicians in the region will receive periodic information about the laboratory diagnosis of hypertension as well as the latest information about other aspects of renal and adrenal hypertension.

Hypertension.—To explore the means of making available the best of modern diagnostic and therapeutic measures to the patients with hypertension in the region.

PULMONARY DISEASES

Training and applied research for intensive and rehabilitative respiratory care.—To (1) familiarize physicians and paramedical personnel of the magnitude of the emphysema-chronic bronchitis problem; (2) disseminate knowledge on the latest advances in the treatment of the problem; (3) to promote and assist in the establishment of respiratory care programs in local communities; (4) obtain greater knowledge on the effectiveness of home oxygen for both hypoxemia and nonhypoxemia individuals and (5) increase the effectiveness of the therapy through the development of improved ventilators and nebulization devices as well as the addition of humidification devices to existing oxygen equipment.

An ambulatory program for comprehensive pulmonary services.—The Maryland General Hospital proposes to establish a model ambulatory pulmonary service unit to demonstrate optimum, comprehensive care for patients with chronic respiratory disease.

Regional program on emphysema and cor pulmonale.—A special out-patient facility for chronic obstructive lung disease will be housed in the city of Memphis Hospital outpatient department. Pulmonary function studies will make use of data processing facilities and will assist in evaluation of results.

Chronic pulmonary disease.—This project will provide a variety of different types of training programs for nurses, physicians, and other health personnel. A treatment center for ambulatory chronic pulmonary patients will be established to demonstrate patient care and educate patients. Two mobile units will provide screening and treatment to patients and continuing education programs to health personnel throughout the region.

The improvement of respiratory care given patients in extended care facilities.—Establish three pilot respiratory care centers to rehabilitate patients with chronic pulmonary disease. One of the centers will be developed more fully than the others to increase the capacity for evaluation of the program. Provisions are made to provide continuing education of both physicians and paramedical personnel in the field of chronic pulmonary disease. Establishment of a 2-year school of inhalation therapy in the Toledo Hospital.

A regional emphysema program for Oklahoma.—A teaching and demonstration unit to be established at the University of Oklahoma Medical Center would serve as a regional emphysema unit. It would be available as a consultative and educational resource to community hospitals in the region. Initially, hospitals in Oklahoma City, Muskogee, Stillwater, Tulsa, and Clinton would cooperate in the University of Oklahoma Medical Center program. The goal of the project, to improve the care of patients with emphysema at the community level, would be achieved by recruiting and training personnel; developing continuing education programs; evaluating equipment and services; establishing more effective collaborative group relationships; improving and expanding screening activities, and establishing evaluative mechanisms.

Areawide total respiratory care.—This is a project under direction of Baylor University to render total respiratory care in an area of 12 counties, utilizing the organizational structure of the San Jacinto Tuberculosis and Respiratory Disease Association, and a State health department region. Public and professional education, areawide screening for tuberculosis and respiratory network of respiratory care facilities are parts of the approach to total care. Model programs of respiratory care will be assisted to serve as teaching and training centers. The first center to be assisted will be the Jefferson Davis Hospital which serves an urban indigent population basis in Houston. The VA hospital and the Methodist hospital will also be utilized to provide a broad base for education, training and patient care.

Chronic respiratory disease program.—Funds are requested to develop a model regional comprehensive pulmonary care program. A nine point program is presented, including correlated educational activities for physicians, nurses, and allied health personnel. Other selected program aspects are: early case finding, out-patient and in-patient care, rehabilitation services, intensive care for acutely ill patients, and extended care services. Maximum use would be made of existing service, teaching, and research services. Four major hospitals will participate in this cooperative program. A site-team which can be any combinations of chest physicians, respiratory nurse specialist, and/or a blood gas technician will be available to all hospitals in the region upon request. This will act as support consultation for problems of diagnosis, management, in-service education, staff conferences, or whichever will serve the local purposes.

A pilot demonstration program for pulmonary thromboembolism, Marshfield Clinic.—To demonstrate a comprehensive program which will encompass diagnostic, preventive, therapeutic, and rehabilitation procedures for patients, postgraduate education, a rapid transportation system for patients from northern sections of the State, cooperation between the clinic and other hospitals and medical schools in the region, collaborative research between the center and the medical schools in basic research in blood coagulation and thromboembolism, and evaluation of the capability of Marshfield-Wausau to function as a subregional medical center of the Wisconsin regional medical program.

NUTRITION

Diabetic consultation and educational services.—To establish three medical teams to deliver services throughout the State; to assist in expansion of diabetic consultations and teaching clinics; to provide seminars for physicians and teaching sessions for nurses and patients to assist in organization of a State diabetes association and local chapters; and to test techniques of data collection.

Diabetes regional center-diabetes detection and education center.—To plan, instigate, and develop new programs through the center aimed at improving the care of patients with diabetes in community hospitals. The program has these phases: (1) Evaluation of existing facilities, personnel, and programs; (2) education courses at the center; (3) development of materials and techniques; (4) implementation of in-service educational programs; and (5) reevaluation.

A regional program in nutrition and diabetes for Oklahoma.—This program seeks to improve the care of diabetic patients at the community level, and to improve nutritional services in hospitals and nursing homes throughout Oklahoma. The program would help support an ongoing diabetes demonstration clinic at the university hospital which would develop the teaching materials and manpower to extend improved care for diabetic patients throughout the region. The program would organize workshops, seminars, and consultation services to physicians, nurses, and dieticians, and would also seek to improve community education. The program would coordinate continuing education and public education with mass screening procedures performed by the State health department.

Southern Oregon diabetic instruction and evaluation.—This project will provide instruction for diabetic patients, responsible relatives, and medical personnel. Courses will vary according to the groups, such as juvenile diabetic, adult insulin dependent, or health professionals. Instructors will be health personnel available in the community. No such program is available to area residents within a 120-mile radius.

Training program to promote better care of the diabetic patient, Good Samaritan Hospital and Medical Center.—Promote for physicians throughout the region a fuller appreciation of those concepts involved in the continuity of care of individuals with diabetes mellitus. Recognize need to train individuals to teach in classrooms for diabetic patients and instruct qualified individuals from nursing homes and similar institutions in the care of diabetic patients. By utilizing individuals who have benefited from this training, it is further proposed to establish centers in various parts of the region for instruction of patients in care and control of diabetes.

A program for patients with diabetes mellitus.—Program of patient education, professional education, and periodic medical evaluation of patients to assess diabetic control would be initiated.

RENAL DISEASE

Home dialysis training program.—To improve understanding of health personnel and the public in the treatment of kidney disease and of involvement in the rehabilitation of patients undergoing home dialysis to provide consultation to community health personnel, to provide highly specialized laboratory services when required, and to develop the capability to provide emergency services for home dialysis patients. Training plans include orientation for physicians and public health nurses; training for physicians from hospitals planning home dialysis services; training for nurses and for technicians from hospitals planning a service program, 3-day training for dieticians; and other health professionals, to be directed by the University of Colorado Medical Center.

Hemodialysis training program.—Train physicians, nurses, and technicians in the skills and procedures of hemodialysis. The facilities at Newark Beth Israel Hospital Institute will be utilized as the training base. Three-week training will be provided for physicians, three per course, who will direct hemodialysis programs in their own hospitals. Nurses will receive training in nursing procedures in a 4-week course, four students per course. Technicians will be trained in 4-week courses, four students per course. Three-day orientation will be provided for physicians attending hemodialysis patients and visiting nurses will receive orientation.

A demonstration hemodialysis unit.—Demonstrate advances in diagnostic and treatment methods. A chronic dialysis unit for patients with severe uremia would

be established by the Medical College. RMP dialysis unit at Medical Center of South Carolina to assist in conducting of certain training.

CANCER

The New York State sigmoidoscopic demonstration teaching program.—To acquaint physicians with incidence, symptoms and recognition of common tumors of the rectum; to teach correct methods for the performance of protosigmoidoscopic examinations; to keep adequate records of utilization and value of the course to the physician; and to assist previous physician-students in their offices if help is desired.

Regional urology program with initial emphasis on cancer of the prostate.—The program would create a consortium of urologists, each of whom would coordinate project activities within his own subregion. Thirteen subregions are identified. Initially, the program would appraise local facilities, resources, manpower and medical practices as they relate to the diagnosis and treatment of cancer of the prostate. The program would analyze hospital records and tumor registries, with follow-up on all new cases, and would identify the local needs for continuing education. This program would interdigitate with other proposed programs, such as the Tulsa poverty area program.

Demonstration project for the detection of cancer of the gastrointestinal tract.—To demonstrate to the physician the value of coordinated diagnostic procedures through presentations of medical groups and through clinical demonstration to the individual physician; also, to serve as a pilot program for technician training, to establish an orientation center for other cancer detection projects and to offer a community education program through cooperative arrangements with local health societies and agencies.

Cancer chemotherapy for adults.—This will be a 3-year cooperative program. It is proposed to build a collaborative chemotherapy service program upon the resources of an established university medical center division of clinical oncology and the experience of practicing chemotherapists located in different parts of the region. Physicians representing seven medical facilities in the region would form the initial group of principal collaborators. An overall objective is to favorably influence morbidity and mortality rates for cancer, and a number of activities will be initiated to achieve this. Cooperative activities will be developed with the cancer committee of the State Medical Society, division of the American Cancer Society, Veterans Administration hospitals, and the Milwaukee County Hospital. It is estimated that about 10,000 new cancer patients might benefit from this project annually.

SCREENING AND RELATED ACTIVITIES

Multiphasic testing of an ambulant population.—To establish centers to perform a series of diagnostic laboratory tests which will identify the most useful tests for separating the ill from the healthy population, either individually or in patterns. Model centers will be established at the university medical center and the State mental hospital. A third is planned for the Smithville complex.

Mass screening, radiology.—To improve the accuracy of radiologic diagnosis of heart disease, cancer and stroke; to evaluate the diagnostic efficiency of various electronic communication media; to determine the applicability of ultrasound and thermography as screening techniques for neoplastic and vascular diseases. Three hospitals will be connected by appropriate electronic communication systems to the department of radiology and medical center computer at the university.

Early disease detection.—To provide multiphasic screening for selected populations throughout the region. Initial efforts would be implemented at Strong Memorial Hospital and be based in the outpatient clinic on a pilot or demonstration basis. The application outlines the service, educational, and research and evaluation objectives. A methodology for implementation is presented. It is estimated that 5,000 patients will be screened during the first year.

Health evaluation studies, multiphasic screening center.—To establish a multiphasic screening laboratory with an OEO-sponsored community health center and to evaluate its effectiveness on screening and treatment of heart, cancer, and stroke, on a defined inner city population group.

Multiphasic health screening.—This project is based on a feasibility study conducted during the planning period. The study provided health screening for

1,360 persons living in the inner city. The tests were administered by persons previously unemployed or underemployed who were specially trained for this program. The proposed operational project will screen 75,000 within 3 years. Testing centers will be placed in four geographical areas which are optimally accessible to the residents.

DISCHARGE PLANNING SERVICES, CONTINUITY OF CARE

A proposal for rehabilitation and continuity of care services.—Develop role of "liaison nurse" (nurse with public health training who coordinated "discharge planning services"). Proposal has three components, involving seven counties (1) Alameda-Contra Costa project, (2) Humboldt-Del Norte area, (3) Sonoma-Mendocino-Lake Counties. Each of the three areas differs somewhat in its methodology and objectives. Each area has a nurse coordinator and secretary with a nurse project director and staff to administer the grant located in San Francisco. Workshops proposed to promote understanding of discharge planning services.

South central health service area continuing care program.—A patient care demonstration model for a continuum of long-term care will be developed in south central health service area using the unique resources of the Yale-New Haven Hospital, chronic disease institutions, extended care facilities, rehabilitation centers, nursing homes, boarding homes, home health agencies, and ambulatory services either in the physicians' offices or the hospital outpatient departments. It will also serve as the continuing education and consultation resource in continuing care for the entire region, with special emphasis each year on five hospitals in other health service areas.

Proposed coordinated discharge planning program for Wicomico and Somerset Counties.—Through the joint cooperation of the Wicomico County Health Department and the Peninsula General Hospital, a public health nurse will coordinate a planned program of followup care for indigent and medically indigent patients discharged from Peninsula General Hospital to home or to chronic disease hospitals or nursing homes.

Homemaker, home health aid project.—Extends a new type of home care service for patients with heart disease, cancer, or stroke. A minimum of 24 individuals would be trained each year to perform both homemaker functions of cleaning, marketing, and child care and home health aid functions relating to personal care of patients. Traditionally, these services have been performed by two individuals but a pilot project indicates the functions can be combined. The Visiting Nurses Association would administer the project with assistance from the Missouri University Extension Service, Burge Hospital staff in Springfield, the county medical society and others. Fees for service will be collected and proceeds applied to administration of the service.

Home health care project.—Susquehanna Valley Home Health Service, Inc., will provide training and home health services for the counties of Snyder, Union, and part of Northumberland which do not now have service.

NATIONAL NUTRITION SURVEY

As a part of the National Nutrition Survey which is administered by the regional medical programs service special efforts are being made to obtain data on the nutritional status for persons 60 years of age and older. The comprehensive nutrition health survey, which includes physical examination, biochemical evaluation, food intake, and socioeconomic studies, is being conducted in 10 selected States (Texas, Louisiana, New York, Massachusetts, Kentucky, West Virginia, Michigan, Washington, California, and South Carolina) and one metropolitan area (New York City).

The target sample selected for study in each State included approximately 1,600 to 2,000 households selected randomly. Enumeration districts of each State were stratified on the basis of urban, rural, and those not classed as urban, but having a population of more than 2,500. Within each stratum, the enumeration districts were ranked by the percentage of families with incomes at or below the poverty category. Enumeration districts were included in the sample until 25 percent of the population within each stratum was achieved, having the lowest mean family incomes. The total sample universe, therefore, represented 25 percent of the population of the State, and particularly those families living in

areas in which the largest percentage had incomes at the poverty level based on the 1960 census information. The families actually studied in the sample were obtained by selecting enumeration districts at random and residential segments at random within these enumeration districts. Within each segment, every third household was included in the actual sample studied.

Socioeconomic data.—Socioeconomic data was collected on the family and other members of each household. It included name, age, sex, marital status, race, and ethnic group, relation to family head, education, and work experience on each person. It also provided basic data on the size, location, and type of housing, presence of sanitary facilities and family income level.

Clinical examination.—All individuals received detalied clinical appraisal of nutritional status. This included medical history, the general physical examination, anthropometry and dental examination. The examination included changes in hair, eyes, lips and gums, and skin which have been associated with onset of nutritional deficiency. In addition, sight and hearing tests were conducted in the Texas study.

Dietary intake data.—Information relating to dietary practices of the family was conducted in one-half of the households. In addition, information on food consumption and eating patterns of persons 60 years or older was conducted in the other half of the households. The food consumed during the previous day was obtained through interview by trained personnel. Information on programs designed to improve nutritional status of the family or family members, including food donation programs, food stamp programs, and similar type programs was also obtained.

Laboratory analyses.—Blood and urine specimens were collected for persons 60 years of age or older in approximately 25 percent of the sample or 400 to 500 households in each State. As a minimum, this consisted of hemoglobin, hematocrit, vitamin A, and carotene, total serum protein, vitamin C and sometimes red cell folate on blood, and creatnine, riboflavin, thiamine, urea, nitrogen, and glucose on the urine.

Followup program.—Technical assistance will be provided to various States in planning and implementing followup programs designed to correct the nutritional problems identified during the survey. In addition, specific efforts are being made to add or improve nutrition services of on-going programs designed to deliver personal health care. It is anticipated that these will include demonstrational projects and research as required to develop appropriate nutrition health services.

Kidney Disease Control Program

The program works with regional medical programs, States, and communities for the development of a national program for kidney disease prevention and control to benefit all persons. Emphasis is on improved kidney transplantation services through development of practical methods to increase the available number and delivery of cadaver kidney organs, and the integration of kidney transplantation with artificial kidney machine therapy facilities. The program also conducts and supports activities related to the prevention of kidney disease, including detection and diagnosis of urinary tract infections.

Smoking and Health

The National Clearinghouse for Smoking and Health has the mission of helping reduce the toll of death and disability caused by smoking. Much of its program is directed to the problem of the adult smoker, providing him with information about the hazards of smoking and supporting him if he decides to give up smoking. The clearinghouse simulates and conducts research into the nature of the smoking habit, collects and desseminates information on the smoking and health problem, and encourages the development of community-wide educational programs on smoking and health for all citizens. Although the programs are directed to persons of all ages with equal vigor, the purpose is to prevent the chronic illness to which cigarettes contribute and this causes death and disability primarily of persons of middle ages and older.

ITEM 14: SOCIAL AND REHABILITATION SERVICE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
January 19, 1970.

DEAR MR. CHAIRMAN: In response to your request of December 17, 1969, enclosed is a report on the activities of the Social and Rehabilitation Service during 1969 affecting the elderly. It does not discuss activities of the Administration on Aging, one of our components, since we are advised that you have requested a separate report from that agency and that it is submitting the requested report.

We shall be pleased to provide you any additional information you may need.

Sincerely,

MARY E. SWITZER, *Administrator.*

[Enclosure]

ACTIVITIES AFFECTING THE AGING, 1969

The Social and Rehabilitation Service has responsibilities to the Nation's older population which extend far beyond its obvious responsibilities to them through the Administration on Aging. The Assistance Payments Administration administers the old age assistance program, to provide badly needed cash benefit supplementation for inadequate—or nonexistent—incomes in old age. The Medical Services Administration administers the medicaid program which meets medical needs of the older poor and near-poor beyond any protection they may have through medicare and other programs and, during 1969 administered two other medical assistance programs for the aging which terminated at the end of that year. The Office of Research, Demonstrations, and Training conducts research and demonstration projects which extend the frontiers of knowledge concerning welfare and rehabilitation for the aged and others. The Rehabilitation Services Administration provides rehabilitation services for the aged who are handicapped, including those whose handicaps are due solely to advanced age. The newly created Community Services Administration brings together under unified direction the provision of social services to individuals and families, including the aged, who are or who may become clients served by public assistance. These various aspects of the work of SRS are discussed in the subsequent sections of this report.

In the final section of the report, there is a discussion of the implications to SRS of the family assistance plan proposed by the President during 1969.

OLD-AGE ASSISTANCE

In June 1969 SRS's Assistance Payments Administration served 2,036,000 persons aged 65 or over through the old age assistance program. While this is a slight increase in number from the preceding year it represents a marked decrease from the all-time high of 2,810,000 aged persons in September 1950. This overall decline has come about despite a steady increase in the number of aged people in our population. The decline is due primarily to the rapid increase in the number of persons receiving old age survivors disability insurance and the increase in these insurance benefits. Amendments to the Social Security Act passed by Congress late in 1969 should effect a future decline in the number of persons receiving old age assistance.

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have old age assistance programs. The national average assistance grant in June 1969 was $70.55. This represents an increase of approximately $2.50 over the preceding year.

As a means of encouraging dependent elderly people to attain either partial or full self-support 35 States now provide for a disregard of some portion of earned income in determining the amount of assistance payments. Additionally, 23 States allow for some disregard of income which is incurred from sources other than earnings.

According to the latest study available the median age of old age assistance recipients is approximately 77 years and trends indicate that this median age will increase in the future. The proportion of assistance recipients living alone in their own homes is approximately 35 percent. Approximately 27 out of every

100 aged persons receiving assistance require help from others in their daily living. More than two-thirds of the recipients are women.

Medical Assistance

During 1969, the Medical Services Administration provided Federal support for medical assistance for the aged under three programs: title XIX (medicaid), medical assistance for the aged (Kerr-Mills), and medical vendor payments paid out of public assistance grants. The last two programs ended on December 31, 1969.

During the year, Colorado, Tennessee, and Virginia began title XIX programs, bringing the medicaid total to 41 States and four jurisdictions, in which reside 83 percent of the population over 65. All State medicaid programs include the "categorically needy" aged—those who are receiving public assistance payments, or are eligible to receive them. Twenty-six States also include the "medically needy" aged—those who have enough income or resources for their daily needs, but not enough to pay medical bills.

Of the nine States without medicaid programs at year's end, six provided medical assistance under the Kerr-Mills program, also known as medical assistance for the aged (MAA); three made medical vendor payments under their old-age assistance programs (OAA).

Medicaid supersedes MAA, OAA, and all other medical assistance programs supported by public assistance grants. States without medicaid programs after 1969 lose the funds previously paid under those grants. (On January 1, 1970, seven States began medicaid programs; in the remaining States, Alaska and Arizona, Federal contributions for vendor payments for medical assistance ceased on that date.)

In fiscal year 1969, Federal expenditures for medical services under medicaid totaled $2,275,457,695. About 42 percent of the total expenditures for medical assistance under the federally aided public assistance programs was spent on the aged.

States and jurisdictions with medical assistance programs under medicaid during 1969:

Colorado
California
Connecticut
Delaware
District of Columbia
Georgia
Guam
Hawaii
Idaho
Illinois
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Montana
Nebraska
New Hampshire
Nevada
New Mexico
New York
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Puerto Rico
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virgin Islands
Virginia
Washington
West Virginia
Wisconsin
Wyoming

States with medical assistance for the aged programs during 1969:

Alabama
Arizona
Arkansas
Indiana
New Jersey
North Carolina

States making medical vendor payments under old age assistance programs during 1969:

Alaska
Florida
Mississippi

Medicaid permits the Federal Government to contribute to the cost of the care of aged individuals in institutions for mental diseases when the State includes this service, and 34 States did so in fiscal year 1969. Over 69,000 mental patients were enrolled in the program. The States involved received about $150 million of Federal funds to help them improve the care of the patients and to develop comprehensive mental health programs.

During 1969, the Medical Services Administration published interim regulations on standards for payment for skilled nursing home care. The regulations

established standards to be met by skilled nursing homes in order to qualify for payments under medicaid.

RESEARCH AND DEMONSTRATIONS

SECTION 1115 PROJECTS

The demonstration projects program in public assistance under section 1115 of the Social Security Act provided grants for at least 21 different projects during the calendar year 1969 which were totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects were carried out under the auspices of State public welfare agencies.

The Kentucky Department of Economic Security together with the programs of the Office of Economic Opportunity, Department of Labor, Department of Agriculture, and Housing and Urban Development is carrying out a project in four counties in eastern Kentucky. The homes of 900 aged, blind and disabled are being repaired to make them safe and suitable for occupancy, thus enabling the recipient to remain in his own home, rather than being placed in a nursing home or institution. Housing aides provide services to the homeowners to insure that individual functioning can be maintained.

In rural northern Alaska, the Department of Health, Education, and Welfare is experimenting with the use of human service aides to provide services to the aged which have never been available before. These consist of transportation to medical facilities, arranging for fuel oil to be provided and delivered, and homemaker help.

In Georgia a project is being conducted in consumer affairs. This project is designed to provide educational materials and help to the elderly as well as other low income families and individuals.

In three neighborhood service centers services to the elderly are being experimented with to determine which services are most wanted and needed at the neighborhood level.

In one model city area the State public welfare agency is experimenting with the use of grandmothers and grandfathers for providing family day care programs for AFDC children whose mothers are in training or employed.

Two model projects under a national plan for protective services to the aged are in their last year of operation. These projects are designed to increase knowledge and skills in the provision of protective services in a metropolitan area serving the elderly in two district offices and in two rural counties in a Western State.

States demonstrating the value of providing homemaker services are enthusiastic about the results which are helping the elderly to remain in their own home or return to their home following hospitalization. In all instances the States experimenting with the provision of homemaker services have, after termination of the demonstration, adopted the project activity into their on-going program.

The use of foster homes for older adults is demonstrating the value in postponing or negating the need for some individuals to enter nursing homes or institutions.

VOCATIONAL REHABILITATION RESEARCH AND DEMONSTRATION PROJECTS

A recently completed review of the literature on vocational adjustment of the older disabled worker has been completed and is now available, providing a comprehensive survey of characteristics of older workers, their motivation and aptitudes, and ways that employment testing and counseling can be adapted to their needs.

Complementary to the above review is a program guide for a neighborhood-based facility for the older worker. This guide describes the steps necessary to develop a workshop, easily accessible to neighborhood residents, which provides long-term sheltered employment. Such a facility is of special value in inner city areas.

A program which has proved very successful is one in which older workshop clients serve as personal counselors to young adult retardates in the workshop, using a "buddy" system of older-younger pairs.

The most massive attack on problems of aging is a program which has been launched for providing a system of industrial placement facilities for the aging in several locations of wide geographic distribution and particular focused on increasing the earning power of the poor.

Rehabilitation Services

The major goal of the Rehabilitation Services Administration's program for the aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

Today, large numbers of older people are "existing" at the poverty level, or below, and when such a predicament is compounded by a disability it is indeed tragic as it is more difficult for the older handicapped person to obtain employment.

It is estimated that there are over 4 million disabled people 40 years of age and older eligible for, and in need of, rehabilitation services.

In an effort to alleviate this situation, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and a steady increase in the number of these individuals rehabilitated has resulted. For example in fiscal year 1959, a total of 80,739 disabled persons were rehabilitated into employment, 24,275 of whom were aged 45 and beyond, while in fiscal year 1969 a total of 241,390 handicapped persons were rehabilitated of which an estimated 65,700—more than twice the 1959 figure—were 45 years of age and over.

State agencies utilize basic rehabilitation services and innovation projects, supported by various types of grant funds, as well as research and demonstration projects and short-term training courses to aid in the rehabilitation of the disabled aging. For example, the Iowa vocational rehabilitation agency cooperates with the Iowa Eastern Seal Society in a homebound project serving a large number of older people; the Delaware agency participated in the foster grandparents program of the Administration on Aging; the Ohio agency is participating in a public housing project designed for the handicapped and senior citizens.

Short-term training courses have stimulated interest in problems of the older handicapped person. A recent course, "Orthopedics and Gerontology," cosponsored by the Rehabilitation Services Administration and the American College of Orthopedic Surgeons was conducted to introduce surgical techniques effective with older patients to young doctors specializing in orthopedic surgery. Other short-term training courses which benefit the aging handicapped include courses for trainees in rehabilitation counseling, nursing, physical therapy, prosthetics—orthotics, speech pathology and audiology, rehabilitation of the blind, deaf, occupational therapy and home economics which includes home health care for the aging, home service for the aging in rural areas and preparation of specially designed clothing for the ill and chronically disabled.

The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as senior citizens month and the foster grandparents program, and it is planned to cooperate fully in the forthcoming White House Conference on Aging scheduled for 1971. RSA also works with the Social Security Administration in utilizing the social security disability applicant load as an important referral source of older disabled persons for State vocational rehabilitation services.

Community Services

The Community Services Administration, established in November 1969, is the newest component of the Social and Rehabilitation Service. The new Administration has as one of its responsibilities providing social services to aged and handicapped individuals in the public assistance program. A principal objective of the Community Services Administration is to strengthen and extend social services to the aged in States and to help them toward an increased participation in family and community life. At the same time, Regional Community Services Administration counterpart staff have been appointed so that a unified and comprehensive approach, at the Federal level, to work with States administering the service programs for aged and handicapped individuals is underway.

Through its Division of Services to the Aged and Handicapped, the Community Services Administration will be responsible for policy and program development for services to the aged in the public assistance program and will maintain liaison and joint planning on the operating levels with those Federal and national agencies and organizations active in the field of aging.

As of the quarter ending March 31, 1969, 223,000 aged individuals, approximately 17 percent of the total aged in the program, received a variety of services which helped them with such problems as meeting health needs, home mainte-

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nance, finding employment, securing adequate housing and community participation in the form of adult education and recreation activities. Of this number, 80,000 needing protection were helped to find a protective institutional placement, or were helped with problems of money management or daily living.

The Federal expenditures for the provision of social services to the aged for fiscal year 1969 was $39.3 million. The fiscal year 1970 estimate is $53.2 million, a sizable increase.

The Community Services Administration will be engaged in program development in the service program to the aged in the forthcoming year. Revised social service policies will be issued soon. These policies will provide a new incentive for expanding services to the aged. This will include policy interpretation, program analysis and review, and the development of designs for services to aged and handicapped individuals and groups. These designs for service will represent new approaches in the development of service content and method, and the development of new approaches in service delivery.

Establishing the Community Services Administration, as the result of transferring the public assistance social services for the aged and handicapped from the AOA and the RSA, all of the social service programs were combined and thus provide a unified and comprehensive approach to the identification and the delivery of social services to an adult welfare population which has many common needs. The blending of these three categories will, it is anticipated, give greater visibility to the needs of the aged, blind and disabled in the program and to the range of constructive services which can benefit the elderly. Thus, a focal point for services is created in the Social and Rehabilitation Service which will be valuable for future planning and programing of nationwide services to these special groups.

The Proposed Family Assistance Plan

The administration's proposed family assistance plan, as embodied in S. 2986 and H.R. 14173, would significantly improve the Federal-State public assistance programs for the aged, blind and disabled in a number of important respects:

1. Federal financial participation in payments would be under a new formula substantially more liberal than the present one. For example, under existing law in New York or California if the average payment is $100 for a recipient of Old Age Assistance (in July 1969 it was $93.90 in New York and $105.65 in California), $50 must be provided from non-Federal funds. Under the new formula, $50 in non-Federal funds would be matched by $71.60 in Federal funds, thus permitting one of these States to increase a $100 average payment to $121.60 without any additional State or local expenditures. States are not required to increase payments, but may not reduce them below existing levels. Under the new formula the Federal Government would provide 100 percent of the first $50 of average payment, 50 percent of the next $15 and one-fourth thereafter up to a reasonable limit which the Secretary would be given authority to establish. The important principle of a minimum income would be established in these programs for the first time. Under the bill the recipient of old age assistance in any State would be assured that his assistance payment, together with his other income, would total at least $90. This figure is higher than the present payment in a significant number of States. In the case of an aged couple, this will assure income above the poverty line.

3. Eligibility requirements would be made more uniform and some of the more onerous ones prohibited. Liens on property and the holding of relatives other than a spouse responsible for the care of an aged person would be prohibited. All States would be required, in determining eligibility, to disregard the home, household goods and personal effects of an individual, other personal or real property not in excess of $1,500 in value and other property which is essential to the families' means of self-support to an extent which warrants its exclusion.

4. A number of new requirements would be imposed upon State plans to assure the improved administration and forward movement of programs. These include requirements for—

(*a*) The training and effective use of social services personnel;

(*b*) The furnishing of technical assistance to units of State government which are furnishing financial assistance or services or for the development through research and demonstration projects of new and improved methods for furnishing assistance or services to the aged, blind and disabled;

(*c*) The use of a simplified statement to determine eligibility with provision for verification through sampling or other scientific techniques;

(*d*) Power by the Secretary to waive the requirement that welfare services be statewide in their availability (thus permitting some flexibility, according to the needs of individual areas);

(*e*) Periodic evaluation of the operations of the State plan not less often than annually;

(*f*) Periodic evaluation of the operation of the plan by persons interested or expert in matters related to assistance or services including persons who are recipients of aid to the aged, blind or disabled;

(*g*) Assuring that States will observe priorities established by the Secretary and comply with performance standards that he may prescribe.

5. Provision is also made for contractual relationships between the Federal Government and the States under which the Department of Health, Education, and Welfare could make the payments and perform such other functions as may be agreed upon (in such cases the State would provide to the Secretary its share of aid and of additional administration cost to the Federal agency). This would permit a single payment of assistance and social security or similar arrangements in line with the State's wishes.

ITEM 15: SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., January 23, 1970.

DEAR MR. CHAIRMAN: I am sending you at this time the reports on developments in social security and medicare during 1969. As you requested, these have been developed in essentially the same form as the reports sent last year. We are including a copy of the Secretary's decisions on the monthly premium rate under part B of medicare and a memorandum explaining the basis for the decisions.

I hope these statements meet your needs.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure]

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration administers the Federal social security program, which is the Nation's basic method of assuring income to the worker and his family when he retires, becomes disabled, or dies, and of assuring hospital and medical benefits to persons 65 or over. When earnings stop or are reduced because the worker retires, dies or becomes disabled, monthly cash benefits are paid to replace part of the earnings the family has lost.

DEVELOPMENTS IN SOCIAL SECURITY

About 92 million people contributed to social security in calendar year 1969. Today, 95 out of 100 mothers and children are protected against the risk of loss of income because of the death of the family breadwinner. The survivorship protection alone, as of January 1, 1969, had a face value of about $960 billion.

About 24.9 million men, women, and children were receiving monthly social security benefits as fiscal year 1969 ended. The beneficiaries include about 15.7 million retired workers and dependents of retired workers, 2.4 million disabled workers and their dependents, and 6.1 million survivors of deceased workers. About 0.6 million noninsured persons 72 and over were receiving special payments that are provided to certain aged persons getting no public assistance payments and little or no other governmental pensions. Virtually the entire cost of these special payments is borne by general revenues of the U.S. Treasury.

Ninety percent of those who were 65 or over at the beginning of 1969 were receiving benefits or would be eligible to receive benefits when they or their spouses retire. Of those who reached 65 in 1969, 92 percent were eligible for social security cash benefits. Projections to the year 2000 indicate that 96 to 98 percent of all aged persons will then be eligible for cash benefits under the program.

What the Program Did in Fiscal Year 1969

BENEFICIARIES AND BENEFIT AMOUNTS

During the fiscal year ended June 30, 1969, benefits paid under the old-age, survivors, and disability insurance program totaled $26,176 million—an increase of $3,351 million over the amount paid in the preceding fiscal year. Total benefit payments to disabled workers and their dependents were $2,443 million, 17 percent higher than in fiscal year 1968. Old-age and survivors insurance monthly benefits rose 16 percent to $23,732 million. Lump-sum death payments amounted to $286 million, about $30 million higher than in the previous fiscal year.

The number of monthly benefits in current-payment status increased by 0.8 million to 24.9 million during the year, and the monthly rate rose $92.7 million (5 percent) to $2.1 billion.

In June 1969, the average old-age benefit being paid to a retired worker who had no dependents also receiving benefits was $96 a month. When the worker and his wife were both receiving benefits, the average family benefit was $168. For families composed of a disabled worker and a wife under 65 with one or more entitled children in her care, the average was $238; and for families consisting of a widowed mother and two children, the average benefit was $257. The average monthly benefit for an aged widow was $88.

During the fiscal year, a period of disability was established for about 347,000 workers, 35,000 more than the previous high set in fiscal year 1968. The number of persons determined to have been disabled since childhood totaled 26,000.

The number of disabled workers receiving monthly benefits rose 8 percent in the fiscal year and totaled 1,342,600 at the end of June. Benefits were being paid to about 1,064,400 wives, husbands, and children of these beneficiaries. By the end of June 1969, child's benefits were being paid at a monthly rate of $15.5 million to 249,000 disabled persons 18 and over—dependent sons or daughters of deceased, disabled, or retired insured workers—whose disabilities began before they reached 18. About 28,000 women were receiving wife's or mother's benefits solely because they were the mothers of persons receiving childhood disability benefits. The number of disabled widows and widowers receiving monthly benefits was about 32,000 at the end of June 1969.

LEGISLATIVE DEVELOPMENTS

On December 30, 1969, President Nixon signed the Tax Reform Act of 1969, which includes as title X the Social Security Amendments of 1969. The amendments provide for a 15-percent increase, effective for months after December 1969, in social security monthly cash benefits. The increase raises the minimum benefit from $55 to $64, the maximum retirement benefits goes from $218 to $250.70, and the maximum family benefit will range from $96 to $434.40 (instead of $82.50 to $434.40). The amendments also eliminate the $105 limitation on wife's and husband's benefit.

To cover the effect of the benefit increase, the allocation of benefit income to the disability insurance trust fund is raised slightly. No revisions in contribution rates or in the earnings base for benefit and contribution purposes were required to finance the changes, since there was a favorable actuarial balance of 1.16 percent in the old-age, survivors, and disability program, sufficient to cover the cost of the amendments.

The law also provides for a 15-percent increase in the special payments for certain persons aged 72 and older, which will go from $40 to $46 a month for an individual (from $60 for a couple to $69).

The March payment, mailed early in April, will be the first to reflect the 15-percent increase in monthly cash benefits, and a separate payment is to cover the retroactive amount of increase due for January and February. A provision in the law requires that States with programs providing assistance payments under titles I, X, XIV, XVI, and part A of title IV of the Social Security Act must, in determining need under such programs, disregard any retroactive social security payments for January and February 1970 attributable to the increase under the Tax Reform Act. In addition, the States must make certain that any individual who receives an assistance payment under titles I, X, XIV, or XVI of the Social Security Act from April 1970 to June 1970 and also receives an OASDI benefit increase under the Tax Reform Act will realize an increase in the assistance payment and OASDI together that is equal to $4 (or the amount of the OASDI increase, if less).

REPORT ON THE MEDICARE PROGRAM

In fiscal year 1969, medicare paid out $6.3 billion for the health-care expenses of men and women age 65 and over covered by the program. About $4.7 billion was paid for hospital care, extended care facility care, and other services covered by the hospital insurance program. In addition, $1.6 billion was reimbursed for physicians services and various related health and medical items covered by the supplementary medical insurance program.

Medicare emerged in response to the basic dilemma that faced older people and private insurers in attempting to provide protection against the high cost of medical care in later life. The fundamental dilemma was that older people need much more medical care than the average younger person, but they could not afford to pay a premium high enough to cover the cost of care. Medicare established a hospital insurance plan, financed from payroll taxes, so that people pay toward this protection while at work without having to pay additional amounts after retirement. The supplementary medical insurance plan covers physicians' fees and other medical services, for which the individual paid $4 a month in 1969 and the Government matched his contribution with a like amount.

The two parts of the program provide for coverage of a wide variety of services, making it possible for the physician to choose the appropriate level of care for his patient. For example, the hospital insurance plan covers not only inpatient hospital care but extended care for people who can leave the hospital but still need full-time nursing care, home health care for those who can be taken care of in their own homes but need the part-time services of visiting nurses or physical or speech therapy and other types of skilled medical care. Outpatient hospital care is covered under the medical insurance program as are physicians' services wherever performed—at home, in the doctor's office, a hospital, nursing home, etc. This coverage of a variety of services was designed to correct the situation that has existed in many other insurance plans that have put major emphasis on expensive inpatient hospital care.

Special provisions were also included in the program to emphasize the importance of quality care by requiring institutional providers of services to meet various standards. Special provisions for helping to control unnecessary hospital and extended care utilization were also included. All institutions are required to have utilization review committees and physicians must certify to the medical necessity of certain types of care and the continued need for hospital and extended care.

The basic design of the administration of the program has been to lodge the Federal responsibility in the Social Security Administration but to rely for the determination of reasonable costs and charges and for bill-paying and reimbursement on intermediaries and carries. These organizations are primarily Blue Cross and Blue Shield plans and private commercial insurance companies that previously had experience in the health insurance area.

Like other parts of the social security program this national system of health insurance for older people is an accepted part of American life and is generally recognized as contributing greatly to the health and security of our 20 million older citizens.

The accomplishments of medicare are well recognized. First of all, older people in this country are getting more hospital care than they received before medicare. This has not only extended lives but added quality to the lives of older people.

These people moreover receive medical care under conditions consistent with their self-respect and dignity. They go to hospitals as patients of their own personal physicians. The concept of charity care in a hospital hardly exists now for older people.

For many people, medicare has meant access for the first time to the best hospitals. Members of minority groups have access to quality care on the same basis as everyone else. All the hospitals and extended care facilities and independent laboratories and other institutions that participate in medicare must meet standards of quality. This benefits everybody in the community, not just older people.

Older people now have a sense of security whether they have large medical bills or not in knowing that the possibility of a very expensive illness wiping out one's lifelong savings has been largely removed.

The medicare program depends for its success upon the understanding and cooperation of large numbers of people and a variety of institutions. Twenty mil-

lion older people, just about all those over age 65, are covered automatically under the hospital care portion of the program. Of these people, 96 percent have also signed up for the voluntary part of medicare and pay a monthly premium to get additional coverage for physicians' bills. Over 16 million hospital stays have been paid for during the first 3 years. Over 76 million medical bills have been paid under the supplementary plan.

There are about 6,800 hospitals involved, 200,000 physicians and 4,850 extended care facilities in addition to 2,200 home health agencies, 2,670 private laboratories and many other health service providers. Some 130 Blue Cross and Blue Shield and private insurance contractors help in the administration of the program and 52 State agencies are involved in the certification of eligibility of providers in terms of quality standards. The following presents statistical highlights for the first 3 years of medicare. Also included is more detailed information on use of hospital and medical services under the program. State data are reported for medicare reimbursements and for admissions to hospitals and extended care facilities.

MEDICARE STATISTICAL HIGHLIGHTS, FISCAL YEARS 1967–69

	Fiscal year		
	1967	1968	1969
Enrollment, Jan. 1 of fiscal year:			
Hospital insurance (pt. A)	19,200,000	19,600,000	19,900,000
Supplementary medical insurance (pt. B)	17,700,000	18,000,000	18,900,000
Participating providers of services (as of June 30 of fiscal year):			
Hospitals:			
Number	6,857	6,865	6,825
Beds	1,200,000	1,200,000	1,200,000
Home health agencies	1,849	2,093	2,209
Extended care facilities:			
Number	4,160	4,702	4,849
Beds	281,000	325,000	342,000
Independent laboratories	2,355	2,566	2,670
Amounts reimbursed:			
Hospital insurance (pt. A)	$2,500,000,000	$3,700,000,000	$4,700,000,000
Supplementary medical insurance (pt. B)	$670,000,000	$1,400,000,000	$1,600,000,000
Hospital and extended care facility admissions and home health plans established:			
Inpatient hospital admissions	5,000,000	5,700,000	5,900,000
Extended care facilities admissions	199,000	448,000	507,600
Starts of home health plans	228,000	258,000	289,300
Medicare bills paid:			
Hospital insurance:			
Inpatient hospital	4,595,000	5,590,000	5,837,000
Outpatient hospital	329,000	666,000	41,000
Home health services	328,000	939,000	924,000
Extended care facilities	179,000	433,000	541,000
Supplementary medical insurance:			
Physicians	8,723,000	24,518,000	30,279,000
Outpatient hospital	152,000	439,000	544,000
Home health services	781,000	3,544,000	3,387,000
Independent laboratory	143,000	400,000	536,000
All other	232,000	974,000	1,655,000

MEDICARE STATISTICS

Admission and start of care rates

Inpatient hospital admission rates per thousand persons enrolled increased from 291 in fiscal year 1968 to 297 in fiscal year 1969; admissions to extended care facilities increased from 23 per thousand persons in fiscal year 1968 to 25.5 per thousand in fiscal year 1969. Comparable rates for home health starts of care were 13.2 per thousand in fiscal year 1968 and 14.5 per thousand in fiscal year 1969. Data on a State basis for fiscal year 1968 are shown on the enclosed table 1.

Medicare reimbursements

Reimbursements under both parts of the medicare program increased each year. Under the hospital insurance program (HI) the total for the United States increased from $2.5 billion in the first year to $4.6 billion in the third year and the average per enrollee rose each year from $134 to $193 and $237. Reimbursements under the supplementary medical insurance program (SMI) more than doubled from $668 million in fiscal year 1967 to $1.6 billion in fiscal year 1969. The SMI average per enrollee rose each year from $38 to $77 and $87.

TABLE 1.—HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH START OF CARE NOTICES, AND RATES PER 1,000 ENROLLEES, BY REGION, CENSUS DIVISION, AND STATE, JULY 1, 1968, TO JUNE 30, 1969 [1]

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care [3]	
	Number (thousands)	Per 1,000 enrollees [2]	Number (thousands)	Per 1,000 enrollees [2]	Number (thousands)	Per 1,000 enrollees [2]
Total, all areas	5,918.4	297.4	507.6	25.5	289.3	14.5
United States [4]	5,879.6	300.2	507.3	25.9	288.7	14.7
New England	342.1	270.8	38.4	30.4	33.6	26.6
Maine	36.5	307.9	3.0	25.3	2.2	18.6
New Hampshire	23.0	287.2	1.5	18.7	2.1	26.2
Vermont	15.1	309.6	.5	10.3	1.3	26.7
Massachusetts	173.7	275.5	19.3	30.6	16.6	26.3
Rhode Island	25.3	246.3	2.9	28.2	3.6	35.1
Connecticut	68.6	242.6	11.2	39.6	7.8	27.6
Middle Atlantic	937.9	240.7	81.0	20.8	74.4	19.1
New York	460.0	235.1	36.3	18.6	36.0	18.4
New Jersey	153.3	225.3	19.4	28.5	16.5	24.3
Pennsylvania	324.6	257.8	25.2	20.0	21.9	17.4
East North Central	1,093.3	288.5	82.5	21.8	46.0	12.1
Ohio	263.6	267.0	22.4	22.7	14.2	14.4
Indiana	133.8	273.1	11.2	22.9	4.7	9.6
Illinois	338.1	310.1	24.8	22.7	11.6	10.6
Michigan	209.8	278.3	14.8	19.6	8.8	11.7
Wisconsin	147.9	315.5	9.2	19.6	6.6	14.1
West North Central	675.0	352.4	36.0	18.8	20.1	10.5
Minnesota	148.2	361.7	9.4	22.9	5.6	13.7
Iowa	122.0	344.8	8.0	22.6	3.3	9.3
Missouri	182.1	327.8	8.9	16.0	7.6	13.7
North Dakota	30.8	459.8	1.0	14.9	.4	6.0
South Dakota	32.2	398.1	1.1	13.6	.6	7.4
Nebraska	64.8	354.6	3.3	18.1	1.0	5.5
Kansas	94.9	357.3	4.3	16.2	1.8	6.8
South Atlantic	824.8	203.5	62.9	23.1	27.9	10.3
Delaware	9.7	221.2	.8	18.2	1.1	25.1
Maryland	60.9	216.6	6.6	23.5	2.7	9.6
District of Columbia	20.9	310.9	.5	7.4	2.0	29.8
Virginia	100.4	284.8	6.2	17.6	3.3	9.4
West Virginia	69.1	351.9	2.3	11.7	2.3	11.7
North Carolina	126.4	315.7	5.0	12.5	1.8	4.5
South Carolina	56.5	303.4	3.8	20.4	1.6	8.6
Georgia	117.2	330.6	6.3	17.8	2.5	7.1
Florida	263.7	315.8	31.4	37.6	10.8	12.9
East South Central	425.0	341.0	25.1	20.1	11.0	8.8
Kentucky	113.9	339.7	7.1	21.2	3.0	8.9
Tennessee	133.5	355.4	8.7	23.2	3.3	8.8
Alabama	100.4	317.1	5.4	17.1	3.3	10.4
Mississippi	77.3	353.4	3.9	17.8	1.4	6.4
West South Central	662.0	374.2	36.2	20.5	17.5	9.9
Arkansas	84.9	366.6	2.6	11.2	1.0	4.3
Louisiana	99.4	336.0	3.9	13.2	3.9	13.2
Oklahoma	107.8	371.8	5.2	17.9	3.0	10.3
Texas	370.0	388.7	24.5	25.7	99.5	10.0
Mountain	237.5	357.3	21.4	32.2	10.5	15.8
Montana	30.2	435.8	1.6	23.1	1.0	14.4
Idaho	21.4	318.3	2.5	37.2	.3	4.5
Wyoming	11.7	384.2	.4	2.2	.2	6.6
Colorado	73.0	395.4	7.0	37.9	3.7	20.0
New Mexico	22.2	322.4	1.6	23.2	.8	11.6
Arizona	48.2	340.4	5.6	39.5	3.0	21.2
Utah	21.5	290.2	2.0	27.0	1.0	13.5
Nevada	9.3	325.2	.9	31.5	.5	17.5

See footnotes at end of table.

TABLE 1.—HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH START OF CARE NOTICES, AND RATES PER 1,000 ENROLLEES, BY REGION, CENSUS DIVISION, AND STATE, JULY 1, 1968, TO JUNE 30, 1969[1]—Continued

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care[3]	
	Number (thousands)	Per 1,000 enrollees[2]	Number (thousands)	Per 1,000 enrollees[2]	Number (thousands)	Per 1,000 enrollees[2]
Pacific	682.0	294.7	123.7	53.4	47.7	20.6
Washington	98.7	313.0	16.2	51.4	4.5	14.3
Oregon	67.0	305.0	9.9	45.1	3.9	17.8
California	502.4	290.2	95.8	55.3	38.9	22.5
Alaska	1.7	271.9	.1	16.0	(6)	(7)
Hawaii	12.2	389.4	1.7	40.3	.4	9.5
Outlying areas	38.8		.3		.6	
Unknown	(6)	(7)	(6)	(7)	(6)	(7)

[1] Data based on notices received between July 1, 1968 through June 30, 1969.
[2] Based on enrollment data for the hospital insurance program, as of Jan. 1, 1969.
[3] Includes home health start of care notices under both hospital insurance and medical insurance.
[4] Includes unknown.
[5] Northeastern includes New England and Middle Atlantic States; North Central includes East North Central and West North Central States; South includes South Atlantic, East South Central and West South Central; and West includes Mountain and Pacific States.
[6] Less than 50.
[7] Less than 1,000.

In comparing the 3 years, it is important to note that fiscal 1967 is understated relative to the other 2 years due to several factors. The primary reason is the substantial lag at the beginning of the program before bills began to come into the Social Security Administration for payment. In fiscal years 1968 and 1969 claims were coming in continuously and there was no such lag. This lag partially accounts for the fact that the increase in reimbursements between 1967 and 1968 was greater than the increase between 1968 and 1969.

Other factors contributing to the substantially lower figures for the first year were the availability of extended-care benefits for only half the year and the application of the entire $50 deductible under SMI for only a 6-month period in calendar year 1966. The $50 deductible is applied on a calendar-year basis. Normally, enrollees would begin accruing bills to meet the deductible in January of any given year, the midpoint of the fiscal year. But because medicare began on July 1, 1966, the $50 deductible had to be met between July and December 1966 before SMI benefits could be paid. The deductible then had to be met again in calendar 1967. The carryover provision mitigated the situation somewhat by permitting any expenses incurred by an individual in the last 3 months of 1966 and applied to the deductible for that year to be carried over and applied to the deductible for 1967.

The annual increases in total and average reimbursements are also the result of increases in both prices and utilization.

The pattern of increases in reimbursements under the HI program in each year held for the individual States as well as the Nation. Data for the first year showed considerable variation among the States in per capita reimbursements. The data for the succeeding 2 fiscal years show that the variation has continued (table 2). The range in fiscal year 1967 covered a low of $66 in Mississippi and a high of $191 in Nevada. For the following year the low was $95 for Alaska and the high was $287 for Connecticut. In fiscal 1969 the low was $145 for Arkansas and Nevada was highest with $397.

The interstate variation displays a strong geographic pattern in all 3 years. In table 2, the States are arranged by census geographic divisions showing that they tend to cluster, with contiguous States having similar values for average HI reimbursement. For example, in fiscal year 1967 the East South Central States had averages ranging from $66 to $113, well below the national average of $134.

The extent of the interstate variation and its geographic pattern have been quite stable over the 3 years. States with high averages in 1967 had high averages in subsequent years and similarly States with low averages in 1967 have remained

low. Continuing the example of the East South Central States, their HI averages in fiscal year 1969 ranged from $153 to $203, still well below the national average in that year of $237. Increases in these averages have been distributed generally so as to maintain the pattern of interstate variation set in 1967.

The average reimbursement for supplementary medical insurance increased for each State in each year, with only three exceptions (table 3). Massachusetts showed no increase between 1968 and 1969 and the averages for Arizona and Iowa actually decreased.

TABLE 2.—HOSPITAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1967-69

Area	1967		1968		1969	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
Total [2]	$2,525,818	$133	$3,736,322	$192	$4,654,000	$236
United States	2,521,139	134	3,727,257	193	4,638,840	237
Regions:						
Northeastern States	730,467	145	1,054,856	206	1,329,404	258
North Central States	757,763	136	1,110,646	196	1,339,122	235
South	575,984	107	903,541	161	1,131,682	197
West	456,925	162	658,215	226	838,631	281
New England	199,162	161	303,849	242	368,940	292
Maine	14,621	126	22,284	189	27,064	228
New Hampshire	10,197	132	12,453	158	18,187	227
Vermont	5,071	106	7,665	158	10,701	219
Massachusetts	105,916	170	161,000	256	196,506	312
Rhode Island	14,457	144	20,166	198	31,576	307
Connecticut	48,900	173	80,280	287	84,906	300
Middle Atlantic	531,305	140	751,007	194	960,464	247
New York	303,521	158	411,358	211	545,548	279
New Jersey	78,317	119	121,476	181	150,865	221
Pennsylvania	149,467	121	218,172	174	264,051	210
East North Central	509,532	138	760,430	202	917,103	242
Ohio	124,220	128	181,537	185	212,844	216
Indiana	53,850	112	81,861	168	102,333	209
Illinois	159,439	149	235,010	217	305,010	280
Michigan	108,028	148	170,292	229	188,076	249
Wisconsin	63,995	141	91,730	198	108,840	232
West North Central	248,231	133	350,215	184	422,019	220
Minnesota	66,882	168	92,915	229	109,418	267
Iowa	41,426	119	59,039	168	72,235	204
Missouri	67,114	124	98,312	179	117,904	212
North Dakota	10,182	157	12,918	195	17,434	260
South Dakota	10,583	135	13,931	173	16,585	205
Nebraska	20,663	116	28,037	155	34,510	189
Kansas	31,381	121	45,064	171	53,933	203
South Atlantic	280,487	111	442,969	168	555,974	205
Delaware	5,322	127	7,725	179	9,038	206
Maryland	32,401	122	49,111	179	59,899	213
District of Columbia	9,820	146	16,499	243	24,992	372
Virginia	32,107	96	51,982	151	62,318	177
West Virginia	19,206	100	28,533	146	34,380	175
North Carolina	34,565	91	54,000	138	72,440	181
South Carolina	14,169	80	22,181	122	30,500	164
Georgia	29,339	87	47,220	135	59,795	169
Florida	103,553	140	165,718	210	202,612	243
East South Central	113,769	95	175,537	143	223,985	180
Kentucky	32,615	100	48,500	146	60,042	179
Tennessee	40,382	113	58,570	159	76,086	203
Alabama	26,868	89	43,593	140	54,400	172
Mississippi	13,904	66	24,874	115	33,457	153

See footnotes at end of table.

TABLE 2.—HOSPITAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION AND STATE, FISCAL YEARS 1967–69—Continued

Area	1967 Amount (in thousands)	1967 Per enrollee [1]	1968 Amount (in thousands)	1968 Per enrollee [1]	1969 Amount (in thousands)	1969 Per enrollee [1]
West South Central	$181,728	$108	$285,034	$164	$351,723	$199
Arkansas	21,071	95	29,768	131	33,492	145
Louisiana	23,544	84	36,809	126	53,424	181
Oklahoma	33,351	120	47,090	165	55,092	190
Texas	103,762	116	171,367	184	209,715	220
Mountain	91,798	147	132,403	205	163,013	245
Montana	9,745	144	14,305	209	16,000	231
Idaho	6,774	105	10,205	155	12,545	187
Wyoming	3,191	108	4,918	163	5,380	177
Colorado	30,555	172	43,194	237	52,958	287
New Mexico	7,460	117	10,795	163	12,646	184
Arizona	21,552	172	31,037	233	38,422	271
Utah	7,719	111	10,664	148	13,702	185
Nevada	4,802	191	7,285	271	11,360	397
Pacific	365,127	166	525,812	232	675,618	292
Washington	44,836	147	64,055	206	71,620	227
Oregon	28,322	135	41,001	191	48,250	220
California	286,290	175	411,390	243	543,740	314
Alaska	483	85	572	95	1,004	161
Hawaii	5,196	135	8,793	218	11,004	261

[1] Based on Jan. 1 enrollment.
[2] Includes Puerto Rico, the Virgin Islands, and other outlying areas.

TABLE 3.—SUPPLEMENTARY MEDICAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1967–69

Area	1967 Amount (in thousands)	1967 Per enrollee [1]	1968 Amount (in thousands)	1968 Per enrollee [1]	1969 Amount (in thousands)	1969 Per enrollee [1]
Total [2]	$669,832	$38	$1,389,622	$77	$1,644,842	$87
United States	668,014	38	1,385,301	77	1,638,689	87
Regions:						
Northeastern States	189,436	39	411,318	85	461,882	93
North Central States	149,720	29	324,333	62	391,214	71
South	169,326	34	357,972	70	449,610	83
West	159,532	60	291,679	107	335,983	117
New England	43,811	37	90,725	76	99,969	81
Maine	3,032	27	5,636	50	6,732	58
New Hampshire	2,005	28	4,239	58	6,174	81
Vermont	1,332	29	2,736	59	3,026	64
Massachusetts	22,842	38	50,679	84	51,301	84
Rhode Island	3,639	38	6,720	70	10,290	104
Connecticut	10,961	41	20,715	77	22,446	81
Middle Atlantic	145,625	40	320,593	88	361,913	97
New York	81,220	45	189,036	103	198,789	106
New Jersey	28,135	45	53,928	84	66,268	100
Pennsylvania	36,270	31	77,578	67	96,856	80
East North Central	94,066	27	210,414	60	258,935	71
Ohio	23,451	26	49,501	55	63,024	67
Indiana	11,146	25	24,899	56	29,484	63
Illinois	27,643	28	64,736	64	80,439	77
Michigan	19,852	29	46,085	66	55,984	77
Wisconsin	11,974	28	25,193	58	30,004	66

See footnotes at end of table.

TABLE 3.—SUPPLEMENTARY MEDICAL INSURANCE: TOTAL AND AVERAGE REIMBURSEMENT PER ENROLLEE, BY REGION, DIVISION, AND STATE, FISCAL YEARS 1967–69—Continued

Area	1967		1968		1969	
	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]	Amount (in thousands)	Per enrollee [1]
West North Central	$55,654	$32	$113,919	$65	$132,279	$72
Minnesota	15,814	42	29,156	76	34,042	86
Iowa	8,099	25	20,355	61	18,402	54
Missouri	14,994	31	34,141	70	39,974	75
North Dakota	2,169	37	4,112	67	4,492	70
South Dakota	2,223	30	3,715	50	4,152	54
Nebraska	5,573	34	10,803	65	12,663	72
Kansas	6,782	30	11,637	48	18,554	73
South Atlantic	85,770	37	180,422	75	225,060	87
Delaware	1,441	36	2,903	72	3,218	76
Maryland	5,949	25	14,393	59	18,604	72
District of Columbia	2,954	48	7,282	121	8,183	132
Virginia	11,152	37	19,141	62	22,875	69
West Virginia	5,846	33	9,985	56	15,043	80
North Carolina	10,342	30	18,756	54	20,929	56
South Carolina	3,830	24	7,905	48	10,230	59
Georgia	8,036	27	18,125	57	21,768	64
Florida	36,220	51	81,932	110	104,210	129
East South Central	28,015	26	59,216	54	78,098	67
Kentucky	7,187	24	14,709	48	22,174	69
Tennessee	10,121	30	20,165	59	22,472	62
Alabama	6,490	23	15,731	56	18,703	63
Mississippi	4,217	24	8,611	49	14,749	77
West South Central	55,541	36	118,335	74	146,452	87
Arkansas	5,138	25	10,362	49	12,846	58
Louisiana	6,627	26	13,940	55	19,840	74
Oklahoma	10,543	40	23,002	86	25,155	90
Texas	33,233	39	71,030	81	88,611	96
Mountain	26,827	46	49,540	83	58,869	93
Montana	2,208	35	4,417	69	4,739	71
Idaho	2,258	38	3,778	63	4,660	72
Wyoming	982	35	1,636	59	2,037	70
Colorado	9,146	54	15,591	90	18,590	104
New Mexico	2,332	41	4,010	70	5,871	96
Arizona	6,858	59	13,998	113	14,457	107
Utah	2,120	32	4,332	65	5,250	74
Nevada	923	40	1,777	72	3,265	121
Pacific	132,705	64	242,139	114	277,114	124
Washington	12,198	43	21,050	72	26,466	87
Oregon	6,799	35	14,191	72	16,723	80
California	111,857	72	202,698	127	228,512	136
Alaska	105	24	237	53	537	109
Hawaii	1,746	48	3,962	104	4,876	119

[1] Based on Jan. 1 enrollment.
[2] Includes Puerto Rico, the Virgin Islands, and other outlying areas.

Like HI, the averages for SMI have maintained the wide variation among States and the regional pattern of that variation set in fiscal year 1967. The range for fiscal year 1967 extended from $23 in Alabama to $72 in California. The low in fiscal year 1968 was $48 (Kansas, South Carolina, and Kentucky) and the high was again California with $127. Finally, the range in fiscal year 1969 extended from $54 (Iowa and South Dakota) to $136 in California.

The regional pattern of the averages was again evident under SMI with States in the South clustering at the low end of the distribution while the States with the highest averages were those in the Pacific and Middle Atlantic regions.

The stability of the regional pattern in the averages for both parts of medicare suggests that the underlying causes of State differences are also stable. These causes are related to—

(1) Differences in the demographic composition of the aged population;

(2) Differences in the availability of care in the form of hospital beds, doctors, and extended care facilities;

(3) Differences in the cost of hospital and extended care facilities and in charges for physicians' and other medical services.

Claims data

Claims approved for payment and processed by the Social Security Administration provide a description of the type and scope of services used. Of the 7.3 million hospital insurance (part A) claims recorded as of December 5, 1969 for fiscal year 1969, 80 percent were for inpatient hospital services, 5 percent for outpatient diagnostic services, 13 percent for extended care services and the remainder were for home health services (table 4). The small proportion of claims for outpatient diagnostic services in fiscal year 1969 reflects the change in coverage of such services under the law. Prior to April 1, 1968 outpatient diagnostic services were covered under the hospital insurance plan; effective April 1, 1968 such services were covered only under the medical insurance program. Reimbursements for inpatient hospital care amounted to $3.7 billion and averaged $639 per claim. Reimbursements averaged $14 per outpatient diagnostic claim, $357 per extended care facility claim, and $76 per home health claim.

Table 5 presents the number of claims for inpatient hospital care approved for payment, the covered days of care, total charges and amounts reimbursed for the 3 fiscal years. Although the number of claims and the covered days of care have increased annually, the average days per claim has remained stable at 13.4 days. Total charges per claim and per day, however, have increased substantially during the 3-year period. In the first year of the program, total charges per claim for short-stay hospital care amounted to $605; by fiscal year 1969, the amount increased to $801. On a per day basis, total charges for short-stay hospital care amounted to $46 in fiscal year 1967, $54 in fiscal year 1968, and $61 in fiscal year 1969.

TABLE 4.—HOSPITAL INSURANCE: NUMBER OF CLAIMS APPROVED FOR PAYMENT AND AMOUNTS REIMBURSED, BY TYPE OF BENEFIT, FISCAL YEARS 1967–69 [1]

Type of benefit	1967		1968		1969	
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution
Approved claims (number in thousands):						
Total	5,431	100.0	7,627	100.0	7,343	100.0
Inpatient hospital	4,595	84.6	5,590	73.3	5,837	79.5
Outpatient diagnostic [2]	329	6.1	666	8.7	41	.5
Extended-care facility	328	6.0	939	12.3	924	12.6
Home health	179	3.3	433	5.7	541	7.4
Amount reimbursed [3] (amount in millions):						
Total	$2,349.1	100.0	$3,471.7	100.0	$4,102.7	100.0
Inpatient hospital	2,236.4	95.2	3,131.2	90.2	3,731.4	90.9
Outpatient diagnostic [2]	3.9	.2	7.8	.2	.6	(4)
Extended-care facility	97.4	4.1	302.4	8.7	329.6	8.0
Home health	11.4	.5	30.2	.9	41.2	1.0
Amount reimbursed per claim:						
Inpatient hospital	487		560		639	
Outpatient diagnostic [2]	12		12		14	
Extended-care facility	297		322		357	
Home health	63		70		76	

[1] Includes only claims approved and recorded in the Social Security Administration central records before Dec. 5, 1969.

[2] Outpatient diagnostic services were covered under the hospital insurance plan prior to Apr. 1, 1968, at which time such services were covered only under the medical insurance plan. Thus, amounts shown under hospital insurance in fiscal year 1969 reflect reimbursements for claims approved for payment in the period but for services rendered prior to Apr. 1, 1968.

[3] Amounts shown represent payments for covered services, based on interim rate and are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductibles and coinsurance amounts and noncovered services as specified by law.

[4] Less than .05.

TABLE 5.—HOSPITAL INSURANCE: NUMBER OF CLAIMS FOR INPATIENT HOSPITAL CARE APPROVED FOR PAYMENT, COVERED DAYS, TOTAL CHARGES AND AMOUNTS REIMBURSED, BY TYPE OF HOSPITAL, FISCAL YEARS 1967-69

				Charges				
		Covered days of care		Total			Reimbursement [2]	
Fiscal year	Number of claims [1]	Total (in thousands)	Average per claim	Amount (in millions)	Per claim	Per day	Amount (in millions)	Percent of total
All hospitals: [3]								
1967	4,595	61,670	13.4	$2,783.1	$606	$45	$2,236.4	80.4
1968	5,590	75,170	13.4	3,914.2	700	52	3,131.2	80.0
1969	5,837	78,149	13.4	4,668.5	800	60	3,731.4	79.9
Short stay:								
1967	4,497	58,573	13.0	2,719.0	605	46	2,182.6	80.3
1968	5,463	71,482	13.1	3,827.1	701	54	3,064.2	80.1
1969	5,696	74,440	13.1	4,562.2	801	61	3,654.7	80.1
Long stay: [4]								
1967	52	1,758	33.7	43.2	828	25	35.8	82.9
1968	56	1,620	28.9	49.0	874	30	37.9	77.5
1969	59	1,551	26.2	55.8	942	36	41.5	74.4

[1] Includes only claims approved and recorded in the Social Security Administration central records before Dec. 5, 1969.
[2] Amounts shown represent payments for covered services, based on interim rate and are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductibles and coinsurance amounts and noncovered services as specified by law.
[3] Includes claims with type of hospital unknown.
[4] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals, and Christian Science sanitoria.

Reimbursements for short-stay hospital care represented about 80 percent of total charges in each fiscal year. The amounts reimbursed represent payments for covered services, based on an interim rate and adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Amounts reimbursed exclude deductibles and coinsurance payments and noncovered services as specified by law.

Under supplementary medical insurance (part B), total bills recorded as of December 5, 1969 amounted to 36.4 million for fiscal year 1969. Of these bills, 83 percent were for physicians' services, 9 percent for outpatient hospital care, and the remaining 8 percent for home health, independent laboratory and other medical services (table 6). Total allowed charges for these bills amounted to $2.2 billion, averaging $62 per bill. For physicians' services, allowed charges averaged $67 per bill; they averaged $66 per home health bill, $27 per outpatient bill, $20 per independent laboratory bill, and $48 for all other bills.

Of the 30.3 million bills for physicians' services, 14 percent were for surgical and 86 percent were for medical bills. Allowed charges for surgical bills amounted to $672 million and averaged $163 per bill; for medical bills, they amounted to $1.3 billion and averaged $51 per bill (table 7).

TABLE 6.—SUPPLEMENTARY MEDICAL INSURANCE: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND AMOUNT PER BILL, BY TYPE OF SERVICE, FISCAL YEARS 1967–69[1]

Bills (number in thousands)

Type of service	1967 Number	1967 Percent distribution	1968 Number	1968 Percent distribution	1969 Number	1969 Percent distribution
All services[2]	10,116	100.0	30,153	100.0	36,439	100.0
Physicians	8,723	86.2	24,518	81.3	30,279	83.1
Home health	152	1.5	439	1.5	544	1.5
Outpatient hospital	781	7.7	3,544	11.8	3,387	9.3
Independent laboratory	143	1.4	400	1.3	536	1.5
All other	232	2.3	974	3.2	1,655	4.5
	Charges[3] (amount in millions)					
All services[2]	$735.4	100.0	$1,727.6	100.0	$2,249.7	100.0
Physicians	691.2	94.0	1,580.2	19.5	2,029.3	90.1
Home health	9.1	1.2	24.9	1.4	35.8	1.2
Outpatient hospital	12.4	1.7	46.1	2.7	92.6	4.6
Independent laboratory	4.0	.5	8.5	.5	10.6	0.5
All other	12.3	1.7	46.7	2.7	79.0	3.5
	Charges per bill					
All services[2]	$73		$51		$62	
Physicians	79		64		67	
Home health	60		57		66	
Outpatient hospital	16		13		27	
Independent laboratory	28		21		20	
All other	53		43		48	

[1] Includes only bills for which reimbursements were made by the intermediaries and which were recorded in the Social Security Administration central records before Dec. 5, 1969.
[2] Includes some bills and their charges for which type of service is unknown.
[3] The allowed charges as determined by the carrier on the basis of customary charges for similar services generally made by the physician or supplier of covered services and also on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.

TABLE 7.—SUPPLEMENTARY MEDICAL INSURANCE: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND REIMBURSED AMOUNT, BY TYPE OF BILLS, FISCAL YEARS 1967–69[1]

Fiscal year	Bills: Number (in thousands)	Bills: Percent distribution	Charges: Total[2] Amount (in millions)	Charges: Total[2] Percent distribution	Charges: Total[2] Per bill	Charges: Reimbursement[3] Amount (in millions)	Charges: Reimbursement[3] Percent distribution	Charges: Reimbursement[3] Percent of total
			All bills[4]					
1967	10,116	100.0	$735.4	100.0	$73	$510.0	100.0	69.4
1968	30,153	100.0	1,727.6	100.0	51	1,246.8	100.0	72.2
1969	36,439	100.0	2,249.7	100.0	62	1,623.7	100.0	72.2
			Surgical bills					
1967	1,530	15.1	278.7	37.9	182	204.3	40.1	73.3
1968	3,221	10.7	535.0	31.0	166	402.4	32.3	75.2
1969	4,115	11.3	672.1	29.9	163	504.3	31.1	75.0
			Medical bills					
1967	7,193	71.1	412.5	56.1	57	276.8	54.3	67.1
1968	21,297	70.6	1,045.3	60.5	49	740.1	59.4	70.8
1969	26,165	71.8	1,327.2	59.0	51	966.2	59.5	72.8

[1] Only bills for which reimbursements were made by the intermediaries and which were recorded in the Social Security Administration central records before Dec. 5, 1969.
[2] The allowed charges as determined by the carriers on the basis of customary charges for similar services generally made by the physician or supplier of covered services and also on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.
[3] Represents 80 percent of allowed charges for covered services each year after the beneficiary has paid the 1st $50 of such charges during the year.
[4] Includes bills for home health, outpatient hospitals, independent laboratory, and other services covered under the medical insurance program; as well as some bills for which type of service is unknown.

Current medicare survey report

Data are available from the current Medicare Survey for two full calendar years—1967 and 1968—on the medical care services used and charges incurred by persons enrolled in the supplementary medical insurance program. The current Medicare Survey is a continuing monthly survey of medical insurance enrollees to obtain current estimates for this part of the program.

During calendar year 1968, an estimated 9.6 million persons used services covered under medicare by the hospital insurance (HI) program and/or incurred sufficient charges to meet the supplementary medical insurance (SMI) deductible (table 8). The SMI deductible amount is the first $50 of covered medical expenses in each calendar year. The estimates, developed from the current Medicare Survey for the period January 1, 1968 to December 31, 1968, take into account the SMI carryover provision, which allows expenses incurred in the last 3 months of a calendar year and applied to the deductible for that year to be carried over and applied to the deductible for the following year.

TABLE 8.—USE OF SERVICES IN THE MEDICARE PROGRAM, UNITED STATES, 1967 AND 1968

[In thousands]

Population group	As of the year end			During the year		
	Number	Approximate standard error	Percent	Number	Approximate standard error	Percent
1967 [1]						
Persons enrolled under hospital insurance, supplementary medical insurance, or both	19,330		100.0	20,460		100.0
Using hospital insurance services and/or meeting supplementary medical insurance deductible	8,490	130	43.9	–9,190	130	44.9
Persons enrolled under both hospital insurance and supplementary medical insurance or supplementary medical insurance only	17,930		100.0	18,890		100.0
Using hospital insurance service and/or meeting supplementary medical insurance deductible	8,300	130	46.3	8,960	130	47.4
Using hospital insurance services only	280	30	1.6	370	40	2.0
Meeting supplementary medical insurance deductible only	4,940	120	27.6	5,040	120	26.7
Using hospital insurance services and meeting supplementary medical insurance deductible	3,080	100	17.2	3,550	110	18.8
Persons enrolled under hospital insurance only	1,400		100.0	1,570		100.0
Using hospital insurance services	190	30	13.6	230	30	14.6
1968						
Persons enrolled under hospital insurance, supplementary medical insurance, or both	19,645		100.0	20,870		100.0
Using hospital insurance services and/or meeting supplementary medical insurance deductible	8,765	140	44.6	9,615	140	46.1
Persons enrolled under both hospital insurance and supplementary medical insurance or supplementary medical insurance only	18,775		100.0	19,180		100.0
Using hospital insurance services and/or meeting supplementary medical insurance deductible	8,620	140	45.9	9,145	140	47.5
Using hospital insurance services only	270	30	1.4	375	40	1.9
Meeting supplementary medical insurance deductible only	5,105	130	27.2	5,235	130	26.4
Using hospital insurance services and meeting supplementary medical insurance deductible	3,245	110	17.3	3,805	110	19.2
Persons enrolled under hospital insurance only	870		100.0	1,060		100.0
Using hospital insurance services	145	20	16.7	200	30	18.9

[1] Excludes from number of persons using hospital insurance services those persons using extended care or home health services in 1967 following a hospital discharge in 1966.

These 9.6 million persons represented 46 percent of all persons enrolled in the medicare program at any time during 1968. In the previous year, an estimated 9.2 million persons, or 45 percent, had met the HI and/or the SMI deductible under either or both parts of the program. The estimated number of persons using HI services in this report is more inclusive than the comparable estimate of persons meeting the HI deductible reported for 1967. Included here are those using extended care or home health services in 1968 following a hospital discharge in 1967. Persons using these services in 1967 following a hospital discharge in 1966 were not included in the 1967 estimates of persons using HI services.

Because there are a substantial number of deaths each year in the population aged 65 and over, an even larger number of newly eligible enrollees, and a small number of disenrollments, two separate estimates are shown: The first is for those persons enrolled as of December 31, 1968. The second is for persons enrolled at any time during the year (January 1–December 31), including those who died or terminated their insurance. Persons electing or terminating SMI coverage at various times in the year are counted as enrolled under SMI during the year.

HEW News, December 27, 1969

Health, Education, and Welfare Secretary Robert H. Finch announced today that the voluntary medical insurance premium older people pay for medicare will be $5.30 a month for the 12-month period that begins next July 1.

Secretary Finch noted that the present $4 premium rate, set in December 1968, is too low to cover costs during the current premium period and that the special medical insurance trust fund is now drawing on its reserves.

He stressed that failure to increase the premium rate last December, in accordance with advice from Social Security Administration actuaries has made it necessary now, in effect, to promulgate two increases at once. Moreover, the depletion of the trust fund that has occurred because of the inadequate rate has made it necessary, Secretary Finch said, to provide for a somewhat higher margin of contingency than would otherwise be necessary.

About half the increase announced today—64 cents—is needed just to finance the program at the level of current operations. The other 66 cents of the $1.30 increase in the monthly premium rate will be needed for the following purposes:

26 cents to cover an estimated increase of about 6 percent in the level of physicians' fees;

About 12 cents to cover an estimated increase of 2 percent in the utilization of services under the program;

About 6 cents because the $50 deductible which a patient pays will be a smaller proportion of the total covered charges; and

The remaining 22 cents to provide a 4-percent margin for contingencies. This margin is needed because the estimates are based upon minimum reasonable assumptions and because the trust fund out of which this program is financed will be at a low level at the beginning of the premium period on July 1, 1970.

The medical insurance program supplements the basic hospital insurance part of medicare by helping to pay doctor bills and a wide variety of other medical expenses in and out of the hospital. The premiums paid by people 65 and older who are enrolled in the medical insurance part of medicare, cover half the cost of their protection. The other half comes out of general Federal revenues. The medicare law provides for annual review of the costs of the medical insurance program and for any necessary adjustments in the premium rate by January 1. The law requires that the premium rate be sufficient to cover all expenses incurred during each premium period.

Statement of Actuarial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program Beginning July 1970

There follows a statement of actuarial assumptions and bases employed in arriving at the amount of the standard premium rate for the supplementary medical insurance program for the period July 1970 through June 1971. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of the actual operating

experience under the program. Virtually complete operating experience figures for the 6 months of 1966 and for 1967 are now available, but because of the time-lag in the submission of bills for this program, figures for 1968 are not quite complete, and only partial data for 1969 are available.

ANALYSIS OF DATA ON A CASH BASIS

Current figures for cash expenditures under the program are available on a complete, accurate basis, but these figures taken alone are misleading because they do not take into account the liabilities arising from the natural delay in benefit payments, which are not made until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians, other suppliers of services, and enrollees in making requests for payment, and the time required by the carriers and intermediaries to adjudicate and pay claims. The data on a "cash" basis are presented first, since they are the base from which the incurred figures needed for the premium-rate determination are developed.

The balances in the supplementary medical insurance trust fund at the end of various selected typical past months are as follows:

[In millions]

	Balance
January 1967[1]	$467
March 1967	570
December 1967	412
July 1968	403
December 1968	421
June 1969	378
October 1969	242

[1] Balances for months in 1966 were unduly low, because no Federal matching payments were made until January 1967.

As compared with the balance of $242 million in the supplementary medical insurance trust fund at the end of October 1969, there were at that time substantial outstanding liabilities incurred for services rendered during the previous months of operation of the program—an estimated $800 million approximately. It is expected that the trust fund balance will continue to decrease during the remainder of fiscal year 1970, because the actuarially inadequate premium rate of $4 per month which was promulgated in December 1968 will still be in effect throughout this period. It is estimated that the trust fund balance will reach approximately $100 million on June 30, 1970.

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures of the program for the 21 months in the first premium period, July 1966 through March 1968, amounted to $5.12. Similarly, the average monthly per capita expenditures on a cash basis in the second premium period, April 1968 through June 1969, amounted to $8.05. Finally, the average monthly per capita expenditures (cash basis) for the first 5 months of the third premium period, July 1969 through June 1970, amounted to $8.84.

ANALYSIS OF DATA ON AN INCURRED BASIS

The figures on a cash basis need to be adjusted for the estimated increase in liability that took place during the period for benefits that will be paid for services rendered during the period, but that had not been paid at the end of the period (and the accompanying administrative expenses). In other words, the premium rate must be set on an accrual or incurred basis, rather than a cash basis.

Estimates on an incurred basis for the 21 months involved in the first premium period (July 1966 through March 1968) indicate that benefits and administrative expenses per capita exceeded income from premiums and matching Government contributions by $0.65 per month (i.e., 32½ cents each), or by 11 percent relatively. These estimates are based on virtually complete experience data. If account is taken of the interest earnings of the trust fund, this deficit is reduced to $0.57 per month, or 9½ percent relatively. If the comparison is made for the 18-month period, July 1966 through December 1967, for which the combined rate of $6 originally applied (having been extended 3 months by legislation in

1967), the differential underestimate would have been 6 percent (taking into account the effect of the interest earnings of the trust fund).

Estimates on an incurred basis for the 15 months involved in the second premium period (April 1968 through June 1969) indicate that the total per capita cost exceeded income from premiums and matching Government contributions by $0.65 per month, or by 8 percent of the combined rate of $8. These estimates are based on moderately complete experience data. If account is taken of the interest earnings of the trust fund, this deficit is reduced to $0.55 per month, or 7 percent relatively.

Similar figures on an incurred basis for the third premium period (July 1969 through June 1970) necessarily must be based largely on estimates of the experience which will develop. Estimates for this period (which are described in more detail later, especially as to assumptions and methodology) indicate that the total per capita cost will exceed income from premiums and matching Government contributions by about $1.28 per month, or by 16 percent relatively. If account is taken of the interest earnings of the trust fund, this estimated deficit is reduced to $1.22 per month, or 15 percent relatively.

It should be noted that this large deficit for the third premium period would not have occurred if the actuarially determined and recommended premium rate of $4.40 had been promulgated, instead of the rate of $4 which was promulgated. If there had not been the administrative action to defer recognition of increases in physicians' fee for reimbursement purposes, a $4.40 rate would have resulted in an estimated deficit (after allowing for the higher interest receipts) of about $0.48 to $0.53 per capita per month, or about 6 percent relatively. Such estimated deficit takes into account the element that the costs of the program were apparently reduced by $0.10 to $0.15 per capita per month by such administrative action. It is possible—although not susceptible of proof—that the promulgation of the higher rate ($4.40) in itself would have led to higher program costs than were actually experienced, because of the psychological effect of having the Government predict a rise in physicians' fees.

In any event, it cannot be emphasized too strongly that the base for the estimate of the premium rate now to be promulgated for the fourth premium period (July 1970 through June 1971) is a presently experienced cost requiring a standard premium rate of at least $4.60 and possibly $4.70 per month, and not the $4 which is currently being collected.

BASIC ESTIMATE OF FUTURE EXPERIENCE ON AN INCURRED BASIS

In estimating the cost of the program for July 1970 through June 1971, it is necessary to provide for the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-term upward trend of the general earnings level and the general price level, which will be reflected in higher physicians' fees, higher costs for other covered services, and higher administrative expenses. In the estimates in this section, the minimum reasonable assumptions as to future increases have been made. Certain other estimates based on somewhat higher cost assumptions are discussed in a later section.

For the purpose of estimating the necessary premium rate for July 1970 through June 1971, it was assumed that, in comparing calendar year 1969 with 1968, the combined effect of increases in physicians' fees and costs of other covered medical services and of increases in utilization would be an increase of 5½ percent. The corresponding figure for calendar year 1970 as compared with 1969 is 7½ percent, while the rate used for 1971 as compared with 1970 is 8½ percent. The breakdown of these aggregate increases into the three components is as follows:

ASSUMED INCREASE OVER PREVIOUS YEAR

Calendar year	Physicians' fees [1] (percent)	Costs of other covered services [2] (percent)	Utilization of services (percent)
1969	2	15	3
1970	4	14	3
1971	6	13	2

[1] As recognized by the program.
[2] Including effect of increased utilization of such services which is in excess of assumed general increase in utilization.

It should be observed that the relatively low rate of increase for 1969 over 1968 reflects the deferment of recognition of increases in physicians' fees for reimbursement purposes that was put into effect by regulations at the end of 1968.

The rates of increase for calendar years 1970 and 1971 are based on the assumption that such deferment will be moved forward successively by 1 year—i.e., that the deferment applicable from July 1970 through June 1971 will be based on the situation as to physician fees as of the end of 1969. It should also be noted that these assumed rates of increase take into account the fact that the costs of covered nonphysician services, such as hospital outpatient care and home health services, which represent only about 10 percent of the total cost of the program, have been increasing more rapidly than physicians' fees and have not been subject to a deferment of recognition of cost changes.

Administrative expenses are assumed to represent about 11½ percent of the benefit payments; this figure is based on the actual operating results in 1969 and budget estimates for future years (all on an incurred basis). The average interest rate on the invested assets of the trust fund is assumed to be 6½ percent (the rate applicable to the entire portfolio as of September 30, 1969). This rate might be somewhat higher during the next premium period, but since the balance in the trust fund will not be very large, the effect of the interest rate assumption is not significant; for example, if a 7-percent interest rate were assumed, the per capita cost would be reduced by less than one-half cent per month.

It is estimated that the incurred monthly per capita total cost, on a calendar-year basis, would have been $8.28 for 1968 if the provisions of the 1967 amendments had been in effect for the entire year (instead of only part of it) and if there had not been the influenza epidemic in late 1968 and early 1969. This consists of $7.46 for benefits and $0.82 for administrative expenses. This approach has been taken in order to obtain a proper base on which to build estimates of future costs; the possibility of epidemics occurring is later taken into account by adding a contingency margin to the estimated costs for "normal" conditions.

On the basis of the foregoing assumptions, it is estimated that the monthly per capita benefit cost on a calendar-year basis will be $7.95 for 1969 (again exclusive of the additional cost arising from the influenza epidemic in late 1968 and early 1969). The corresponding benefit-cost figures estimated for 1970 and 1971 are $8.65 and $9.50, respectively. To these must be added the monthly per capita costs for administrative expenses, which are estimated at $0.93 for 1969, $1.03 for 1970, and $1.13 for 1971. Thus, the monthly per capita total cost on an incurred basis is estimated at $8.88 for 1969 (exclusive of the additional cost with respect to the influenza epidemic), $9.68 for 1970, and $10.63 for 1971.

The monthly per capita total cost for fiscal year 1969 averages out at $8.58; this is increased to $8.73 if the actual effect of the influenza epidemic is taken into account. The corresponding estimated costs for fiscal years 1970 and 1971 (assuming no influenza epidemic) are $9.28 and $10.16. Thus, as indicated previously, the standard premium rate for fiscal year 1970, promulgated at $4 per month in December 1968, should have been at least $4.60, and quite possibly should have been $4.70. The figure of $10.16 for fiscal year 1971 (half of which is $5.08) indicates that, allowing even a small margin for contingencies (as required by law), the standard premium rate for the period July 1970 through June 1971 would need to be $5.20 per month at the very least. However, as indicated in the analysis which follows the estimates presented up to this point (which are on a reasonable minimum cost basis), the only safe course of procedure—considering the currently depleted state of the trust fund—is to set a rate of $5.30 per month.

OTHER ESTIMATES OF FUTURE EXPERIENCE

A similar analysis of the possible experience in 1969–71 was made with more detailed and refined methodology and with somewhat higher assumptions as to future increases in medical costs and utilization, all under the assumption that the deferment of recognition of increases in physician fees for reimbursement purposes would be continued on the present lag basis moved up 1 year. This indicated monthly per capita total costs of $8.94 for fiscal year 1969 (including 38 cents for the additional costs due to the influenza epidemic), $9.44 for fiscal year 1970, and $10.46 for fiscal year 1971. The last figure indicates that, according to this estimate, a standard premium rate of $5.30 per month should be promulgated for fiscal year 1971, if some reasonable margin for contingencies is to be included.

The level of benefit expenditures indicated by the foregoing estimate was confirmed by an independent calculation of the accrued benefits in 1969, starting with the cash expenditure in calendar year 1969 and adjusting for the benefits incurred but unpaid (due to the aforementioned lag) at the beginning and at the end of 1969, for the effect of the influenza epidemic, and for the liability of the program for certain payments for inpatient radiology and pathology services paid from the hospital insurance trust fund.

Still another type of analysis was made by using as a starting point the actual cash expenditures in fiscal year 1969. These data were adjusted downward for the nonrecurrent nature of the influenza epidemic and upward for certain payments attributable to the supplementary medical insurance program for inpatient radiology and pathology services but, during that time, paid from the hospital insurance trust fund. These calculations yielded a cash-basis per capita cost of $8.26 per month for fiscal year 1969. This figure was then projected to fiscal year 1970, yielding $8.86. Then, the latter figure was converted from a cash basis to an incurred basis, yielding $9.26. Finally, the latter figure was projected for 1 year, to fiscal year 1971, and the result was $10.26, so that on this basis the standard premium rate should be $5.20 with a small allowance for contingencies, and at least $5.30 with a sufficient allowance.

EFFECT OF INTEREST EARNINGS OF TRUST FUND

The interest earnings of the trust fund are available toward the margin for contingencies. If they are not needed to pay benefits and administrative expenses in the current period, they will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings for fiscal year 1971 are estimated to be the equivalent of only about 5 cents per capita (i.e., 2½ cents as compared with the enrollee premium) in available income, thus providing income toward a contingency margin of only small magnitude.

SUMMARY AND RECOMMENDATION

Based on all available evidence and analyses, the standard premium rate for fiscal year 1971 should be promulgated at $5.30 per month. This is based on the assumptions that there will continue to be a deferment of recognition of increases in physicians' fees for reimbursement purposes and that this deferment will not be advanced more than 1 year (so that, in the new premium period, July 1970 through June 1971, no recognition will be given of changes in fees after December 1969).

Although a rate of $5.30 is desirable to provide a sufficient margin for contingencies (as required by law), it should be noted that, even if this margin is not actually used for any contingencies arising in the premium period, it would nevertheless fill the very useful purpose of building up the trust fund balance to a more desirable level, one which is more in keeping with the concept that the program should be operated on an incurred-cost basis.

It is particularly important to provide a reasonable and adequate contingency margin in the premium rate now being promulgated, since the balance in the trust fund at the beginning of the new premium period will be considerably less than 1 month's benefit outgo. A rate as low as $5.20 (the next lowest possible rate under the law, which requires rounding to $0.10 units) would make very little allowance for possible adverse experience, such as might result from another influenza epidemic or for higher rates of increase in utilization or physicians' fees than the minimum reasonable rates assumed. If the trust fund balance at the beginning of the new premium period were to be larger—as would have been the case if the premium rate had not been maintained at $4 by the promulgation made in December 1968, but rather had been increased to the actuarial recommendation of at least $4.40—it might now have been possible to promulgate a rate of $5.20. Such a rate, under these circumstances, would have been able to depend upon the interest earnings of the trust fund serving as a major part of the protection against unforeseen contingencies.

The explanation of the $1.30 increase in the monthly standard premium rate for the new permium period can be summarized in the following manner:

(*a*) The cost of the protection under the program as in effect in the current premium period is estimated to exceed income from premiums and matching Government contributions by about 16 percent—an increase of about 64 cents.

(*b*) The utilization of medical services is assumed to be higher in the new premium period than in the current period, and so the program cost is higher—an increase of about 12 cents.

(c) The level of physicians' fees recognized by the program and of the costs and charges for other covered services is assumed to be higher in the new premium period than in the current period, and so the program cost is higher—an increase of about 26 cents.

(d) The $50 deductible represents a smaller proportion of the total covered reimbursable charges when these increase as a result of either higher charges or costs of providers of services or higher utilization—an increase of 6 cents.

(e) The promulgated rate includes a minimal allowance of about 4 percent so as to provide a margin for contingencies, especially since the foregoing cost figures are based on reasonable minimum cost projections and do not allow for any possible adverse morbidity experience (such as the influenza epidemic of 1968–69), and to provide for an adequate contingency reserve to be present in case of adverse experience, since the trust fund balance at the beginning of the premium period will be very low—an increase of 22 cents.

ITEM 16: SPECIAL ASSISTANT TO THE PRESIDENT FOR CONSUMER AFFAIRS

THE WHITE HOUSE,
Washington, February 9, 1970.

DEAR SENATOR WILLIAMS: I am pleased to have the opportunity to report the activities of my office related to the aging for inclusion in the annual report of the Senate Special Committee on Aging. I commend you, Mr. Chairman, and your committee for this compilation of activities to assist the elderly.

The report for my office is enclosed.

Sincerely,

VIRGINIA H. KNAUER,
Special Assistant to the President for Consumer Affairs.

[Enclosure]

REPORT ON 1969 ACTIVITIES OF THE PRESIDENT'S COMMITTEE ON CONSUMER INTERESTS RELATING TO THE AGING

This office recognizes the multiplicity and seriousness of consumer problems of the aging and is committed to give them priority attention. However, cognizance in this report on 1969 activities of the office must be given to the fact that the Special Assistant to the President for Consumer Affairs, Virginia H. Knauer, served in that capacity only the last 8 months of 1969. Therefore, activities in 1969 cannot fully reflect her concern and anticipated attention to the problems of the aging as consumers.

Her general objectives for this office relating to the aging were outlined shortly after her appointment in testimony before the Subcommittee on Consumer Interests of the Elderly, U.S. Senate Special Committee on Aging. (See attached testimony for inclusion in report at this point.)

LEGISLATIVE AND ADMINISTRATIVE PROPOSALS

President Nixon's consumer message of October 30, 1969, reflecting recommendations of this office, proposed a comprehensive legislative and administrative program which would materially assist the elderly as consumers. Four administration bills were subsequently introduced in the Congress. Mrs. Knauer was active in support of the proposals in 1969 through testimony, speeches, and press conferences.

The Consumer Representation Act of 1969 (S. 3240 and H.R. 14758) would establish a statutory Office of Consumer Affairs in the Executive Office of the President, giving every American consumer, including the aged, a permanent voice in the White House.

The Office would have central responsibility for coordinating and reviewing Federal consumer policies and programs to eliminate duplications and gaps, and in general to increase responsiveness to consumer needs. It would assure that the interests of consumers are presented and considered in a timely manner by appropriate levels of the Federal Government in the formulation of policies and in the operation of programs that may affect the consumer interests. The office would

submit recommendations to the President on measures and priorities for improving Federal programs and all activities affecting consumers, and assist in the legislative and administrative hearing process.

To bring consumer problems into national focus, the Office would conduct investigations, hearings, conferences, and surveys concerning needs, interests, and problems of consumers; encourage and coordinate research conducted by Federal agencies leading to improved consumer products, services, and consumer information; cooperate with and encourage private enterprise in the promotion and protection of consumer interests.

To increase consumer information, the Office would develop programs for disseminating information concerning consumer items which the Government purchases for its own use. It would encourage and coordinate the development of information from Federal agencies which would benefit consumers, including publication and distribution of periodicals and other printed materials.

It would provide direction for publication and distribution on a regular basis of a Consumer Register. This publication would contain, in layman's language, consumer information which now appears in legalistic language in the Federal Register. Consumers in general do not usually understand the legal terminology and, therefore, are not now sufficiently able to participate in the present Federal administrative process.

To increase consumer education, the Office would be responsible for encouraging, initiating, coordinating, evaluating, and participating in consumer education programs and consumer counseling programs.

To underscore assurance of consumer safety, the Office would undertake the continued evaluation and surveillance of consumer product safety and make recommendations to the President.

To effect increased consumer protection at the State and local level, the Office would encourage, cooperate with and assist State and local governments.

As an important step in making the consumer's voice heard, including the voice of the aging consumer, the Consumer Representation Act of 1969 would provide for establishment of a 20-member Consumer Advisory Council.

The Consumer Representation Act also provided for creation of a new Consumer Protection Division in the Department of Justice, with both an advocacy and enforcement role. It would act as the consumer's lawyer in Federal agency proceedings and protect the consumer's rights in the courts.

The Consumer Protection Act of 1969 (S. 3201 and H.R. 14931) would expand the Federal Trade Commission's authority to deal with practices which "affect" commerce. Since much consumer fraud and deception is at a local level, and since the elderly are frequently the special targets for the unscrupulous, this will be of major assistance for aging consumers.

Of material benefit to the elderly will be the prohibition by the act of 11 specified types of consumer fraud and deception which constitute the vast bulk of fraud and deception. For example, the act would outlaw on a nationwide basis bait-and-switch advertising and deceptive pricing which are the two most common deceptive practices in use today. Also on the list of practices to be outlawed are statements that services, replacements, or repairs are needed with knowledge that they are not. This, too, would eliminate a common problem for the aging—being deceived into spending money for services, replacements, or repairs which actually are not needed.

Yet another provision of the proposed bill of material benefit to the elderly is the provision to help victims of unfair or deceptive practices recover their loss. For years, consumers have been left without any private remedy or means of redress. The elderly have been among those who can least afford the loss, are least likely to know the legal procedures for recovery, are most hesitant to involve themselves with lawyers and the law and are least able to pay the cost of litigation if they knew the procedure. Often the elderly are physically unable to seek redress on their own behalf.

Under the administration's Consumer Protection Act, any consumer, including classes of consumers, may bring private action for money damages or for other relief upon the determination of a succesful Government action against any of these practices, using the final judgment or decree as prima facie evidence. Reasonable attorneys' fees may also be collected by successful private consumers.

The Consumer Product Testing Act (S. 3286 and H.R. 15229) would allow the Federal Government to review standards for evaluation which are used by private testing laboratories and to publish its findings as to their adequacy.

The Drug Identification Act of 1969 (S. 3297 and H.R. 15450) would make possible rapid identification of drugs and drug containers in a time of personal emergency.

Another administration bill materially affecting the elderly as consumers on which Mrs. Knauer testified was the Wholesome Fish and Fishery Products Act of 1969 (S. 2712 and H.R. 12986) which would protect against unwholesome fish and fishery products in the marketplace.

Administrative proposals reflecting recommendations of this office:

Reactivation of the Interagency Task Force on Appliance Warranties and Guarantees, chaired by Mrs. Knauer, to study and comment on the need for guarantee and warranty legislation in the household appliance industries and in other fields.

Stronger efforts in the field of food and drug safety, including a thorough reexamination of the Food and Drug Administration, and a review of the products on the "generally regarded as safe" list.

A newly activated National Commission on Consumer Finance to investigate and report on the state of consumer credit.

Other reforms, including an expansion of consumer activities in the Office of Economic Opportunity and greater efforts to encourage the strengthening of State and local programs.

TESTIMONY ON CONSUMER ISSUES

During 1969, the Special Assistant to the President for Consumer Affairs or her representative testified 18 times before Congress or Federal agencies on matters which would affect consumers, including the elderly consumer, such as the Fair Credit Reporting Act, improved packaging and labeling, mailing of unsolicited credit cards, price advertising practices of the automobile industry, poison prevention packaging, product safety, meat prices, gasoline octane rating disclosure, care labeling of textile products, consumer warranties and guarantees, retail food store advertising and marketing practices.

Of particular importance to the elderly with health problems requiring low cholesterol diets was Mrs. Knauer's appeal that the Department of Agriculture set the fat content in hot dogs and sausage at 30 percent instead of the 33 percent proposed. The fat content maximum subsequently was set at the lower 30 percent.

LIAISON WITH ADMINISTRATION ON AGING AND OTHER DEPARTMENTS OR AGENCIES

Mrs. Knauer discussed consumer problems of the aging with Commissioner of Aging John Martin to encourage inclusion of "Consumer Problems of the Aged" as a discussion and programing topic at the 1971 White House Conference on Aging.

Meetings were held with the Administration on Aging to establish procedures for monthly input for the proposed PCCI Consumer Newsletter, to review Administration on Aging consumer publications, and to review topics for possible future publications for the elderly.

This office has been working closely with the Department of Housing and Urban Development in its Operation Breakthrough to increase availability of housing in all income levels, particularly for the low- and moderate-income consumers, which would include the elderly.

This office has been involved in the evaluation of some 300 housing systems which have been proposed by private industry to meet the housing needs of the Nation. In addition to the housing structure, we have also been concerned with innovative ways to finance homeownership among the low- and middle-income consumers. To assure that consumers are getting greater protection in new home purchases, this office has been actively seeking the promotion of better warranty agreements.

DIRECT ASSISTANCE TO THE ELDERLY

During 1969, specific assistance was given by his office to individual aged consumers through office followup and response to a rapidly increasing number of individual letters requesting information or assistance in resolving individual consumer problems. By commission of the White House, Mrs. Knauer began direct contact with company President and officials to seek quick resolution of problems brought to her attention in letters.

LIAISON WITH INDUSTRY GROUPS

A continuing contact was maintained with industry in efforts to evolve and encourage effective voluntary actions to resolve consumer problems including those of the elderly.

LIAISON WITH ORGANIZATIONS REPRESENTING THE ELDERLY

During 1969, the office maintained continuous liaison with national organizations with special emphasis on the aging, such as the American Association of Retired Persons, National Retired Teachers Association, and National Council of Senior Citizens. The office encouraged them to develop further their programs to inform and educate the aging consumer as to problems in this area, resources at his disposal for assistance on local, State, and national levels, and sources of information.

CONSUMER EDUCATION

During 1969, consumer education activities of the office included publication of the Consumer Education Bibliography, containing many references appropriate to programs for the elderly. The bibliography was distributed widely for use by educational institutions, community organizations, and other groups in the planning of programs for the elderly.

In addition, the committee also provided guidance and assistance to those same educational groups for the elderly by cooperating with other Federal agencies in disseminating their materials, which included the following:

1. Pamphlets of the Administration on Aging (Dept. of Health, Education, and Welfare).
2. Pamphlet on "Protection for the Elderly," prepared by the Federal Trade Commission.
3. "Consumer Information," published by the Superintendent of Documents, GPO, containing a special section of consumer references "For the Senior Citizen."
4. "Food for the Elderly," and related materials prepared by the Department of Agriculture.

Plans were formulated in 1969 for 1970. These include continuation of the kinds of activity and distribution just mentioned, and also publication by the committee of materials for special groups such as the elderly, particularly those with limited incomes. That material, educational in nature, will be useful for adult educators and community leaders.

TESTIMONY BY VIRGINIA H. KNAUER, SPECIAL ASSISTANT TO THE PRESIDENT FOR CONSUMER AFFAIRS, BEFORE THE SUBCOMMITTEE ON CONSUMER INTERESTS OF THE ELDERLY, U.S. SENATE SPECIAL COMMITTEE ON AGING

Mr. Chairman and members of the subcommittee, I am pleased that one of my first occasions to testify before a congressional committee is before this subcommittee, concerned as it is with problems which will have high priority in my office—the consumer problems of the elderly. As I stated on the day my appointment as Special Assistant to the President was announced, I believe very strongly that older citizens comprise one of the groups in our society whose consumer problems deserve special attention.

Unquestionably, consumer needs change with the various stages of retirement. In the earlier years, the retiree is generally well and active. Except for his problem of adjusting to a lesser income than he had when working—an income which may be inadequate—his consumer problems are generally not unlike those of the population in general. In his later retirement years, his needs usually center more on such problems as medical care; services he is no longer able to perform for himself; and products designed for use by persons living alone who are perhaps less agile or have some physical handicap.

I believe the point cannot be stressed too often that many of our older persons are fully capable of functioning at all levels. No wonder they generally resent the stereotype which suggests that most persons past 65 are decrepit, unemployable, and incompetent. Your subcommittee is to be commended for its efforts to combat that stereotype. Many older persons manage extremely well on the amount of money they have. In many cases it is the marketplace and our consumer protection, information and education systems which need changing.

I believe there are still gaps in information about consumer behavior of the elderly. We need to know more about the psychology of the elderly as consumers. I believe the elderly consumer does not wish to be set apart in the marketplace, yet he does hope to find products which are designed with his needs and desires in mind. Ease of use is important. Clothes with style yet with the length, the fit, and the fastenings which can be managed by persons living alone or persons who are less agile, are important. So are houses and housing fixtures designed for their convenience, and food packaged in sizes which one or two can use without waste. And public buildings and transportation facilities designed with the limitations of the elderly in mind. The list is long. But let me point out that there are young people for whom these same considerations would be helpful. Hopefully the business community will give this market increased attention.

We will also be working with industry in efforts to upgrade safety standards and performance of products. Safety is important to all, but especially to those whose reaction time in avoiding a potential danger might be somewhat slower.

Inadequate income, of course, continues to be the No. 1 problem of older people. In my conference keynote address earlier today I pointed out that many factors have combined to make the income of the average retiree far below an acceptable standard. For one thing, the depression of the thirties prevented many of today's retirees from saving money during what should have been their most fruitful years.

The loss of purchasing power through inflation also contributes to inadequate income. Generally the problem is that the elderly live on fixed incomes which do not go up proportionately with the cost of living. As President Nixon pointed out in a recent statement, "Inflation has seriously eroded the value of every pay raise won by the average wage earner; it has done unquestionable harm to the economic welfare of the very poor in our society and those millions of Americans living on pensions and Social Security . . ." This administration is concentrating on halting that inflation, thus restoring the spending power of the older person's income.

But the other side of the coin—and the side where my office can make the greatest contribution—is helping older Americans make the most of the income they have. I recognize that the Administration on Aging and other offices within Government are concentrating on this aspect, as is this subcommittee, organizations in the private sector, and organizations of older Americans themselves. I know some segments of industry are giving it their attention. I hope to work closely with all groups in this endeavor, for it will take a sizable effort. We need to mount a massive attack on the whole variety of consumer problems of older persons, problems often based on calendar age alone.

We must make sure that older persons—in fact, all consumers—know their rights under the law, and we must warn them of pitfalls in the marketplace.

On the basis of my previous experience as Director of the Consumer Protection Bureau in the Office of the Attorney General in Pennsylvania, I believe the consumer needs a great deal of protection. He also needs a great deal of information, especially information which will prevent his becoming a victim of fraud and will assist him instead to get the most for his money.

But for the older person, particularly those I would term the "old elderly," there are some additional consumer problems. This group may be much less physically mobile, so they cannot shop around as easily to compare products and prices in order to get the best buy, if indeed they can go to shop at all. They may be residents of the inner city ghetto areas where availability of merchandise, price differentiation, and quality limit their choice. Hence they may pay more, and for lower quality. Their anxiety, fear, and pride make them hesitate to ask questions in the stores, or to admit they have made a mistake in time to correct it. They may not hear clearly, may not realize they do not hear well, or may be too proud to ask the clerk to repeat. Their vision may be somewhat dim, so that reading the fine print is difficult. But pride may prompt them to indicate they have read it. They may not have had an adequate educational background. Living alone, and perhaps not wishing to be a burden on children or friends, they may hesitate to seek advice. And they may not know where or whom to consult for legal advice, or perhaps they are unable to afford a lawyer.

For these reasons, the older person is often the special target of the practitioner of fraud. Retirement land deals, promises of medical "cures," devices or gadgets which may seem at the time worth a chance, make-money-at-home schemes, and home repair and improvement deals which play on the older person's community

pride and his efforts to maintain his own home as long as he is able—all these and more often constitute traps for an older consumer. Losses cut deep into limited incomes, and too often there is little hope of recovery of the loss. And in any case of a fraudulent health scheme, even worse than the financial loss is the delay in seeking legitimate medical care.

How do the fraudulent manage year after year to get away with such practices? Chiefly because most of us are not trained to recognize frauds and fraudulent schemes. Some cannot believe the friendly and understanding salesman could possibly have cheated them. Others are embarrassed or ashamed to admit they were so easily tricked. Still others do not even realize they have been victimized. In defense of the older American, let me parenthetically state, however, that they are not the only ones taken in by such schemes. So they should not be hesitant to seek asistance when these situations occur.

Our goal is to help, yet enable the elderly citizen to retain his pride and self-respect. We must recognize his competence in judgment, but at the same time make more information and counseling available. We must make certain that the information is clear and to the point, available in Spanish or other languages, and is widely disseminated. Our Consumer-Protection Bureau in Pennsylvania published a series of consumer pamphlets, one of which warned older people of "The Meanest Racket of All—the Fine Art of Swindling." The President's Committee on Consumer Interests in 1968, in cooperation with the Administration on Aging and the Food and Drug Administration, developed a wallet-size cautionary checklist for use in business transactions. It also provided a place to list local sources of counseling and protection. I known there are other information publications available, but I still believe we are reaching too few people. Wider exploration of the use of television and movies is needed. We must develop new means of getting our material into the homes of the elderly, especially with regard to matters of particular concern to the older American—e.g., information about hearing problems and the purchase of hearing aids.

But not all of the older consumer's problems can be resolved by informing and educating him as an individual. It is also our priority that he be provided with more effective means to make himself heard, and to obtain redress for his grievances. We have made progress, but the aggrieved and the defrauded still have problems. It should be possible for the consumer to get satisfaction without being out of pocket, and to receive reimbursement for losses sustained. Too often a $50 loss can only be recouped through a $150 lawyer's fee. Voluntary arbitration at the community level should be encouraged. Greater use of class suits would help to alleviate crowded court dockets and would enable the consumer on a fixed and inadequate income to obtain redress for his grievances without expending large amounts of money. More information regarding the use of small claims courts would also be most useful in achieving this goal.

Today 33 of the 50 States have consumer assistance offices. Many are just being established and have a minimum staff or budget for investigation and enforcement. What we need is a consumer assistance office in every State, with branch offices throughout the State, especially in neighborhoods where those with inadequate income are congregated. Enactment of the "Little FTC Act" at the State level will go far toward establishing a firm base of consumer protection. My office will be encouraging the States to take such action. We will also be encouraging the local, State, and Federal consumer agencies to cooperate closely to provide a network of consumer protection, information, and education.

We must continue our efforts to encourage the establishment of more multi-service Senior Service Centers throughout the country. I applaud the rapid increase in the number of these Centers, but understand consumer education and legal services are not yet available in the majority of the Centers. The Administration on Aging is now developing a proposed model Center concept for issuance to communities planning such a Center, and we will be working with them to encourage inclusion of consumer education, counseling, and legal assistance in new Centers as well as those already in operation.

A lack of choice is yet another major problem of many older consumers. Federal Trade Commission studies indicate that low-income consumers in the inner cities may pay more for food, furniture, clothing, and other necessities due in large part to a lack of competition among retailers in those areas. We must seek to increase the choice of the inner city resident by all means at our disposal. Encouraging competition is of major importance. Cooperative shopping plans, reduced transportation costs to broaden the shopping range of the residents, and other transportation aids deserve further attention.

Your subcommittee is to be commended for its accomplishments in helping bring to national attention the consumer problems of the elderly. It is my hope that your subcommittee and my office can be of mutual assistance as we strive to resolve these problems.

Thank you.

ITEM 17: VETERANS' ADMINISTRATION

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., January 19, 1970.

DEAR MR. CHAIRMAN: I am pleased to respond to your letter of December 17 requesting the enclosed summary of Veterans' Administration activities during 1969 relating to aging.

During the next 15 years it is estimated that the veteran population age 65 and older will increase in size by over 2½ times—i.e., from 1.96 million to 5.10 million—and that by 1985 almost one-half (49 percent) of the total U.S. male population will be veterans. Because of this the VA is very much interested in finding solutions to many of the problems of older veterans and their families. We know that the work your committee is doing to help older Americans will be invaluable to us in our endeavors.

I hope that you will find the enclosed information useful.

Sincerely,

DONALD E. JOHNSON, *Administrator.*

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1969

DEPARTMENT OF MEDICINE AND SURGERY

(1) VA hospitalization

As of November 26, 1968, there were 23,940 patients 65 years and older remaining in VA hospitals. They represented 26.3 percent of all patients in VA hospitals on that date. Within that group, 9,655 were 75 or older. During calendar year 1968, 23.8 percent of all discharges from VA hospitals were represented by the 65-and-older group.

Since many of the conditions affecting older individuals tend to be chronic, the older veterans represent a high percentage of the population in long-term facilities, and special programs to meet their needs have been developed.

(2) Extended care service

(*a*) *Inpatients.*—Within the VA Department of Medicine and Surgery, the Extended Care Service operates a system of facilities for long-term care. These serve not only the aging veteran, but all those requiring such long-term care. However, well over one-half of all patients cared for in these facilities are aged 65 and over.

Specifically, the Extended Care Service consists of intermediate care for patients who are chronically ill but still require more or less daily medical services in a ward, nursing home care for those who require continued or protracted nursing care but do not require daily medical supervision; domiciliary care for veterans who are ambulatory and able to perform activities of daily living despite chronic medical or psychiatric disabilities; restoration programs for those who may be expected to be able to return to community living after a period of rehabilitation; and hospital-based home care for those who are bedridden, but can be cared for at home with professional support by the hospital staff. Some of these programs are paralleled by similar facilities operated by the several States and by individual community enterprises.

Throughout the Extended Care Service, emphasis is placed on encouraging the patient to make maximum use of his remaining facilities and on preventing further deterioration. The goal is always to reduce institutionalization to a minimum, and to treat the individual patient at the lowest level of institutional care consistent with his well-being.

(*b*) *Outpatients.*—In the outpatient treatment program as well, the older age group—65 and over—continued to represent a sizable percentage of the total load. In fiscal year 1969, patients in this age group made over 908,000 visits to staff and fee basis physicians for outpatient treatment, representing about 14 percent of the total outpatient treatment load.

(*3*) *Social work service*

Social workers do assist each older person in the VA Health Care System to utilize his remaining abilities to the fullest extent possible. Every effort is made to encourage movement from a sick dependent role which implies prolonged institutionalization to a more healthy independent role in a private family setting located in the mainstream of community life. For some, continued care in an institution of some type is necessary and the VA offers long-term nursing care in VA hospitals and in private nursing homes in the community. Some ambulatory self-care patients are transferred to VA domiciliaries where many rehabilitation services are available to assist in the restoration process. Others, without families, who are able to live more independently are assisted in moving into a well-developed foster home program where they can enjoy the full benefits of private family life. Social workers offer necessary supporting services to ensure continuous successful living in the community. Most older patients prefer to return to their own families and special attention is given to providing services to re-establish and maintain the integrity of these family groups.

In addition to offering direct services to patients and their families, VA social workers organize and direct the activities of volunteers who are interested in helping patients in readjusting to all facets of community life. Social workers also participate with other public and private health and welfare organizations on both a local and national level in identifying needs of the older person and developing programs to meet these needs.

(*4*) *Voluntary service*

Retired and elderly citizens serving as volunteers have become the backbone of the VA voluntary service program and their services are considered indispensable in the care and treatment of patients in the hospital and those patients returning to their homes and communities.

The older volunteers have demonstrated they have the time, patience, and the capacity to win the confidence of patients through the development of personal relationships. This so-called friendship or companionship therapy is getting marvelous results in motivating and stimulating patients, many of whom are elderly, to regain the limits of their potential for restoration and return to community living.

The elderly volunteers in supplementing the efforts of hospital staff have made it possible to expand and extend many services and programs for patients and to improve the quality of the care and treatment activities.

Through voluntary service retired and elderly volunteers have found and made new lives of their own. They are the pride and joy of their families because they have discovered that they can be just as essential to society in their later years as in the earlier years of their lives.

(*5*) *Psychology service*

The psychological facets of the elderly have assumed increasing importance. The appropriate care, treatment, and rehabilitation of the aging veterans is in a large part determined by their mental outlook and their mental status. To meet the problems presented by these patients, psychologists in the Veterans' Administration now work in the nursing home units, intermediate care services and domiciliaries as well as in the psychiatric hospitals where there are large numbers of aged veteran beneficiaries. These veterans post the broadest diversity of psychological problems. For instance, efforts have been ongoing to assist nursing home supervisors in establishment of psychologically harmonious environments in the VA nursing home units. This has included both the mental and physical aspects. The aim is to assist the elderly patients to maintain their spatial and temporal orientations, thus keeping confusion, memory loss and anxiety at minimal levels. Psychology trainees are encouraged to work in these areas with preference for appointment being given to psychology students who have major interests in the problems of the aged and to universities which are engaged in psychology programs in gerontology.

Special programs based upon principles developed from learning theory are currently being utilized to assist the aged veteran patient. Classlike sessions are held to teach and to help retain such things as the date, where they are (hospital location), the names of people who care for them, etc. These orientation classes have significantly reduced the development of confusion and regression in many elderly patients, as well as helping aged veterans to regain lost faculties. On an individual patient basis "reinforcement therapy" techniques, instituted by psychology, are being used to assist in the development of appropriate behaviors which are needed in order to allow the psychiatrically aged patients to maintain themselves in noninstitutional settings. Such things as neatness, eating habits, and control of bodily functions are especially helped by these psychological treatment techniques. This particular therapeutic approach is readily adapted to the types of problems encountered with the elderly psychiatric patients.

New automated equipment for the measurement of psychological deficits in the aged has been developed by VA psychology. Studies using this equipment will become one of the main components of a Psychological Aging Study Center being developed by the VA in conjunction with a major university in Florida.

(6) *The research program on aging*

To meet its responsibilities to our increasing number of aging citizens and older patients, the Veterans' Administration sponsors basic and clinical research programs on a broad front. Aging studies include investigations in the mechanisms of aging from the standpoint of current concepts in biology, heredity, biochemistry, disease processes, and the environment with emphasis on the changes that occur with age. Thus, just as fundamental research was important to broadening and strengthening our knowledge of disease processes, fundamental research is of vital importance for advancing our understanding of aging or of mechanisms bearing on the aging process. A survey showed that 11 chronic conditions are significantly more prevalent among older individuals. These 11 conditions are arthritis and rheumatism, asthma-hay fever, heart conditions, hearing impairments, peptic ulcer, high blood pressure, hernia, visual impairments, diabetes, chronic bronchitis, and paralysis. A few examples of aging research sponsored by the VA follow.

Dr. R. L. Davis and Dr. C. H. Burrows at the Bay Pines VA Hospital are conducting microbial, animal, and human studies of metabolic changes during aging. They observed that serum RNase levels increase with age and are attempting to determine whether pathology or more RNase in the aged is required to inactivate increased RNA synthesis. Since 1958, these two investigators and other VA researchers have been studying 105 Spanish American War Veterans (SAW's) obtaining a complete medical history, medical profile, nutritional history, and blood biochemistry. Comparison of blood biochemical levels of the SAW's and institutionalized domicile residents of similar mean age indicated many similarities and some differences. In 1969, out of the original 105 subjects, 57 survivors with an average age of 89 years are in the study.

Some investigators contend that the skin may serve as a mirror of systemic metabolic events. Dr. Harry Sobel at the VA hospital in Sepulveda, Calif., has been particularly concerned with the response of the skin to nitrogen-losing states. His laboratory is developing techniques for estimating degree of nitrogen loss in debilitating conditions such as following surgery, chronic disease, in aging and explaining reduction of mucopolysaccharides in skin which occurs with age. The studies in his laboratory are consistent with the concept that the "ground substance" of tissues in a limited sense may serve as a protein storage site. The findings suggest the existence of a very sensitive feedback system which operates to conserve protein in more vital organs. In this regard, Dr. Sobel is investigating the question whether an explanation of the reduction in the mucopolysaccharide content of skin with age may not lie in the changes which take place in these constituents during nitrogen loss.

At the VA hospital at Jefferson Barracks, Mo., Dr. Shui Yes Yu is conducting a comprehensive investigation concerned with the histochemical and biochemical alterations in various connective tissues and their related structures with aging. By a technique called enzymatic digestion, Dr. Yu isolated elastic fibers from young and arteriosclerotic aortas. From comparative studies of the outer core of elastin and the intact elastin he observed characteristic age differences with respect to chemical composition, amino acid composition and fluorescence substances primarily in the outer core of the elastic fibers. Furthermore, from the

amino acid composition, the characteristic change of aging of elastin was found in the primary structure of the protein. Based on this finding, a hypothesis is proposed that a specific protein in one lifespan alters its primary structure by aging or arteriosclerosis. This could be attributed to somatic mutation or a metabolic alteration of the young and old fibroblasts which are the cell units responsible for synthesis of elastin.

The loss of bone tissue as a consequence of aging is a well-documented occurrence. Just why this negative calcium balance occurs has been explained satisfactorily; but it seems probable that a change in bone cellular regulation is involved. Dr. Paul Thorton, at the VA hospital, Lexington, Ky., hypothesized that adrenal cortex hormone secretions are implicated in the subtle loss of bone tissue during the aging process, since an excess of these particular hormones (glucocorticoids) is associated with net loss of bone tissue in individuals afflicted with Cushing's syndrome. Dr. Thornton's study of bone metabolism as influenced by aging factors showed that young rats and guinea pigs respond to excess glucocorticoid hormone with an increase in serum calcium which is mobilized from bone while old animals do not exhibit an increase in serum calcium.

At the VA hospital in Jackson, Miss., Dr. Joseph Haining is conducting research on the rate of turnover or removal of enzymes as a function of aging. His thesis is that fundamental understanding is lacking of the capabilities and limitations of aging cells for autorenewal with respect to protein-enzymes and the efficiency with which they function as a dependent of aging. Dr. Haining observed that the kinetics of accumulation in rat liver of an enzyme-tryptophan pyrrolase, in response to administration of the amino-acid tryptophan undergoes age-related alteration which is not the result of changes in the pattern of tryptophan uptake with age. He is pursuing these observations with studies on enzyme indication as a function of age by examining the response of several inducible enzymes to administration of hydrocortisone, a secretion of the adrenal gland. The objective of this research project is an attempt to separate and contrast the anabolic and catabolic components (tissue building and tissue breakdown, respectively) of the dynamic equilibrium of proteins which theoretically plays a role in growth and in aging.

At the Bedford VA Hospital, Dr. George H. Stidworthy and colleagues are studying the mechanisms for the biosynthesis of glycosaminoglycans in an in vitro system. In recent years, increasing emphasis has been placed on the role of these materials in normal aging and disease processes. To properly evaluate the information already available, a great deal must be learned about the synthesis and turnover, the control mechanisms, and the influence of chemical and physical factors of glycosaminoglycans. Tissue culture, an ideal method to study many of these problems, is employed.

The relation of age to protein synthesis and enzyme activities is under investigation by Dr. Kuang-Mei H. Wang at the Buffalo VA Hospital. This investigation of enzymatic activities is studied in the brain, heart, liver, and kidney of a given laboratory animal throughout the animal's whole life span to examine possible correlations between the development of enzymatic activities and the appearance of certain functions in these organs. The changes in enzymatic activities may indicate increase or decrease of protein synthesis. Therefore, the studies of protein synthesis of embryonic organs involving activation of amino acids and transfer of the amino acids into ribosomes by soluble RNA for the final assembly of polypeptides would help to explain the changes in enzymatic patterns relating to aging.

Also at the Buffalo VA Hospital, Dr. Eleanor A. Jacobs and colleagues found that treatment of senile patients with oxygen at high pressures significantly increased their cognitive functions (those mental operations associated with I.Q.). The researchers do not believe it likely that the treatment modifies the basic degenerative processes associated with aging, but they know of no other form of therapy that offers statistically significant improvement of mental functions. The patients treated were all suffering from severe deterioration of cognitive function which was essentially disabling and prevented them from caring for themselves. Opinions of ward personnel confirmed measured improvement in the treated group and the patients themselves commented spontaneously that their memory seemed better.

Visualizing aging as an irreversible process in which "mistakes" in metabolism accumulate and result in the deterioration and eventual death of the cell, Dr. Anthony T. Soldo at the Coral Gables VA Hospital is studying the effect of radia-

tion on aging and protein and nucleic acid synthesis in chick and paramecium embryos. He found that the RNA/protein ratio in certain muscle of the embryonic chick diminished more rapidly in X-irradiated animals than in nonirradiated controls. This observation led to a more detailed examination of the qualitative and quantitative changes with respect to chemical composition and distribution of RNA in subcellular fractions of normal embryos during development. RNA in these normal animals differed significantly in base composition and in the distribution of RNA in subcellular fractions. These results led to further postulates which are currently being tested.

Certain patients at the Martinsburg VA Hospital showed unusually low thyroid uptakes but had clinically normal thyroid glands. Dr. Thomas McGavack and Dr. Hans H. Hoch considered this finding of particular interest as it occurred in individuals in whom it may have been a consequence of a metabolic adjustment to aging. They have obtained serum-iodine data for aging subjects. During these experiments a low molecular weight thyroxine-binding material was discovered in the serum. The methodology developed appears promising for a study of alterations of this thyroxine-binding material as a function of age.

At the Los Angeles VA Center, Dr. Seymour Fisher recently completed a study of the value of immunization in diphtheria, tetanus, and influenza in a geriatric setting. He also studied the various methods of immunizing. A preliminary evaluation of data obtained from several thousand immunized individuals, the majority aged 60 or over, indicates that immunization apparently did afford protection to these aged individuals during recent epidemics.

Based on a pilot study, planned in collaboration with the Armed Forces Institute of Pathology, a cooperative study is in progress on the endocrinological aspects of aging in men. This is a study of endocrine glands obtained at autopsy. The primary purpose is to observe the structural characteristics, both gross and microscopic, of the endocrine glands and their target organs at various adult male ages and within various disease categories; to evaluate and provide a description of the frequency of these characteristics in the various age groups and disease groups. The secondary purpose is to attempt to detect any trends or relationships in the structural data collected which might appear to reflect aging per se; trends which could be made the basis for future separate studies each designed to test some specific hypothesis, Dr. Thomas H. Capers of the Dallas VA Hospital is the principal investigator.

Also at the Dallas VA Hospital, Dr. Eugene P. Frenkel and Dr. Richard G. Sheehan are studying the mechanism of action of vitamin B_{12} in neutral function. The technical literature indicates that beyond the age of 60 years the mean serum level is lower than in those younger than 60 and in addition, a further decline was suggested with each successive decade. Another better established observation is that peripheral nerve degeneration occurs with aging. Pathologic studies have documented that the nerve sheath deteriorates with aging. Since vitamin B_{12} has a critical bearing on the integrity of neural tissue, the relationship of the serum level of vitamin B_{12} is under investigation. Other aspects of the work of these investigators are studies of gastric factors which are important in iron absorption since gastric atrophy and achlorhydria are common findings in the aged.

The satellite laboratory aging program.—In an effort to focus more intensely on the mechanisms of aging—an understanding of which will ultimately provide the means for retarding or preventing aging-related disease and deterioration—The VA Research Service, in 1964, conceived its satellite laboratory program. Under this unique concept, outstanding non-VA senior researchers are able to undertake investigations of the nature and causes of the aging processes which are related to their particular areas of interest. Laboratory facilities are provided at VA stations in close proximity to the organizations of the collaborating scientists.

The number of such laboratories fluctuates but at the end of fiscal year 1969, three satellite laboratories were in operation:

1. Bedford VA Hospital (sponsored by Marott Sinex, chairman and professor of biochemistry at Boston University School of Medicine): This laboratory is concerned with changes in RNA and DNA, the substances that are the basis for inheritance. The work here is concerned with investigating one of the theories of aging; that it is a process "programed" at birth by the genes inherited from our ancestors.

2. Downey VA Hospital (sponsored by Dr. Arthur Veis, Northwestern University): This group is studying the lens of the eyes, susceptible to "aging" rather early in life and more readily accessible than many body tissues, as a model for the aging mechanism.

3. Sepulveda VA Hospital (sponsored by Arthur Cherken): The mechanisms of memory and their changes with age are under investigation in this laboratory. The relationship of these mechanisms to normal sleep and to surgical anesthesia is also being pursued. Another aspect of the program at Sepulveda is concerned with the effects of manipulation of the embryo on the rate and nature of aging, and the effects of aging on the reproductive system. Still another phase of the program is the study of the effects of one type of cell on another in the same tissue culture and on transplantation from one animal to another. The mechanisms whereby these interactions influence normal growth, aging, and abnormal growth (cancer) are the focus for this work.

DEPARTMENT OF VETERANS BENEFITS

(1) *Guardianship program*

There have been three areas of development in the guardianship program which affect aging incompetent VA beneficiaries. There has been a policy change, concerning the type of court-appointed fiduciary preferred. Previously, corporate guardians were preferred over individual guardians. This policy has been reversed. The cases in which it is necessary, in the best interests of the beneficiary, to obtain a court-appointed fiduciary have increasingly involved veterans and other adults who live alone in rooming or boarding homes without relatives to look after them. In such cases, an individual guardian is usually in a better position to give more personal attention to the beneficiary and to take more immediate action in emergency situations than a corporate guardian would be able to do.

The Federal fiduciary concept has been expanded in an effort to provide more alternatives to a court-appointed fiduciary. The appointment of a State court fiduciary, with the attendant costs, fees, and commissions, decreases the amount of money available for the care of the beneficiary. Also, the stigma of incompetency still exists when an individual has a court-appointed fiduciary. These factors can be avoided if a suitable fiduciary relationship can be established with a Federal fiduciary.

The timing and frequency of personal contacts with beneficiaries has been tailored to each individual case in order to give necessary service within available resources. Experience has shown that where an incompetent beneficiary is living with relatives, friends, or in other types of sheltered environment, personal contacts by our field personnel need not be as frequent as in situations where the beneficiary is living alone without anyone to look after him. Scheduling contacts in accordance with each situation assures that our attention is focused where the need is the greatest.

(2) *Compensation and pension programs*

The Veterans' Administration, through the various programs administered by the Department of Veterans Benefits (compensation, pension, and dependency and indemnity compensation), provides all or part of the income for over 1,700,000 persons age 65 or older. This total is broken down to: 986,972 veterans, 607,402 widows, 148,296 mothers and 56,393 fathers of veterans.

(3) *Educational assistance*

Public Law 90–631, enacted October 23, 1968, and effective December 1, 1968, extends eligibility for a maximum of 36 months entitlement to educational benefits under the provisions and at the rates of chapter 35 of title 38, United States Code, to widows of veterans who died of service-connected causes or wives of veterans who are permanently and totally disabled from service-connected disabilities. Counseling under this law is optional but not mandatory. This portion of the law is primarily intended to assist the wives and widows of the younger veterans of the Vietnam era. However, the law contains no age limit so that the benefit would be equally available to wives and widows over age 65 who are otherwise qualified. It is not presently possible to determine whether many in this older category will choose to take advantage of the benefit.

Appendix 2

STATISTICAL INFORMATION ON OLDER AMERICANS[1]

[1] Prepared by Mr. Herman B. Brotman, Chief, Reports and Analysis, Administration on Aging, HEW, 1970.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, SOCIAL REHABILITATION SERVICE, ADMINISTRATION ON AGING

To: Mr. John B. Martin, Commissioner on Aging.
From: Herman B. Brotman, ABB, Chief, Research and Statistics, PLA.
Subject: The Aged Poor—II.

On September 4, 1969, I sent you a memorandum outlining some preliminary findings from the retabulation of the data on poverty resulting from the application of a revised definition.

The Bureau of the Census has now released the detailed tabulation for families and for unrelated individuals and I hope to find the time to summarize and analyze these data in the near future.

I have been, however, successful in securing some unpublished data on the number of older persons regardless of family status, based on concepts that are most easily handled and understood. These are presented in the attached table showing the aged poor in 1959 and 1968 by color and by sex.

The 6 million aged poor in 1959 represented about 30% of the total aged and about 15% of the total poor. By 1968, the number of aged poor had dropped more than a fifth to 4.6 million and they made up less than a quarter of the total aged. However, since the younger poor decreased even faster than the aged poor, the aged poor in 1968 made up 18% of the total poor (rather than the 15% in 1959).

Among the aged poor, the number of males decreased three times as fast as the females and the number of whites decreased almost three times as fast as the "other" races. In fact, the number of female aged poor other than white actually increased slightly.

[Enclosures]

EXHIBIT 1.—THE AGED POOR; NUMBER OF PERSONS, BY COLOR AND SEX, 1959 AND 1968

[Numbers in thousands]

Color and sex	1959	1968	
		Number	Percent change
Total	5,972	4,630	−22.5
Male	2,520	1,611	−36.1
Female	3,452	3,019	−12.6
White	5,210	3,939	−24.4
Male	2,160	1,323	−38.8
Female	3,050	2,615	−14.3
Other	762	692	−9.2
Male	360	288	−20.0
Female	402	404	+0.5
Negro	736	655	−11.0
Male	346	274	−20.8
Female	390	380	−2.6

Source: Unpublished data, Bureau of the Census.

42-923 O—70——23

EXHIBIT 2.—ESTIMATES OF THE RESIDENT POPULATION OF ALL AGES AND 65+, BY STATE, JULY 1, 1968

[Numbers of persons in thousands]

State	Numbers: Total, all ages: Number (thousands)	Numbers: Total, all ages: Percent change from Apr. 1, 1960	Numbers: 65+: Number (thousands)	Numbers: 65+: Percent change from Apr. 1, 1960	Numbers: 65+: Percent of total all ages	State rank[1]: Total, all ages: Number	State rank[1]: Total, all ages: Percent change from Apr. 1, 1960	State rank[1]: 65+: Number	State rank[1]: 65+: Percent change from Apr. 1, 1960	State rank[1]: 65+: Percent of total all ages
Total, 51 "States"	199,846	+11.4	19,134	+15.5	9.6					
Alabama	3,522	+7.8	309	+18.3	8.8	21	32	21	17	33
Alaska	276	+21.9	6	+11.6	2.2	51	6	51	33	51
Arizona	1,667	+28.0	138	+53.4	8.3	34	2	35	1	39
Arkansas	1,983	+11.0	226	+16.2	11.4	32	22	28	19	7
California	19,179	+22.0	1,692	+22.9	8.8	1	5	2	8	34
Colorado	2,067	+17.8	180	+14.0	8.7	30	9	33	24	35
Connecticut	2,961	+16.8	276	+13.6	9.3	24	10	25	26	26
Delaware	533	+19.5	41	+14.9	7.7	47	8	47	22	41
District of Columbia	802	+5.0	69	−.6	8.6	40	41	41	51	36
Florida	6,210	+25.4	824	+49.0	13.3	9	3	7	3	1
Georgia	4,579	+16.1	347	+19.3	7.6	15	12	17	14	42
Hawaii	775	+22.4	41	+39.7	5.3	41	4	48	4	50
Idaho	709	+6.3	65	+12.3	9.2	42	36	44	32	29
Illinois	10,958	+8.7	1,066	+9.4	9.7	5	28	4	38	22
Indiana	5,065	+8.6	478	+7.3	9.4	12	29	12	48	24
Iowa	2,775	+.6	346	+5.7	12.5	25	47	18	49	2
Kansas	2,291	+5.2	260	+8.0	11.3	29	40	27	45	9
Kentucky	3,224	+6.1	329	+12.6	10.2	23	37	20	31	21
Louisiana	3,710	+13.9	289	+19.6	7.8	19	18	23	12	40
Maine	978	+.9	116	+8.8	11.9	38	46	36	43	4
Maryland	3,716	+19.8	276	+21.7	7.4	18	7	26	9	45
Massachusetts	5,438	+5.6	619	+8.2	11.4	10	38	10	44	8
Michigan	8,673	+10.9	734	+15.0	8.5	7	23	8	21	37
Minnesota	3,663	+7.3	400	+12.8	10.9	20	33	14	29	13
Mississippi	2,349	+7.9	214	+12.7	9.1	28	31	29	30	31
Missouri	4,610	+6.7	543	+7.9	11.8	13	34	11	46	6
Montana	696	+3.2	67	+2.6	9.6	44	44	42	50	23
Nebraska	1,453	+2.9	179	+8.9	12.3	35	45	34	42	3
Nevada	449	+57.3	27	+51.3	6.1	48	1	50	2	49
New Hampshire	703	+15.9	78	+15.4	11.1	43	14	39	20	10
New Jersey	7,070	+16.5	664	+18.4	9.4	8	11	9	16	25
New Mexico	994	+4.5	67	+30.5	6.7	37	42	43	5	48
New York	18,186	+8.4	1,914	+13.4	10.5	2	30	1	28	18
North Carolina	5,131	+12.6	389	+24.6	7.6	11	20	15	6	43
North Dakota	624	−1.4	65	+11.4	10.5	46	48	45	34	19
Ohio	10,610	+9.3	967	+7.8	9.1	6	26	5	47	32
Oklahoma	2,542	+9.2	283	+13.7	11.1	27	27	24	25	11
Oregon	2,004	+13.3	214	+16.5	10.7	31	19	30	18	16
Pennsylvania	11,750	+3.8	1,233	+9.3	10.5	3	43	3	40	20
Rhode Island	908	+5.6	98	+9.4	10.8	39	39	37	39	15
South Carolina	2,669	+12.0	182	+20.6	6.8	26	21	32	10	47
South Dakota	665	−2.2	79	+10.6	11.9	45	49	38	36	5
Tennessee	3,952	+10.8	366	+18.6	9.3	17	24	16	15	27
Texas	11,013	+15.0	926	+24.2	8.4	4	17	6	7	38
Utah	1,031	+15.7	72	+19.9	7.0	36	15	40	11	46
Vermont	429	+10.0	48	+9.1	11.1	49	25	46	41	12
Virginia	4,604	+16.1	346	+19.6	7.5	14	13	19	13	44
Washington	3,296	+15.5	308	+10.4	9.3	22	16	22	37	28
West Virginia	1,819	−2.2	192	+11.3	10.6	33	50	31	35	17
Wisconsin	4,211	+6.6	457	+13.6	10.9	16	35	13	27	14
Wyoming	322	−2.3	30	+14.6	9.2	50	51	49	23	30

[1] States ranked in decreasing order; State with largest quantity ranked "1," State with lowest quantity ranked "51." In order to avoid fractional rankings, States with identical quantities are ranked consecutively alphabetically.

Source of basic data: Bureau of the Census.

EXHIBIT 3.—THE OLDER POPULATION: GROWTH, 1900 TO 2000

Year	Total[1]	Men[1]	Women: Number[1]	Women: Per 100 men
Trend:				
1900	3.1	1.6	1.5	98.0
1930	6.6	3.3	3.3	99.4
1960	16.6	7.5	9.1	120.7
1990	27.0	10.9	16.1	147.7
Current: 1969	19.5	8.3	11.2	134.7
Projections:				
1975	21.2	8.8	12.3	139.5
1980	23.1	9.5	13.6	142.6
1985	25.0	10.2	14.8	145.5
1990	27.0	10.9	16.1	147.7
1995	28.1	11.3	16.8	149.1
2000	28.2	11.3	16.9	149.8

[1] In millions.

In 1900, the 3 million Americans aged 65+ made up 4% of the population or 1 in 25. Today, the 20 million older Americans make up 10% of the population—every tenth person. In these 70 years, the total population grew to almost three times its size in 1900 while the older population grew to almost 7 times its 1900 size.

In 1900, older men outnumbered older women—102 to 100. Today, because of the longer life expectancy for women, older women outnumber older men—135 to 100.

By 2000, the older population will exceed 28 million and will still constitute a tenth of the population but older women will outnumber older men 150 to 100.

EXHIBIT 4.—THE OLDER POPULATION, AGE AND SEX

Age	Number (millions): Total	Number (millions): Men	Number (millions): Women	Percent distribution: Total	Percent distribution: Men	Percent distribution: Women	Women per 100
Total 65+	19.5	8.3	11.2	100.0	100.0	100.0	134.7
65 to 69	6.8	3.1	3.7	34.9	37.2	33.1	119.9
70 to 74	5.2	2.2	3.0	26.5	26.5	26.5	134.7
75 to 79	3.9	1.6	2.3	20.1	19.3	20.7	144.8
80 to 84	2.3	.9	1.4	11.9	11.1	12.5	151.8
85+	1.3	.5	.8	6.6	5.9	7.1	163.1

More than a third of the older population is under 70.

Half of the older population is under 73.

Six out of 10 older people are under 75.

More than a million are 85 or over.

There are 135 older women per 100 older men. The ratio increases from 120 at ages 65 through 69 to more than 160 at 85+.

EXHIBIT 5.—THE OLDER POPULATION, COLOR

	Of every 100 older people[1]: Total	Men	Women
Total	100	43	57
White	92	39	53
Other	8	4	4
Negro	7	3	4

[1] Each "one" equals 200,000 older people.

White persons make up less than 90% of the total population but 92% of the older population because of the difference in life expectancy.

Older white persons enjoy better incomes, health, housing, etc. Older persons who are not white are indeed in "double jeopardy".

EXHIBIT 6.—THE OLDER POPULATION: MARITAL STATUS

	Total	Men	Women
Of every 100 older people:[1]			
Total	100	43	57
Married	52	31	21
Widowed	39	8	31
Single or divorced	9	4	5

[1] Each "one" equals 200,000 older people.

Most older men are married; most older women are widows. There are almost four times as many widows as widowers.

Four out of every 10 older married men have wives under 65 years of age.

An estimated 15,000 older women and 35,000 older men marry in the course of a year. In about 13,000 marriages, both the bride and groom are 65+; the other 2,000 older brides and 22,000 older grooms take under-65 partners.

EXHIBIT 7.—THE OLDER POPULATION: LIVING ARRANGEMENTS

	Total	Men	Women
Of every 100 older people:[1]			
Total	100	43	57
Living in a family	70	35	35
Married, spouse present	48	29	19
Other head of family	8	2	6
In home of a relative	14	4	10
Not in a family	30	8	22
Living alone	22	5	17
Living with a nonrelative	3	1	2
In an institution	5	2	3

[1] Each "one" equals 200,000 older people.

Seven of every 10 older persons live in families; about a quarter live alone or with nonrelatives. Only one in 20 lives in an institution.

Living arrangements differ widely between older women and older men. Two-thirds of the older men but only one-third of the older women live in families that include their spouse.

Three times as many older women live alone or with nonrelatives as do older men, mostly because of the preponderance of widows and their desire to be independent.

EXHIBIT 8.—THE OLDER POPULATION: GEOGRAPHIC DISTRIBUTION

By State

The older population is distributed in almost the same pattern as the total population except that there is a somewhat greater concentration in the most populous States. The total number of older exceeds the total population of the 20 smallest States.

In terms of internal concentration (proportion of the State's total population which is aged 65+), the largest percentages (more than 11%) occur in the agricultural mid-west, in New England, and in Florida. Except for Florida, where there has been in-migration of older persons, the concentrations result mostly from the exodus of younger persons.

California, New York, Pennsylvania, and Illinois each have more than a million older people. By 1985, when the older population will have increased by about 40% to 25 million, California and New York will each have more than 2 million older people and Florida, Illinois, Ohio, Pennsylvania, and Texas will each have over one million.

BY AREA OF RESIDENCE

	65+	Under 65
Total	100	100
Metropolitan areas	61	65
In central city	33	29
Outside central city	28	36
Nonmetropolitan areas	39	35
Nonfarm	34	30
Farm	5	5

Better than 60% of the older people live in metropolitan areas, a slightly smaller proportion than the younger group. However, in these areas, most older people live in the central city while most under-65 people live in the suburbs. This is especially true for older women.

Like the white older persons, about 60% of Negro and other older minority group members live in metropolitan areas but the vast majority of them live in the central city rather than the suburbs.

EXHIBIT 9.—THE OLDER POPULATION: AGES OF HUSBANDS AND WIVES IN COUPLES

Age of husband	Age of wife: Total	Under 65	65+
Numbers (millions):			
Total	43.9	40.2	3.7
Under 65	38.2	38.0	.3
65+	5.7	2.2	3.5
Percent distribution:			
Total	100	92	8
Under 65	100	99	1
65+	100	39	61
Total	100	100	100
Under 65	87	94	7
65+	13	6	93

There are about 6 million couples containing at least one 65+ partner. In 58% or 3.5 million couples, both the husband and the wife are 65+; in 38% or 2.2 million couples, only the husband is 65+; and in the remaining 4% or 300,000 couples, only the wife is 65+.

From the point of view of retirement at age 65, almost 40% or 2.2 million 65+ husbands had under-65 wives; almost 25% or 1.4 million husbands had under-62 wives, and 17% or 1.0 million had under-60 wives.

EXHIBIT 10.—THE OLDER POPULATION, EDUCATIONAL ATTAINMENT

[Numbers in thousands]

Years of schooling completed	25 to 64		65 and over: Total		Men		Women	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	87,449	100.0	19,020	100.0	8,164	100.0	10,856	100.0
Elementary:								
0 to 4 years	3,273	3.7	2,975	15.6	1,454	17.8	1,521	14.0
5 to 7 years	7,091	8.1	3,383	17.8	1,542	18.9	1,841	17.0
8 years	9,935	11.4	5,058	26.6	2,165	26.5	2,893	26.7
High school:								
1 to 3 years	16,238	18.6	2,486	13.1	1,000	12.2	1,486	13.7
4 years	31,699	36.2	2,904	15.3	1,060	13.0	1,844	17.0
College:								
1 to 3 years	9,120	10.4	1,134	6.0	407	5.0	727	6.7
4 years	6,281	7.2	700	3.7	282	3.5	418	3.9
5 or more years	3,810	4.4	380	2.0	254	3.1	126	1.2
Median years	12.2		8.6		8.5		8.7	

Whereas half of the population aged 25 through 64, who have presumably completed their education, have had at least a high school education, half of the 65+ have not completed elementary school.

Almost 16% or 3 million older people are functionally illiterate, having had no schooling at all or less than 5 years around the turn of the century. This is four times the proportion for the 25–64 group which was only 4% functionally illiterate.

EXHIBIT 11.—THE OLDER POPULATION: DEPENDENCY RATIOS

Year	Number in nonproductive ages (under 18 and 65+) per 100 in productive ages (18 to 64): Total: Under 18 and 65+	Under 18 only	Aged 65+ only
1940	60	49	11
1950	64	51	13
1960	82	65	17
1969	80	63	17

Although the ratio of persons in the "non-productive" ages (under 18 and 65+) to those in the "productive" ages (18 through 64) has grown in the last 30 years, there has been no relative increase in the "burden" carried by the 18–64 group because of the large increase in the productivity of the economy.

The under-18 portion of the "dependent" group is, on the average, about four times as large as the 65+ portion and accounts for most of the increase in the dependency ratio.

Between 1940 and 1970, the number of older persons per 100 aged 18–64 increased by 6; the number under 18 increased by 14.

EXHIBIT 12.—THE OLDER POPULATION, MONEY INCOME—I

	All	Head fully employed[1]
1968 median income of families:		
With heads aged 14 to 64	$9,198	$10,167
With heads aged 65 and over	$4,592	$7,979
Percent of 14 to 64	49.9	78.5
1968 median income of unrelated individuals (living alone or with nonrelatives):		
Aged 14 to 64	$4,073	$5,837
Aged 65 and over	$1,734	$3,866
Percent of 14 to 64	42.6	66.2

[1] Percent fully employed—Family heads aged 14 to 64, 76 percent. Family heads aged 65 and over, 16 percent. Individuals aged 14 to 64, 54 percent. Individuals aged 65 and over, 8 percent.

Half of the 7.1 million families with 65+ heads had incomes in 1968 of less than $4,590. This median was half of that for younger families.

The median income of older families with fully-employed heads (7,980) was 78% of that for comparable younger families but only a sixth of all older families had such earnings.

Half of the 5.3 million 65+ persons living alone or with nonrelatives had incomes of less than $1,730. This median was only 43% of that for comparable younger individuals.

The median income of fully-employed older individuals ($3,870) was almost two-thirds of that for comparable younger individuals but only one in 12 of all older individuals had this amount of employment in 1968.

EXHIBIT 13.—THE OLDER POPULATION, MONEY INCOME—II

Percent with 1968 incomes of less than—	Families (7.1 million)	Individuals (5.3 million)
$10,000	84	97
$9,000	80	96
$8,000	76	96
$7,000	70	94
$6,000	63	92
$5,000	54	90
$4,000	44	85
$3,000	29	77
$2,500	22	71
$2,000	13	59
$1,500	7	48
$1,000	3	12

In 1968, about a quarter of all older persons were living in households with incomes below the poverty line for that type and size of family.

Almost 30% of the older families had incomes of less than $3,000 in 1968: more than 40% of the older people living alone or with nonrelatives had incomes of less than $1,500.

Of the more than 4.4 million older couples in 1967, three quarters had incomes below that needed for the higher BLS retired couple budget, almost three fifths couldn't afford the intermediate budget, and more than a third couldn't meet the lower budget.

Low money income and lack of assets are twin characteristics of the older population in general.

Appendix 3

MATERIALS RELATED TO RETIREMENT INCOME

ITEM 1: LEGISLATION ENACTED INTO LAW[1]

1969 Civil Service Retirement Amendments.—On October 20, 1969, H.R. 9825—amendments affecting civil service retirement financing and benefits—was signed into law (Public Law 91–93). Major provisions in the new law would:

—Permit employees who retire on or after October 20, 1969, to draw annuities based on their highest three average salary rather than the old "high-five" formula

—Allow workers to receive credit for any unused sick leave

—Require agencies and employees to increase their contributions to the Civil Service Retirement Fund on January 1, 1970, from 6.5 to 7 percent of the gross salary

—Provide an additional 1 percent to the cost of living raises given to Federal retirees and survivors in order to take into account the 6 months time lag between the cost of living survey and the time annuitants actually receive the money

—Permit widows and widowers of Federal annuitants to keep their survivor pension upon remarriage provided they were 60 at the time of remarriage

—Provide an annuity (for survivor annuity purposes) similar to Social Security payments for employees who have completed 18 months of Federal service

—Give the surviving spouse at least 55 percent of 40 percent of the employee's average salary, or 55 percent of the annuity projected to age 60, whichever is lower

Central Intelligence Agency Retirement Act Amendments.—Signed into law on December 30, 1969, Public Law 91–185 would make similar revisions in the CIA Retirement Act of 1964 to conform to changes already made with respect to the Civil Service Retirement Act under Public Law 91–93.

ITEM 2: PENDING LEGISLATION

Institute on Retirement Income Act.—Senator Williams of New Jersey introduced S. 869 on February 4, 1969, to establish an Institute on Retirement Income. It would be a "think tank" agency, modelled after the Urban Institute, and designed to conduct comprehensive studies of all aspects of retirement income and make recommendations to solve the increasingly urgent and complex problems associated with income maintenance.

Full Civil Service Annuities.—On March 4, 1969, Senator Magnuson introduced S. 1297 which would authorize full annuities under the Civil Service Retirement Act, regardless of age, for employees who have completed 30 years of service.

Credit for Service in Federal-State Programs.—Introduced by Senator Montoya on March 20, 1969, S. 1610 would allow credit under the Civil Service Retirement Act to Federal employees for periods of service in Federal-State programs in a State or one of its instrumentalities.

[1] See App. 1, report by Social Security Administration, for details on other legislation.

ITEM 3: COMPARISON OF MAJOR PROVISIONS: SOCIAL SECURITY REFORM BILLS INTRODUCED BY—THE ADMINISTRATION (H.R. 14080); BY SENATOR HARRISON WILLIAMS (S. 3100); AND BY REPRESENTATIVE JACOB H. GILBERT (H.R. 14430)

EXISTING LAW	H.R. 14430 AND S. 3100	H.R. 14080—ADMINISTRATION PROPOSAL
1. Benefit Amounts		
(a) Basic Amounts		
Benefits for a worker beginning at age 65, range from $55 to $218. Benefits for dependents and survivors are based on these amounts.	Benefit amounts for the worker would be increased in 2 steps of 20% each: Beginning and range: January 1970, $90 to $293. January 1972, $120 to $537.	All benefits would be increased by 10 per cent in March 1970. The increased benefits for a worker would range from $61 to $250.
	Benefits for dependents and survivors would be increased proportionately.	Same.
	(b) Automatic Adjustment	
No provision.	Thereafter, benefit amounts would be automatically adjusted annually for each 3 percent or more of increase in the cost of living.	Same as H.R. 14430.
	(c) Actuarial Reduction	
Benefits for workers, and their wives or husbands, who start getting benefits before age 65 are payable at reduced rates. The benefits are reduced to an amount that will on the average give the same total lifetime benefits that would have been paid if the benefits had not begun until age 65. A worker's benefit at age 62 is 80 percent of the benefit he would have gotten at age 65; a wife's or dependent husband's benefit is 75 percent of the amount payable at age 65.	Smaller reductions would be made. A worker's benefit at age 62 would be 85 percent of the unreduced amount; a wife's or husband's, 82½ percent.	No provision.
(d) Widow's and Widower's Benefits		
Benefits beginning at or after age 62 are equal to 82½ percent of the benefit amount that would be payable to the deceased spouse.	The amount payable where benefits begin at or after age 65 would be equal to 100 percent of the benefit amount that would be payable to the deceased spouse.	Same as H.R. 14430.

	Benefits beginning before age 65 would be reduced; where benefits begin at age 62 the benefit amount would be equal to 82½ percent of the benefit of the deceased spouse.	
	(e) Disabled Widow's and Widower's Benefits	
Disabled widows and widowers can get benefits at or after age 50. Where benefits begin before age 62, the benefit amounts are reduced.	Benefits would be payable to a disabled widow or widower at any age. No reduction would be made in benefits that begin before age 62; the benefit amount would be 82½ percent of the deceased spouse's benefit, the amount payable under present law and under the bill to a widow who begins getting her benefits at age 62.	No provision for disabled widows and widowers.
	(f) Dependent Parents' Benefits	
Benefits are provided for the dependent parents of deceased workers.	Benefits would be payable to dependent parents of disabled and retired workers.	Same as H.R. 14430.
	(g) Disabled Child's Benefits	
Benefits are provided for the disabled child of a worker provided that the disability begins before age 18.	Benefits would be provided for the disabled child of a worker provided that the disability begins before age 22, rather than age 18.	Same as H.R. 14430.
	(h) Special age-72 payments	
Certain people who reach age 72 before 1972 and who have not worked under social security long enough to get regular benefits can get special payments of: \$40 for an individual; \$60 for a couple.	The special payments would be increased in 2 steps: Beginning: *Individual* / *Couple* January 1970 — \$48.00 / \$72.00 January 1972 — 57.60 / 86.00	The special benefits would be increased to \$44 for an individual and to \$66 for a couple in March 1970.
	(i) Lump sum death payment	
Equal to 3 times the worker's benefit amount but not more than \$255. Range: \$165 to \$255.	The \$255 limit would be increased to \$500.	No provision.

EXISTING LAW—continued	NEW OMNIBUS PROPOSAL—IDENTICAL TO H.R. 14430—continued	H.R. 14080—ADMINISTRATION PROPOSAL—continued
	2. Benefit computations	
All social security benefit amounts are based on the insured worker's average monthly earnings. Nearly all benefits are now based on average monthly earnings after 1950—figured over 5 less than the number of years after 1950 and up to the year the worker reaches age 65 (62 for women), becomes disabled or dies.	The number of years used in figuring the worker's average monthly earnings would be reduced by ⅓ beginning in December 1970, and to his best 10 years out of any 15 consecutive years beginning in December 1972. The average monthly earnings figured over the shortened periods would be adjusted to take account of the length of time the person worked under social security.	No provision.
Average monthly earnings for a man are determined over a period of years ending at age 65, while for a women it is determined over a period of years ending at age 62, earnings after age 65, or 62, may be substituted for earnings before those ages.	Average earnings for men would be determined over a period of years ending at age 62 as is provided in existing law for women.	Same as H.R. 14430.
	3. Earnings test	
No benefits are withheld on annual earnings of $1,680 or less. For earnings up to $1,200 above $1,680 (i.e., $2,880), $1 is withheld for each $2 of earnings, and for additional earnings $1 is withheld for each $1 of earnings, except that no benefits are withheld for any month in which a person does not earn more than $140 in wages nor render substantial services in self-employment.	No benefit would be withheld on earnings of $1,800 or less. For earnings up to $1,200 above $1,800 (i.e., $3,000) $1 would be withheld for each $2 of earnings, and for additional earnings $3 would be withheld for each $4 of earnings, except that no benefits would be withheld for any month in which a person does not earn more than $150 in wages nor render substantial services in self-employment.	No benefits would be withheld on earnings of $1,800 or less. For earnings above $1,800, $1 would be withheld for each $2 of earnings. However, no benefits would be withheld for any month in which a person does not earn more than $150 in wages nor render substantial services in self-employment.
No provision for automatic increases.	Beginning in 1973, the $1,800 and $150 amounts specified above would be automatically increased as average earnings levels rise.	Same as H.R. 14430.

	4. Disability provisions	
Benefits cannot be paid until after a 6-month waiting period, and are payable only if the disability is expected to last for at least 12 months or to result in death.	The waiting period would be reduced from 6 to 3 months, and the requirement that the disability must be expected to last 12 months or to result in death would be eliminated.	No provision.
Workers must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment.	Workers aged 55–64 could qualify if unable to engage in substantial gainful activity (by reason of a medically determinable physical or mental impairment) in their regular work or in any other work in which they have engaged with some regularity in the recent past.	No provision.
	5. Medicare	
	(a) Financing	
Hospital insurance is financed by contributions from employers, employees, and the self-employed. Supplementary medical insurance is financed by monthly premiums paid by enrollees and matched by the Federal Government. Moneys are deposited in, and benefits and administrative expenses are paid from, 2 separate trust funds. Eligibility for hospital insurance is based on eligibility for cash benefits (except for a special transitional provision) while medical insurance is available to virtually all those over 65.	Beginning July 1970, would eliminate supplementary medical insurance premiums and provide for financing both hospital and medical insurance programs through contributions of employers, employees, and the self-employed, and a matching contribution by the Federal Government. All moneys would go into a combined trust fund, which would pay the benefits and administrative expenses of both programs. Eligibility requirements for both hospital and medical insurance would be identical to that required under existing law for hospital insurance.	No provision.
	(b) Medicare for disabled beneficiaries	
Medicare is available only to people age 65 and over (without regard to disability).	Would extend medicare, under the combined financing approach described above, to people under age 65 entitled to monthly cash disability benefits. Benefits would begin with the first month for which the individual is eligible for cash benefits and end 12 months after cash benefits cease.	No provision.

5. *Medicare*—Continued

(c) Drug coverage

Generally, drugs are covered only if they are provided in a hospital or an extended-care facility. Drugs are covered on an outpatient basis only if the drug is one which cannot be self-administered.	Would extend coverage of out-of-hospital prescription drugs under hospital insurance program. Drugs covered would be selected by the Secretary with the advice of an expert committee provided for by the bill. Reimbursement would be made to providers of drugs (pharmacies, etc.) on the basis of acquisition and dispensing allowances. The beneficiary would be required to make a $1 co-payment per prescription or per refill.	No provision.
	6. *Military service credits*	
Military basic pay has been covered under social security since January 1, 1957. For service from September 1940 through December 1956 noncontributory credits of $160 a month are provided. For service after 1967 noncontributory credits of $100 a month are provided. There are no noncontributory credits for service performed from January 1957 through December 1967.	Noncontributory credits of $100 a month would be provided for service performed from January 1957 through December 1967.	Same as H.R. 14430.
	7. *Contribution and benefit base*	
The amount of annual earnings on which social security contributions are payable and that can be counted toward benefits is $7,800. No provision for automatic increases.	The amount of annual earnings to be counted for contribution and benefit purposes would be increased as follows: To $9,000 for 1970 and 1971; To $15,000 for 1972; and For years after 1972, the annual earnings amount would be automatically increased (in even-numbered years) as average earnings levels rise.	The amount of annual earnings to be counted for contribution and benefit purposes would be increased to $9,000 for 1972. Beginning in 1974 the base would be automatically increased as wage levels rise.

8. *Contribution rate schedule*

EMPLOYER-EMPLOYEE, EACH (PERCENT)

Year	OASDI	HI	Total
1970	4.20	0.60	4.80
1971–72	4.60	.60	5.20
1973–75	5.00	.65	5.65
1976–79	5.00	.70	5.70
1980–86	5.00	.80	5.80
1987 and after	5.00	.90	5.90

SELF-EMPLOYED (PERCENT)

Year	OASDI	HI	Total
1970	6.30	0.60	6.90
1971–72	6.90	.60	7.50
1973–75	7.00	.65	7.65
1976–79	7.00	.70	7.70
1980–86	7.00	.80	7.80
1987 and after	7.00	.90	7.90

EMPLOYER-EMPLOYEE, EACH (PERCENT)

Year	OASDI	HI	Total
1970	4.20	0.60	4.80
1971–72	4.80	.65	5.45
1973 and after	5.10	.90	6.00

SELF-EMPLOYED (PERCENT)

Year	OASDI	HI	Total
1970	6.30	0.60	6.90
1971–72	6.90	.65	7.55
1973 and after	7.10	.90	8.00

EMPLOYER-EMPLOYEE, EACH (PERCENT)

Year	OASDI	HI	Total
1970	8.4	1.2	9.6
1971–72	8.4	1.8	10.2
1973–74	8.4	1.8	10.2
1975–76	9.2	1.8	11.0
1977–79	9.6	1.8	11.4
1980–86	9.8	1.8	11.6
1987 and after	10.0	1.8	11.8

SELF-EMPLOYED (PERCENT)

Year	OASDI	HI	Total
1970	6.3	0.60	6.9
1971–72	6.3	.90	7.2
1973–74	6.3	.90	7.2
1975–76	6.9	.90	7.8
1977–79	7.0	.90	7.9
1980–86	7.0	.90	7.9
1987 and after	7.0	.90	7.9

9. *Federal contributions*

No. provision.

General revenue contributions equaling specified percentages of payroll taxes and gradually increasing over a 10-year period to an amount equal to approximately ⅓ the total cost of the program.

No provision.

Appendix 4

MATERIAL RELATED TO HEALTH AND THE ELDERLY

ITEM 1: PENDING LEGISLATION

Preventicare.—S. 16, introduced by Senator Harrison Williams on January 16, 1969, would authorize Federal assistance for the establishment and operation of regional and community health protection centers to provide periodic health appraisals and disease detection services for adults 50 years or older. Additional Federal grants would be available for research and for administration of community education programs on preventive health care.

In discussing the need for this legislation, Senator Williams stressed:

> Available evidence indicates a modest national investment in more and better preventive health services would pay for itself many times over in reduced public and private outlays for curative measures after illness strikes, and, even more important, would prevent much human suffering, disability, and death.
>
> Someone has said that we in the United States live in a golden age of treatment and a dark age of preventive medicine. While chronic disease in the United States takes an economic toll of approximately $57 billion annually in direct and indirect costs, we spend just a small fraction of for the prevention of illness. In other words, we sit patiently while disease develops, then treat it when it has reached crisis stage. We give disease a headstart, and then we run to catch it.[1]

Research on Aging Act.—S. 870, sponsored by Senators Harrison Williams, Kennedy, Mondale, Muskie, Prouty, Randolph, Stephen Young, and Yarborough, would establish an Aging Research Commission to prepare a 5-year program to promote coordinated research into the biological origins of aging.

In his statement, Senator Williams pointed out:

> Social scientists, physicians, and gerontological experts agree that basic research into the process of aging could possibly lead to mastery over the process which makes men old.[2]

Household Aide Bill.—On July 28, 1969, Congressman Gilbert introduced H.R. 13139 to authorize coverage under Medicare for services furnished to an individual by a "home maintenance worker" as part of a home health service plan. A similar bill, S. 3333, was introduced by Senator Harrison Williams on January 24, 1970.

ITEM 2: SUMMARY OF INTERIM REPORT MADE IN NOVEMBER 1969 BY TASK FORCE ON MEDICAID AND RELATED PROGRAMS

("McNerney Report.")

In November, the Task Force on Medicaid and Related Programs—reflecting a well-balanced membership of many views—submitted an interim report dealing with far-reaching questions about the Medicaid program and our present health care system. Major findings by the Task Force concerning our present health care system stressed:

—It has serious organizational, financial, productivity and access problems
—Bolder moves will be necessary to achieve measurable improvement
—Appreciable investment of money will be necessary, but more importantly, substantial changes in the present delivery system will be essential

[1] Congressional Record, Jan. 15, 1969, p. S. 268.
[2] Congressional Record, Feb. 4, 1969, p. S. 1213.

—Quality of care has often been handicapped by confusion, duplication of effort and inadequacy of surveillance of its effectiveness
—Medicaid has not been structured or administered to reflect the importance of the goal of providing quality health care to millions of indigent Americans.

A total of 52 recommendations was urged, which dealt largely, but not exclusively, with the Medicaid program. Some of the major recommendations include:

—As soon as practicable, States should be required to use the simplified method of determining eligibility for access to the Medicaid program
—Certification of eligibility should be for a minimum period of three months.
—Availability of services should be broadened. Innovative facilities for provision of medical care—such as neighborhood health centers, community health centers, and group practices which provide neighborhood, comprehensive ambulatory care, and other facilities—should be included as eligible vendors which Medicaid recipients may elect and be encouraged to use
—States should be required to establish Medicaid program effectiveness systems designed to assure that payments made are in accord with the appropriate rate structure; assure quality, appropriateness, and timeliness of care received by persons eligible under the program; and encourage efficient and economical health care program planning, evaluation and administration
—Enactment of legislation to make 5 percent of Federal Medicaid appropriations per year available for improvement and development of health care services and resources. Priority would be given to localities with a high proportion of low-income persons and where the need for development and improvement of health care resources has been determined in cooperation with State and areawide health planning agencies
—Enactment of legislation requiring uniform provisions and unified State standard-setting, certification, and consultative functions for providers of service under Medicaid and Medicare
—"Model educational programs" should be developed in consultation with the States, and should include outreach efforts, utilizing potential Medicaid beneficiaries
—Appropriate steps must be taken to restructure the Medical Services Administration (which has administrative responsibility for Medicaid) in HEW to provide the staff, resources and support required to carry out its mission effectively

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ITEM 3: SUMMARY OF RECOMMENDATIONS MADE BY THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL IN REPORT ISSUED IN JUNE 1969

LEGISLATIVE RECOMMENDATIONS

1. The Council recommends that after consultation with professional groups, the Secretary submit legislative proposals to the Congress that would enable the program to discontinue reimbursement for services of a physician or supplier when one or more of the following is found: evidence of fraud; repeated overcharging of the program or its beneficiaries; a pattern of rendered servcies substantially in excess of those justified by sound medical practice; persistent failure to cooperate with the program in clarifying cases which may involve excessive charges or services; or documented rendering of services or supplies which were harmful to beneficiaries or found to be grossly inferior by peer review.

2. The Secretary in consultation with appropriate professional groups, should seek the development of feasible and desirable standards of eligibility for the rendering of various types of medical services by physicians under the Medicare program, and the administrative procedures necessary to enforce them with a view to recommending appropriate legislation to the Congress.

3. The Council recommends legislation which would remove the present limitations on the Secretary's authority to establish health and safety standards for hospitals, contained in section 1865 of the Social Security Act, so that:

The Secretary would have the authority to establish health and safety standards for hospitals commensurate with his authority to establish such standards for other providers of services and for independent laboratories.

The Secretary may, in the case of any national accrediting body with stand-

ards and certification procedures equal to or higher than those established by the Secretary for a class of providers or independent laboratories, find that such accreditation provides reasonable assurance that the conditions of participation are met.

4. The Council recommends that legislation be enacted which authorizes the Secretary, in addition to his option to recognize the findings of accrediting bodies, to arrange with State agencies to survey accredited facilities at intervals between accreditation surveys and, when finding deficiencies:

to convey this information to the accrediting agency; and

to report to the Secretary and make recommendations with respect to certification.

The Council recommends that the Secretary be given the legislative authority to develop and apply standards for Medicare covered ambulance services. These standards would cover the various types of ambulance and emergency equipment, qualifications, and training of ambulance attendants, methods of communication and dispatch, and policies of agencies rendering ambulance services.

The Council recommends that legislation be enacted which would:

place all home health benefits under Part A, with a maximum eligibility of 200 visits per year;

remove the 3-day hospital stay requirement for home health benefits;

provide for coinsurance for the second 100 visits per year.

7. The Council recommends that legislation be enacted which would require utilization review of home health services to become effective 1 year after the Secretary issues regulations.

8. The Council recommends that the general exclusion of immunizations from coverage under Medicare be deleted from the statute.

9. The Council recommends that the legislative requirement for the blood deductible be eliminated.

10. The Council recommends the enactment of legislation which would allow the participation of community mental health centers in the Medicare program.

11. The Council recommends that the 190-day lifetime limit on inpatient psychiatric hospital benefits be removed if a review of past experience shows that such removal would significantly increase health benefits to Medicare beneficiaries, in relation to the costs involved.

12. The Council recommends that the legislative provisions relating to the incentive experiments should be broadened so that the Medicare, Medicaid, and Maternal and Child Health programs can participate in experiments which seek to achieve greater economy and efficiency by modifying health benefits and coverage in ways that may promote improvements in the organization and delivery of health services without increasing the costs of these programs.

13. The Council recommends that appropriate legislation be developed, to be effective when and where appropriate health facilities planning bodies become operational, which would assure that the reimbursement under Medicare would not be inconsistent with the plans and findings of these bodies. One method of insuring the rapid establishment of such planning groups would be the adoption of the recommendation by the Secretary's Advisory Committee on Hospital Effectiveness which would make Federal health grants to States conditional upon the establishment of planning bodies.

14. The Council recommends that legislation be enacted authorizing the Secretary to negotiate capitation reimbursement payments to group practice prepayment plans.

ADMINISTRATIVE RECOMMENDATIONS

1. The Council has recommended to the Secretary that quality standards and reimbursement levels be established in such a way as to, if at all possible, encourage the consolidation of laboratory services.

Consistent with the Council's belief that uniform standards should be applied to all classes and categories of clinical laboratories, it has recommended to the Secretary that the conditions for coverage of services of independent laboratories be revised to require satisfactory participation by all independent laboratories in proficiency testing programs acceptable to the Secretary.

The Council has recommended to the Secretary revision of the Medicare regulations to require that mail order laboratories develop and maintain procedures for evaluating the stability of specimens which are not stable to a degree sufficient to assure satisfactory clinical accuracy with respect to original values.

The Council believes that marketing standards may be required to assure that diagnostic laboratory equipment be of sufficient quality to produce accurate results, especially when operated by individuals not specifically oriented toward the practice of pathology. It has, therefore, requested that an expression of the Council's concern be transmitted to the Secretary, with a recommendation that a study of this problem be undertaken and evaluation made of the need for appropriate regulatory legislation, recognizing that this problem affects all patients, not only Medicare beneficiaries.

Also, the Council encourages and supports efforts and activities directed toward development of national standards relating to reagents, purified chemical substances, and standard reference methods for use in clinical laboratories.

The Council has recommended to the Secretary that in cooperation with organized medicine, survey mechanisms be developed to obtain data on the nonpathologist physicians who do their own laboratory work, the scope of such laboratory services, the kinds of personnel doing such work, and the results obtained.

The Council has no recommendations to make at the present time with respect to the major provisions for deductibles and coinsurance under Medicare.

The Council does believe that these provisions need further study and should receive the attention of the Social Security Advisory Council, which will be appointed shortly to consider modifications in social security legislation.

The Council has recommended to the Secretary that additional efforts be taken to assure that the use of home health services is preceded by a thorough medical evaluation of the health care needs of the patient.

The Council has recommended to the Secretary that the regulations under part A be amended to reduce the certification periods below the current 14 and 21 days, such as to 12 and 18 days.

The Council intends to follow the course of the incentive reimbursement experimentation program closely, and will make such recommendations as seem appropriate in view of how the program develops.

The Council strongly endorses the effort to secure more rigorous and uniform application by part B carriers of the reasonable charge determination criteria, and has recommended that the Administration continue to move ahead vigorously in developing and carrying out measures designed to assure full application of the resonable-charge concept under the medicare program.

The Council strongly supports efforts of the Social Security Administration to obtain the accurate definition and uniform reporting of medical services by clarifying and implementing the pertinent instructions to part B carriers and by working with physicians and professional groups. The Council also urges that the profession support package charges where they are feasible rather than further fragmenting services and charges.

The Council has recommended to the Secretary that the Social Security Administration continue to exercise careful supervision over carrier and intermediary performance in the matter of reasonable charge and cost determination and utilization safeguards. In reviewing performance of carriers and intermediaries when contract continuation is being considered, the Social Securty Administration should place particular weight upon their performance in the field of cost control.

The Council also has recommended to the Secretary that the Social Security Administration undertake a study of how the concept of incentive reimbursement can be applied to carriers and intermediaries, so that outstanding performance can be rewarded and poor performance penalized, without the sole reliance on the "massive retaliation" of contract termination.

The Council supports the use of cooperation and persuasion to seek improvement among carriers and intermediaries, but in those cases where persuasion is unsuccessful and the agency fails to carry out the policy standards which are established, termination of the contract will have to be the avenue which is pursued.

The Council urges that ways be sought to provide the essential statistical information base as promptly, completely, and accurately as possible, taking into account, of course, the limitations on funds which are appropriate to the task.

The Council urges that, to the extent feasible, Medicaid programs delegate their functions to the organizations which perform analogous functions for Medicare.

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Appendix 5

SUMMARY OF "MEDICARE AND MEDICAID, PROBLEMS, ISSUES, AND ALTERNATIVES," A REPORT OF THE STAFF OF THE SENATE COMMITTEE ON FINANCE, FEBRUARY 9, 1970; AND RESPONSE BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FEBRUARY 26, 1970

ITEM 1. SUMMARY OF FINANCE COMMITTEE REPORT

INTRODUCTION

The medicare and medicaid programs are in serious financial trouble. The two programs are also adversely affecting health care costs and financing for the general population.

Medicare began providing benefits on July 1, 1966. Its financing had been established on what Congress believed to be conservative and safe bases. Yet, little more than 1 year after the program started, Congress found it necessary to increase medicare taxes by some 25 percent in order to meet hospital cost increases beyond those originally anticipated.

The President submitted to the Congress, in September 1969, a proposal calling for an additional $136 billion in medicare payroll taxes over the next 25 years. The $136 billion is in addition to prospective increases in medicare taxes already scheduled in the Social Security Act. Of the $136 billion, $131 billion represents the amount by which medicare's expenditures are expected to exceed its anticipated income and the remaining $5 billion is a safety factor. Without those additional taxes, the Social Security Administration estimates that the hospital insurance trust fund will be exhausted by 1973.

When medicare started on July 1, 1966, the medicare beneficiary was responsible for paying at least the first $40 of his hospital bills in accordance with the deductible and copayment requirements of the law. On January 1, 1969, the deductible was increased to $44 and effective on January 1 of this year it was raised to $52. According to Social Security's Chief Actuary, the deductible will very likely jump to $60 in 1971; $68 in 1972; $76 in 1973; and to $84 on January 1, 1974.

The part B portion of medicare—the supplementary medical insurance plan for payment of doctors' bills—has also soared in cost. The monthly premium charge to the elderly is now $4—up from $3 monthly when medicare began on July 1, 1966. Under the law, the monthly premiums paid by the elderly are matched with an equal amount from the general revenues of the Federal treasury.

In December 1969, the Secretary of Health, Education, and Welfare announced that the part B premium would be increased to $5.30 monthly effective July 1, 1970. That increase amounts to $600 million annually of which $300 million will represent increased Federal expenditures and $300 million will come from the pockets of 20 million older citizens.

Under present law, the institutional suppliers of covered health services under medicare (and medicaid, in large part, also) are paid whatever it costs them to provide the services. Physician bills under medicare are essentially paid as rendered. Unlike most areas in the private economy no incentives exist to produce or supply a given health service at the most economical price consistent with quality of care. To the contrary, hospitals and extended care facilities can, under present medicare and medicaid reimbursement rules, spend money on virtually anything and be paid for it by Government.

Unless the rapid and continuing escalation in the costs of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to

extend the medicare and medicaid programs to encompass large segments of the population not now covered under these public health payment plans.

Those pressures for expansion and extension will come from citizens with moderate incomes who are now covered by Blue Cross-Blue Shield and other private health insurers. People are being priced out of the private health insurance market as a result of the frequent and substantial premium increases required to meet the ever-greater costs of health care.

The charges for adequate nongovernmental health insurance are rising to levels beyond the financial capacity of millions of hardworking Americans. Most of those people probably would prefer to continue their private coverage rather than become part of a monolithic system of governmental health care. Under present and foreseeable conditions, however, whatever choice they now have in the matter may be removed by circumstances beyond their control.

The working man today is confronted with:

(*a*) Social security tax increases to pay for medicare.

(*b*) Increases in his private health insurance premiums.

(*c*) Increased State and local taxes to pay for medicaid.

(*d*) More of his Federal tax dollar going to the Federal share of medicaid and medicare costs.

(*e*) More out-of-pocket costs to cover his coinsurance portion of higher and higher medical charges.

(*f*) More out-of-pocket costs for rapidly rising charges for largely noninsured health services such as dental care.

To simply expand the medicare and medicaid programs as now constituted and operated would, we believe, compound costs and confusion. That would not solve the problems of increasing costs—rather it would add to them. Eventually, under such conditions, the individual would have traded higher insurance premiums for even higher taxes, and there would be little private health insurance as we know it today available to our people.

With a view toward improving the medicare and medicaid programs the staff has included suggestions and recommendations which we believe provide bases for remedying the serious, costly, and pervasive problems we have found. We believe these suggestions can make medicare and medicaid work more efficiently and economically.

The key to making the present system workable and acceptable is the physician and his medical society. We are persuaded that at this point in time neither the Government nor its agents have the capacity for effective audit to assure that a given physician functions responsibly in dealing with the publicly financed programs.

While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health care professions) to do what is required with respect to monitoring care provided and charges made for the care. In the absence of such constructive effort, we fear that virtually insurmountable pressures will develop for alternative control procedures which may be arbitrary, rigid and insensitive to the legitimate needs of both the patient and his physician.

SUMMARY

The staff in its review of the status and operations of the medicare and medicaid programs focused upon the principal problem areas. Our findings and suggestions for improvement are summarized following a brief discussion below of the fiscal impact of the medicare and medicaid programs.

1. Fiscal Impact of Medicare

Hospital Insurance Plan (Part A):

In 1965 when medicare was enacted, the insurance program for payment of hospital bills was estimated to cost 1.23 percent of taxable payroll. (Taxable payroll is the total of all earnings subject to social security taxes.) Consistent with the express intent of the Congress that medicare estimates be conservatively made, it was specifically assumed that the maximum individual wages subject to medicare tax would remain at $6,600 annually during the life of the 25-year cost estimate.

After only 3 years of experience, the conservative assumptions have been abandoned due to soaring costs resulting from price increases and greater-than-

anticipated utilization of covered services. Currently, medicare's hospital plan is estmiated to cost 2.27 percent of taxable payroll based upon $7,800 of individual annual wages subject to the hospital tax.

Boiled down to dollars, as the following table reveals, the estimated cost for calendar year 1970 has jumped from the original projection of $3.1 billion to a current estimate of $5.8 billion. And, from 1970 onward, the yearly gap between original estimates of costs and current projections progressively widens by billions of dollars.

HOSPITAL INSURANCE BENEFIT COST PROJECTIONS

[In billions of dollars]

	Estimate of 1970 costs	Estimate of 1975 costs	Estimate of 1990 costs
Actuarial estimate made in 1965	3.1	4.3	8.8
Actuarial estimate made in 1967	4.4	5.8	10.8
Actuarial estimate made in January 1969	5.0	7.6	16.8
Current estimate	5.8	(1)	(1)

1 Not available.

As was noted in the introduction, the estimated deficit between the costs of part A of medicare and projected income under present law amounts to $131 billion over the next 25 years. The hospital insurance trust fund will be exhausted in 1973 under present financing.

The President has requested, and Congress will consider imposing, additional taxes necessary to finance the $131 billion shortfall. In all of this, it is obvious that the repeated and enormous demand for new taxes to pay for existing levels of medicare benefits serves to preempt payroll tax potential which might otherwise be available for program improvement. The staff points out that legislative alternatives are reduced when Congress is forced to increase medicare taxes simply to keep the existing program above water.

Supplementary Medical Insurance Plan (Part B):

When medicare began on July 1, 1966, the insured beneficiary paid a monthly premium of $3 with an equal amount paid by the Federal Government from general revenues (total monthly premium of $6 per person), toward coverage of his doctor bills.

The costs of part B have soared. The original $3 monthly premium was increased to $4 on July 1, 1968, and is scheduled to jump again to $5.30 monthly on July 1, 1970.

In the simplest of terms, the Federal share of part B costs will have increased from $623 million in fiscal year 1967 to an estimated $1,245 million in fiscal year 1971. (The insured elderly will match that $1,245 million from their own resources.)

2. Fiscal Impact of Medicaid

The budgetary impact upon State, local and Federal Governments of expanded eligibility and benefits coupled with increases in unit costs of medical assistance under the various welfare programs has been enormous.

In fiscal year 1965 total Federal-State medical assistance expenditures amounted to $1.3 billion of which the Federal share was $555 million. For fiscal 1970, the Department of Health, Education, and Welfare estimates total expenditures of $5.5 billion (including the costs of intermediate care facilities) of which the Federal share is $2.8 billion. Based upon the above figures, Federal expenditures for medical assistance will have increased five-fold from fiscal year 1965 through fiscal year 1970 with commensurate increases in expenditures by State and local governments.

3. Reimbursement of Institutions Providing Medical Care

Comprehensive assessment of the financial position of hospitals in light of medicare reimbursement must await more complete data than are available in usable form now—even though more than 3½ years have elapsed since the program started. There is, however, consensus concerning a need for ultimate revisions—liberalizing and restricting—in both reimbursement procedures and the formula itself.

Making "Reasonable Cost" More Reasonable

The basic direction in any changes will presumably be toward more equitable reimbursement—from the standpoint of both Government and health care providers—coupled with simplified and coordinated cost reporting requirements.

Where a given institution demonstrates that it incurs greater than ordinary costs in caring for medicare patients, those additional costs should be reimbursable provided they are not unreasonable. However, blanket recognition of increased nursing and clerical time should be avoided. It appears illogical, for example, to pay a plus factor for increased nursing time to institutions which do not fully meet the conditions for medicare participation, particularly those with staffing deficiencies.

Cost finding and auditing have proved to be highly expensive undertakings in medicare as well as a source of much friction. The legislative history indicates a concern that proper accounting be required not only for proper determination of payment but also as desirable adjuncts of good management. However, Congress did not intend accounting and audit "overkill" in pursuit of those objectives. The Bureau of Health Insurance should be encouraged in its efforts to revise procedures so as to avoid requiring what in essence amounts to duplicate cost finding on the part of hospitals. Additionally, less extensive and simpler costs data might be required of smaller institutions.

There have been inordinate and protracted delays in final settlement of accounts for specific calendar years—delays of years in many instances. To encourage prompt settlement, it is recommended that the Government pay interest on any amounts due to an institution where unreasonable delay in settlement is the responsibility of the Government. Similarly, interest should be charged on amounts due the Government where unusual delay in settlement is caused by the participating facility.

Cost-plus reimbursement was dropped from medicare effective July 1, 1969. That policy encouraged duplication, overlapping, and unnecessary expansion of facilities and services and created an unhealthy economic incentive to maximize operating costs. The pursuit of equitable reimbursement is not served, in our opinion, by any cost-plus method of payment except where the "plus" factor is related on an incentive basis to economical performance.

The 2-percent bonus in medicare had been rationalized as a growth factor by hospital organizations. Perhaps the Federal Government would want to expand its efforts to meet the capital needs of hospitals which cannot otherwise be met through depreciation, contributions, regular borrowings, and so forth. If it should, we suggest that it be done by direct appropriations for that purpose and not financed through devices in the medicare reimbursement formula. In our judgment, medicare was enacted for a wholly different purpose. Any significant capital improvement financed in whole or part by the Federal Government should be contingent upon approval of an appropriate and technically qualified community or State planning agency broadly representative of all of the various types of health care and services. The planning body should not be directly or indirectly controlled or dominated by hospitals. Capital expenditures should be approved only after thorough consideration has been given to existing and alternative health care resources already available or appoved in a given community or medical service area. Simply stated, the capital expenditure should be necessary in the context of priorities for meeting overall community needs.

Where approved capital needs cannot otherwise be met, the existing reimbursement formula might be modified to allow the expenditure to be depreciated in one-half the time ordinarily accepted but only where the expenditure had been approved as expected to substantially contribute to efficiency.

As indicated in the report, the entire reimbursement formula and procedures for medicare need careful review and substantial revision. In the staff's opinion the existing formula and its implementation have undoubtedly contributed significantly to the unanticipated rise in part A costs, and to the $131 billion projected 25-year deficit in medicare.

Legislation presently before the committee, S. 1195, provides bases for moderating the extent of this anticipated "shortfall." The proposal would preclude reimbursement to the extent that a hospital's increase in average per diem operating costs over the previous year rose at a rate greater than the Medical Care Price Index for that particular geographic or metropolitan area. The Secretary of Health, Education, and Welfare could, under unusual and justifiable circumstances, authorize payments in excess of the limitation. However, medicare could

not pay under cost reimbursement more to an institution than its charges for the same services to the general public. No reimbursement could be made for capital costs associated with an expenditure specifically disapproved by a State's "partnership for health" agency. The staff urges serious consideration of the provisions of this bill.

In addition, the staff suggests that payment for care provided in one institution be limited to not more than a reasonable difference above costs for comparable care and services in a similar, less expensive, institution in the same area.

Reimbursement of Hospital "Reasonable Costs" Under Medicaid

The statutory requirement that States pay hospitals on the basis of "reasonable costs" under medicaid has been interpreted by the Department of Health, Education, and Welfare to mean payment identical with that of medicare. That interpretation has been costly to the States and has hampered their efforts to control costs. The staff believes that Congress intended, as with many other welfare requirements, that States be permitted to define "reasonable costs" within general guidelines issued by the Secretary of Health, Education, and Welfare. The medicare pattern could fall within those guidelines but States should not be restricted to the medicare formula or even to the medicare pattern. This understanding seems reasonable in view of the difference between medicaid and medicare, and in terms of the ages of the populations assisted, sources of financing, and primary administrative responsibility. The staff recommends that congressional intent be clearly established with respect to the relationship between reimbursement under medicare and medicaid.

Other Issues in Institutional Reimbursement

Among specific additional problems in institutional cost reimbursement are:

Payment for empty beds costs.—Under present regulations it is possible for a new hospital or extended care facility (or even older facilities) to be paid for such costs to an unreasonable degree. For example, an extended care facility in Wisconsin with patient capacity of 25 beds had no more than three beds occupied at any given time, with medicare patients accounting for the limited occupany. As a result, an average cost per diem of $87 was claimed from medicare.

To deal with such situations, the staff suggests payment of the lesser of costs or the published charges ordinarily payable by a nonmedicare patient and limiting medicare's empty beds reimbursement to a proportion based upon average actual medicare occupancy in relation to the total number of beds available.

Bad debt collection.—Information has been developed indicating that some hospitals and extended care facilities make only perfunctory efforts to collect the deductible and copayment sums due from beneficiaries toward the costs of their care. Those unpaid amounts are then charged-off as a reimbursable "bad debts" expense under medicare. The result is that medicare bears the entire cost of care, thus thwarting the purpose of the deductible and copay features in the medicare statute. With the present $52 deductible expected to rise to $84 by 1974, with accompanying commensurate increases in other part A copayment requirements, it is important that all participating institutions make a genuine effort to collect from beneficiaries before passing those amounts on to medicare as uncollectible.

Reimbursement for bad debts attributable to nonmedicare patients is not allowable under medicare. Yet, Social Security, despite concern expressed by the General Accounting Office, has authorized payment of a proportionate share of collection costs of nonmedicare bad debts. Such collection is often undertaken by independent collection agencies in return for a specified percentage of amounts collected. Where such collection costs are recognized, medicare, in effect, is paying for nonmedicare bad debts. The staff recommends termination of such payments by medicare.

The liberal depreciation allowances payable under medicare—including accelerated depreciation—may well be causing the sale and resale of proprietary facilities at inflated prices. The objective in such situations would be to repeat the writeoff of the facility and its equipment through accelerated depreciation and thereby realize inordinately high and duplicative cash payments from the Government.

This situation is also conducive to transformation of for-profit facilities into nonprofit institutions with the owners selling to a pro forma nonprofit organization at a high price with the purchase price payable on an installment basis from the excess of revenues over expenses of the now "tax free" institution.

The staff suggests issuance of regulations (and assurance of their enforcement) providing for tightened appraisal procedures where facilities change hands. In such appraisals "goodwill" should not be recognized as an element of cost, and depreciation should be allowable only on a straight line basis as is the case under the tax laws.

4. Tax-Exempt Status of Community Hospitals and Obligation To Provide Charitable Care

The staff again calls the committee's attention to a recent ruling by the Internal Revenue Service (Revenue Ruling 69–545) which overturns prior Service policy that a hospital must provide charitable services to the extent of its financial ability in order to justify tax exemption. The new ruling was announced on October 8, 1969, after the House passed H.R. 13270, the tax reform bill, which included a provision similar in purpose to the ruling, but before the Finance Committee deleted the House amendment. The Senate's action in removing the provision was accepted by the House. The Finance Committee in deleting the amendment noted that it desired to consider the question later in the context of medicare and medicaid.

If the Service, despite the recent legislative history, retains the policy enunciated in the new ruling, it is conceivable that:

1. Many marginal income families, not now eligible for help with hospital bills under either medicare or medicaid and whose resources are insufficient to pay for necessary care might be denied hospital care now available to them. This is especially true in the many States which do not now pay for hospital care provided to welfare recipients of general assistance. In turn, this would place greater pressure upon States and Congress to expand medicaid at the very time Congress is seeking means of contracting and moderating the program.

2. To the extent hospitals insist that medicare and medicaid did not pay their full costs they might contend that they were being asked to provide free or below-cost care. Those hospitals, perhaps might refuse to serve or limit service to medicare and medicaid patients, unless the Federal and State Governments met their unilateral cost determinations and demands. Without the balancing effect of the requirement that free and below-cost care be provided, Government might be faced with the choice of complying with payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals to which contributions may be made on a tax-deductible basis.

It is also a matter of fact that the extent of free and below-cost hospital care has diminished greatly since the advent of public programs such as medicare and medicaid.

The staff strongly recommends revocation of Revenue Ruling 69–545 and continuation of the prior position of the Service. Such action by the Service would assist in protecting the availability of necessary hospital care to medicare, medicaid, and other poor patients.

5. Payment for Physicians' Services

The provisions of the statute and the clear congressional intent that medicare carriers should not pay physicians more than they would ordinarily pay for their own subscribers has not been followed. Congress said that in paying physicians "consideration" should be given to customary and prevailing fees. In actual practice the medicare regulations require that payment should be made solely on the basis of customary and prevailing fees and that private insurance schedules should not have any influence on what medicare paid. As a consequence, medicare generally allows payments for the aged which are substantially higher than those paid under Blue Shield's most widely held contracts for the working population, and thus physicians' incomes have been inflated.

The failure to maintain detailed data with respect to customary charges for each physician and for prevailing fees in each locality has led to weak administrative practices, unwarranted delays in payments to physicians and beneficiaries, and high administrative costs. No doubt medicare's pattern of inflated payments has also served to increase physicians' charges to the general public because a doctor is not permitted to charge more under medicare (at least theoretically) than he does for his other patients.

There is evidence that many physicians are resorting to "gang visits" and unnecessarily frequent visits to nursing home and hospital patients in order to up

their medicare payments. Under this practice a physician may see as many as 30, 40, and 50 patients in a day in the same facility—regardless of whether the visit is medically necessary or whether any service is actually furnished. The physician in many cases charges his full fee for each patient, billing medicare for as much as $300 or $400 for one sweep through a nursing home.

In addition, it appears that many physicians are now billing separately for services which were previously routinely included in an office visit or a surgical fee. For example, routine laboratory tests which were part of the office visit charge are now billed in addition to the fee for the visit. In some cases a surgeon now charges separately for preoperative and postoperative visits, services which used to be included in his surgical fee.

The results of the above deficiencies, abuses, and lack-luster administration are reflected in rapidly rising premium charges for part B. In the opinion of the staff unless basic changes are made in the structure of reimbursement for physicians' services, substantial additional premium increases can reasonably be anticipated.

The staff believes that the existing interpretation of the part B statutory limitation is erroneous and not consistent with the congressional intent. We recognize, however, that the interpretation has been applied for more than 3 years; thus the first suggestion offered below is intended as a stopgap measure. As a permanent solution we think the provisions concerning reimbursement of physicians should be rewritten in the statutes. With that thought in mind, the staff has developed a basis for comprehensive revision which is outlined in the second recommendation below.

Recommendation for Reasonable Limit on "Reasonable Charges"

To conform present medicare practice to the congressional intent expressed in the statute and contemporaneous committee reports and if no substantive changes are made in part B the staff recommends that all Blue Shield plans serving as medicare carriers be required to limit the physician's charge recognized as "reasonable" to not more than the average payment actually made for a given service or procedure under all of its basic surgical-medical subscriber contracts during a reasonably recent prior period of time. Thus, for example, if Blue Shield in Massachusetts under all of its various subscriber contracts actually paid an average of $250 for removal of cataract (excision of lens) during 1968, medicare would not recognize charges above $250 as "reasonable" for purposes of reimbursement.

For those services which medicare covers but which Blue Shield does not, maximum allowances could be calculated on a basis relative to the average actual payments which Blue Shield made on the services it does cover.

Additionally, to avoid, at least to some extent, costly and often medically unnecessary "gang visiting," amounts allowed should be reduced for multiple visits, on the same day to patients in the same facility. Similarly, limitations on amounts allowed for "injections" and routine laboratory tests should be established and applied.

Fee Schedules: Recommendation for a Part B Program With Built-In Cost Limitations

We have developed a basis for possible revision of part B of medicare, in large part based upon customary insurance practices in the private sector, which the committee might consider as a mechanism to substantially simplify administration and control costs.

1. An advisory board of actuaries and underwriters would be selected by the Secretary of Health, Education, and Welfare from private health insurance companies to assist in developing a schedule of fixed indemnity allowances for surgical and medical care for each of the nine census regions in the Nation (in recognition of geographic variation in charges for similar medical services). The allowances for any given region should not be more than 10 (or possibly 15) percent greater than the average for all other census regions combined. Appropriate provision should also be made so that prepaid group practice and similar programs can provide care and be reimbursed on other man a fee-for-service basis.

2. The advisers would recommend specific maximum amounts allowable for covered services based upon a total monthly premium of $8 for beneficiary—the amount now paid—after allocating a sufficient portion of the premium for reserves and administrative costs.

3. The $50 deductible now in part B would apply only to charges for services rendered by nonparticipating physicians.

4. Payments would be made on the basis of 80 percent of the maximum amount allowable specified in the benefits schedule or 80 percent of the actual charge, whichever was less.

5. A participating physician would be one who agrees to accept the scheduled allowance as his full charge for the services he renders to all medicare beneficiaries. In the case of a participating physician payments would be made directly to him by medicare. He would collect 20 percent of the scheduled amount from the beneficiary. Alternatively, a co-pay approach might be employed. For example, the beneficiary would pay out of pocket the first $2 or $3 of the charge for home and office visits.

6. Where a doctor did not elect to become a participating physician all payments due from medicare to beneficiaries for services rendered by him would be made directly to those beneficiaries on the basis of a receipted or nonreceipted bill.

7. A physician could, upon appropriate notice, elect, or withdraw from, status as a participating physician.

8. The $8 monthly premium rate would be fixed by law and could not be changed except by legislative action.

9. In case the premium and reserves were inadequate to fully meet the obligations of the program in a given year, the advisory board would be expected to adjust the scheduled allowances downward so as to make up the deficit in the following year or years. Such revisions could be made applicable only to those regions experiencing abnormal utilization or could be made applicable nationally.

Recommendation for Uniform Definitions of Medical Procedures

To avoid fragmentation of fees the staff recommends that uniform definitions of medical procedures and services be applied in the payment of benefits under part B.

Adoption of uniform definitions would avoid situations such as that where a surgeon charges one fee for the actual surgery and then charges additional separate fees for normal preoperative and postoperative visits. Most Blue Shield plans allow a single inclusive fee covering the preoperative and postoperative care ordinarily and routinely provided in conjunction with the surgery itself.

Appropriate definitions can be obtained from Blue Shield and others.

6. Payments to "Supervisory" Physicians in Teaching Hospitals

A major and costly problem has arisen in medicare with respect to payment for the services of so-called "supervisory" physicians in teaching hospitals. Such services may involve medicare payments of $100 million or more annually.

The problem concerns charges to "institutional" (also called "service") patients in contrast to bona fide private patients.

The institutional patient generally does not have a private physician in the normal sense.

Private patients on the other hand generally have their own doctors who visit and treat them during the hospital stay. The private patient has chosen and in effect, contracted with his doctor, whereas the institutional patient—without a private doctor of his own—has an attending physician assigned to him by the hospital. The service patient, thus, looks to the institution for his medical care rather than to a private physician.

Serious questions have arisen with respect to payments to supervisory physicians designated as attending physicians for medicare beneficiaries—including possible fraudulent submission of claims for services never rendered.

What has occurred is that medicare offered teaching institutions and physician associations an opportunity to secure funds through billing the institutional patient as if he were a private patient. The teaching physicians, themselves, do not appear to be profiting personally from the billing to medicare of private patient fees for institutional patients.

The services to institutional patients are often actually provided by interns and residents and are paid for under the hospital insurance plan. Medicare may be paying for the same service twice when it also pays the "supervisory" physician under the medical insurance plan.

Prior to medicare, few Blue Shield plans or commercial health insurers paid on a fee-for-service basis for supervisory services rendered by teaching physicians in teaching hospitals. Relatively few teaching institutions even attempted to bill for such services—it was not "customary" nor did it "prevail."

The basis for reimbursement of supervisory physicians under medicare was established by the Bureau of Health Insurance upon recommendations of an advisory group it appointed whose membership consisted solely of those who might benefit from those recommendations.

The staff questions whether the medicare beneficiary is under any legal obligation to pay for such services and, as noted, found little precedent prior to medicare for submission of charges for "supervisory" physicians.

We believe the practice is wrong and must be stopped. While medical schools and teaching hospitals are undoubtedly in need of additional sources of funds, the staff does not believe that millions of older people should be required to subsidize medical education through their part B premiums. The proper approach to additional financing of medical education is through the appropriations process where needs can be established, justified, and met on the basis of specific requirements of specific institutions.

7. Large Payments to Health Care Practitioners

The Appropriations Committee of the Senate annually secures and publishes a listing of those to whom payments aggregating $5,000 or more, are made by the Department of Agriculture. Additionally, where crop support and other Agriculture Department payments aggregate $600 or more, these amounts are routinely reported to the Internal Revenue Service.

Against that background, the staff requested the Department of Health, Education, and Welfare to prepare separate listings of health care practitioners paid $25,000 or more, directly or indirectly by either medicare or medicaid in 1968.

The incomplete and partial listings indicated that at least 4,300 individual practitioners plus an additional 900 physician groups each received at least $25,000 from medicare in 1968. The solo practitioners included at least 68 who were known to have received $100,000 or more.

Following receipt of the names of physicians paid $25,000 or more under medicaid, the Bureau of Health Insurance was requested to supply the amounts, if any, also paid those same physicians by medicare. (That was done because a physician who received $100,000 from medicaid might have received less than $25,000 from medicare and would not, therefore, have appeared on the medicare listings.)

The combined listings—by amounts paid and type of practice—appear in appendix B, p. 163. The data—which the staff emphasizes is partial and incomplete—reveal that both programs are reimbursing many physicians many thousands of dollars each.

Hundreds of the payments profiles indicate that the physicians involved might be abusing the program. For example, we found many general practitioners each paid $15,000, $20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases, we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, medicare's payments structure did little to discourage—in fact it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians.

In sum, it appears absolutely necessary that each carrier under medicare and each State's medicaid administrator be required to regularly compile and evaluate basic payments profile information with respect to each health care practitioner. The questionnaire developed by the staff undobutedly can be modified and improved into a more effective screening device. Nonetheless, the kinds of data requested in the staff's rather elementary questionnaire are those which tend to indicate patterns of overutilization and overcharging.

Shortcomings exist with respect to the present capacity of the Government and its agent-carriers to undertake complete and professional evaluation and followup on their own of the specific data gathered on thousands of health care practitioners who were paid large sums under medicare and medicaid. It might be

appropriate, therefore, to consult with and enlist the support of all professional organizations concerned which might be helpful in evaluation and follow-up programs. However, procedures which involve peer review by professional associations should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token.

The staff would also suggest that each State be routinely and regularly provided medicare payments profile data with respect to physicians practicing in that State. Such information would enhance the State's utilization and cost control capacity in its medicaid program inasmuch as many physicians serving medicare beneficiaries also care for medicaid recipients.

8. Incentive Reimbursement Methods for Hospitals, Extended Care Facilities and Physicians Under Medicare

With a view toward spurring increased efficiency and economy in the medicare programs, the staff is working to perfect an incentive reimbursement system. We believe that effective incentives to improved performance will result if better-than-average performance in rewarded with a money payment—the better the cost control the larger the payment. This premise parallels (if it is not the same as) that underlying the competitive enterprise system—better performance and efficiency of operation yields higher returns.

We believe also that to be workable an incentive reimbursement system must recognize the role of the physician as the key to controlling major portions of health care costs. It is the physician who determines whether a patient is to be hospitalized or placed in an extended care facility. It is the physician who determines the patient's length of stay in a health care institution or a hospital. It is the physician who orders the endless variety of costly services—such as X-rays, laboratory services, and drugs—which are provided to the hospitalized patient.

The theory on which our work is progressing involves a sharing with the providers of health care of a portion of the savings to the medicare program growing out of their increased efficiency and greater control over utilization in the future as compared to the first 3 years of operation of medicare.

We also believe that to be effective, an incentive must include a disincentive to continued poor performance.

It is our hope that our recommendation for an incentive reimbursement system can be submitted to the committee at an early date, and that it will stimulate the public discussion and consideration which must precede serious legislative action on so important and sensitive a matter.

9. Certification of Extended Care Facilities

With the inclusion of posthospital extended care benefits under medicare, the Congress introduced a new concept into the hospital insurance program; an alternative, less costly institutional setting for the provision of medical care. The benefit was intended to encompass an "extension" of hospital care—care which in the absence of an extended care setting might otherwise have to be provided in the hospital. Extended care was not a term denoting duration—but rather a type of care somewhat less intensive and comprehensive than that ordinarily provided the acutely ill patient in the hospital. It was a type of care not ordinarily provided by nursing homes.

Congress intended that extended care facilities meet requirements designed for convalescent and rehabilitative care of high quality. The "conditions of participation"—requirements to be met by a facility in order to qualify—were drafted by the Department of Health, Education, and Welfare on a basis consistent with the congressional intent.

Despite the high standards, in the actual process of certifying facilities, nursing homes have not been required to fully meet the conditions of participation. Rather, in applying these standards, all that has been required is "substantial compliance" and progress toward full compliance. Some facilities were certified as in "substantial compliance" which could not, by any reasonable criteria, be considered to be without serious deficiencies.

With respect to this problem, the staff recommends that certification of facilities with deficiencies—other than those of an insignificant and minor nature—be prohibited.

The statute permits a "distinct part" of an institution rather than the entirety to be certified as an extended care facility, so as to encompass hospital wings or distinct infirmary sections with a high level of care in nursing homes. But the provision has been used in another way.

About 800 nursing homes have had a portion of their institution certified as an ECF. The vast majority of these are not in full compliance with the standards. At present, there need be no physical separation of beds or appropriate accounting separation of costs and it is difficult to determine which personnel work where. This enables homes to increase or decrease the number of beds designated as "extended care" so as to maximize medicare reimbursement. Surplus or unoccupied beds tend to be arbitrarily designated as "extended care" beds with resultant excess apportionment of costs to medicare.

The Secretary of Health, Education, and Welfare called attention to this problem in his Second Annual Report on medicare. To our knowledge no action has, however, been taken to date to remedy the situation.

The staff suggests that administration of the "distinct part" provision be modified to encompass only a physically and clearly distinct section of a practical size operated as a department with a separate nursing station. Further, clear accounting distinctions should be made for the "distinct part" and a reasonable vacant bed limitation applied which is not higher than the unoccupied bed ratio in the nonmedicare portion of the facility.

10. Medicaid Skilled Nursing Home-Intermediate Care Facility Relationship

In a major effort to control rapidly rising skilled nursing home costs under medicaid, the Committee on Finance approved an amendment to the Social Security Act in 1967 to pay for care in an institution providing "services beyond room and board but below the level of skilled nursing homes." Such facilities were to serve as a lower-cost alternative to more expensive skilled nursing home or hospital care.

The service was intended according to the statute for those who: "* * * because of their physical or mental condition (or both) require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities: and do not have such illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide."

The committee report stated that the care to be appropriate to the needs of the individual and that regular independent professional audit was to be made of his needs to assure that he was properly placed.

The congressional intent is not being fulfilled. Nursing homes have been reclassified as intermediate care facilities on a wholesale basis where they cannot or will not meet the standards required for participation as skilled nursing homes under medicaid. This approach appears designed more as an accommodation of substandard institutions than to encourage development of reduced levels of care appropriate to the needs of persons capable of being transferred from skilled nursing homes and mental hospitals.

Perhaps of greater importance is that the independent professional or medical audit—required in the case of skilled nursing home patients—is often not rendered in the case of each patient to determine that *his* needs would best be served in that particular intermediate care facility.

Quite simply, contrary to the letter and intent of the law, facilities and patients are classfied as "intermediate" care on a wholesale basis. Furthermore, in several States, including Massachusetts, Rhode Island, and Ohio, many intermediate care facilities are being paid for care at rates greater than those paid to many skilled nursing homes participating in medicaid in the same areas. Again, this is expressly contrary to the congressional intent that intermediate care was to be a less costly alternative to skilled nursing home care. It is certainly inconsistent to pay more for services in a facility which by law is an institution in which a lower level of care is provided, than in an institution which, also by law, requires a higher level of care.

The staff recommends that appropriate legislative action or administrative action by the Department of Health, Education, and Welfare be taken to prohibit payments to intermediate care facilities at the same or greater rates than those made to skilled nursing homes in an area. The Department should also be requested to assure that States do not ignore the statute and congressional intent with respect to independent medical or professional determinations that the needs of a particular person can best be met in an intermediate care facility.

11. Institutional Utilization Review Mechanisms

One of the important provisions which Congress included in the original medicare law as a control and safeguard on unnecessary and excessive usage of institutional care was the requirement that each participating hospital and extended care facility have a utilization review plan.

The detailed information which the staff has collected and developed indicates clearly that the utilization review requirements have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. One State medical society described the present situation in these words: "Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token."

Widespread failure to effectively apply utilization review results from several factors:

1. The regulations which have been issued on institutional utilization review requirements are not in accordance with the terms and intent of the statute.
2. Certification of hospitals and extended care facilities for participation in the program have been continued by the State health agencies and the Department of Health, Education, and Welfare despite the fact that basic statutory requirements have not been met by those institutions.
3. Many intermediaries under the program have either ignored or been negligent in assuring that institutions have functioning and effective utilization review mechanisms.
4. The Social Security Administration has made little effort to verify that contracting agents—State health agencies and intermediaries—carry out the terms of their contracts on this point.

In addition to improving administration of the present institutional utilization review requirements, certain legislative changes might be considered which could further improve the review process. Some possible changes are:

1. Where feasible, have the physician positions on a utilization review committee for a particular hospital filled by physicians associated with another hospital.
2. Require that utilization review plans for extended care facilities be organized outside the institution, either through a hospital affiliation, the local medical society, or the local health departments.
3. By appropriate Federal and State legislation, exempt health care practitioners from legal liability for decisions made during required utilization review or medical audit activity.
4. Require intermediaries to employ and apply local, regional, and possibly national utilization criteria in evaluating the provision of institutional services.
5. Offer homemaker benefits, on a demonstration basis initially, as an alternative to more costly institutional care. The homemaker benefits, while chargeable as a home health benefit, would be distinct from the services presently available from home health agencies.

12. Medicare Fiscal Intermediaries

Under the law, groups or associations of providers of services—hospitals, extended care facilities, and home health agencies—can nominate an organization to act as "fiscal intermediary" between them and the Government.

The Department of Health, Education, and Welfare may not enter into an agreement with any intermediary unless the Secretary finds that use of the intermediary is consistent with "effective and sufficient administration" and the intermediary is able and willing to assist providers in the application of safeguards against unnecessary utilization of services.

Most nonprofit community hospitals nominated the Blue Cross Association as intermediary through their membership in the American Hospital Association. Somewhat more than one-half of the extended care facilities also nominated Blue Cross as intermediary.

A number of serious problems and issues related to intermediary nomination and performance have come to the attention of the staff.

1. Inasmuch as providers select the intermediary, some intermediaries have been reluctant to apply positive administrative requirements with respect to costs and utilization review for fear of losing the providers' nomination. Other

intermediaries have apparently solicited providers with implicit promises of preferential treatment. Some intermediaries also sell insurance to the providers they serve—creating an implicit conflict of interest situation.

In this regard, the staff concludes that the original purpose of the provision for provider nomination of intermediaries has been largely served. With the maturation of medicare consideration should be given, in order to avoid the types of problems discussed above, to authorizing the Secretary of Health, Education, and Welfare to designate intermediaries under part A as he now selects carriers under part B.

2. The Blue Cross Association is the prime contractor as intermediary with the Bureau of Health Insurance. The association seeks to coordinate the activities of the many local Blue Cross plans who actually function as intermediaries. The system which the association has established has been criticized as often constituting an additional, costly, and duplicative layer of administration. The administrative capacity of individual Blue Cross plans ranges widely—yet the Bureau of Health Insurance has so far taken the good plans with the poor ones under this all-or-none prime contract arrangement with the Blue Cross Association.

The Bureau of Health Insurance should in any subsequent contracts with the Blue Cross Association reserve and exercise the right to select as local intermediaries only those Blue Cross plans which are capable of proper and efficient performance. Social Security regional offices should also have authority to deal directly with local Blue Cross plans on medicare matters without the necessity of routing all but the most nominal inquiries through the offices of the Blue Cross Association.

3. Intermediary performance varies widely with respect to processing time on medicare bills, the proportion of bills returned from Social Security to intermediaries because of errors, the proportion of bills pending for long periods of time and administrative costs.

The performance of some intermediaries appears so much below average that serious consideration of replacement by a better performing intermediary seems called for. That process would be facilitated if the intermediary nominating procedure was modified as the staff suggests.

13. Medicare Carriers

Medicare carriers are selected by the Secretary of HEW to process and make payment for part B claims and to serve as a channel of communication between the Bureau of Health Insurance and those furnishing services covered under the Supplementary Medical Insurance Plan.

Carrier performance under medicare has in the majority of instances been erratic, inefficient, costly and inconsistent with congressional intent. The Bureau of Health Insurance has taken little action to weed out and terminate the inefficient carrier. Extensive comparative data collected for the staff clearly indicates wide variation and frequent low levels of performance.

Unquestionably many millions of dollars of public funds have gone to subsidize carrier inefficiency. Some of this expense was unavoidable but much of it could, the staff believes, have been avoided through alert, aware, and prompt action by the Social Security Administration. While millions of dollars invested in inefficient carriers, thus far, would be lost through termination, the staff believes that the Government (and the older citizens who pay half of those costs) would gain far more in the long run by replacing them now. What appears needed are fewer carriers and a benefits and administrative structure lending itself to genuine competition for appointment to the job of medicare agent.

A number of Blue Shield plans initially refused to comply with that part of the instruction by social security to identify, by name, physicians who had been paid $25,000 or more by medicare in 1968. Most of the plans which declined to provide the information requested said that they had not been "authorized to do so by the physicians involved."

Clearly, the issue raised did not involve "authorization" by physicians. The staff could find no provisions in law, regulation or carrier contracts which provided that identification would not be made to the Federal Government except with express physician "authorization."

The underlying concern of those Blue Shield plans which resisted providing names is understandable. Blue Shield works with and depends upon the goodwill of physicians for much of the success it enjoys in its regular day-to-day business

where in most instances it actually contracts with individual doctors. In medicare, however, the contract is with the United States Government. The Government's obligation is to undertake such procedures as will assist in assuring its citizens—particularly the millions of elderly who pay premiums—that their money is being properly expended.

The Government is "trustee" of the part B trust fund. The staff stresses that its concern is with the basic issue of public accountability—not with any advocacy of publication of the names of individual physicians and the amounts paid them. As we previously suggested in item 7, the staff believes identification by name of physicians receiving large payments is vital to any serious effort at cost and utilization control.

14. The Quality of Administration of Medicare

A number of areas of administrative laxity by Social Security in implementing, operating, and supervising medicare have been previously noted. Other areas where improvement in performance seems necessary are in the quality of information supplied to and requested of carriers and intermediaries as well as in present program evaluation and research activities.

In response to staff questionnaires, carriers, and intermediaries frequently indicated their belief that Bureau of Health Insurance instructions were not issued in timely fashion, were often too voluminous and detailed, and not written in clear and concise fashion with appropriate examples. Those comments (unidentified as to source) have been turned over to the Social Security Administration for their use in improving their instructions. The staff, on the other hand, is not unaware that some of the carrier and intermediary criticism may have been self-serving and intended to gloss over their own poor performance.

One of the more important elements in appraising administrative performance is the quality of the research and program evaluation effort. One of the most important uses of program statistical data—sound cost estimating—deserves mention because some 3½ years after the start of medicare, they are still based on incomplete program experience and only utilization estimates are based upon any substantial program data. Principle causes of the delay in securing data arise from the fact that so few hospital accounting periods have been finally settled, and from an ineffective and cumbersome health insurance research effort.

The staff concludes that the present health insurance research and program evaluation effort needs to be substantially revised. In this connection the following suggestions are made:

1. Health insurance research directly related to day-to-day evaluation of program administration should be given the highest priority and should be placed in the Bureau of Health Insurance as an administrative control under the authority of the Director of the Bureau of Health Insurance.
2. Program data useful for cost-estimating purposes should be given a priority only slightly lower than program evaluation data and should be designed and analyzed by the Office of the Chief Actuary.
3. Health insurance research related to the impact of the program on beneficiaries and the health industry should have the next priority and should be carried out, as now, under the direction of the Office of Research and Statistics.
4. Contractors with the program—carriers, intermediaries, and State agencies—should be relieved of as much data gathering and report making as possible consistent with the objectives of the research and should be the regular recipients of analyses of data which might be useful to improvement of their performance.

15. Medicaid Administration

There are serious and costly deficiencies in the operation, administration and supervision of the medicaid program. The typical medicaid patterns are slow payment to suppliers of health care goods and services; little effective effort to determine whether those goods or services were necessary (or even given); little or no control over recipient abuse; and, general laxity of administration. Findings of the HEW Audit Agency, reviews of State programs made by the Medical Services Administration (the HEW agency responsible for overseeing medicaid), General Accounting Office reports and those of various individual State agencies, as well as staff conferences with State legislators, administrators, and others—all underpin the negative conclusions of the staff.

The recommendations which follow may serve as the basis for committee consideration of methods of improving medicaid. Another key element, however, is essential if the program is to function as intended. While the Medical Services Administration probably requires additional personnel if effective Federal supervision is to be realized, it appears vital that any additional and present personnel—including officials—operate with a greater sense of responsibility and direct involvement than has been manifested heretofore. The Medical Services Administration needs dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as medicaid is to be soundly administered.

The staff recommends the following actions to improve the medicaid program:

1. Require usage of fee schedules for payment of health care practitioners.
2. Reduce drug costs through adoption of the type of amendment offered by Senator Russell B. Long in 1967 which was approved by the Senate but not enacted at that time.
3. Curb overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment.
4. End costly "doctor shopping" by recipients through requiring designation by the recipient of a "primary physician."
5. Facilitate reporting and detection of abuse and fraud by requiring States to provide medicaid recipients with statements outlining payments made in their behalf.
6. Modify present law so as to make practicable reasonable cost-sharing payments by the medically indigent.
7. Prohibit making of vendor payments to independent collection and discount agencies to whom providers have sold their medicaid or medicare due bills.
8. Improve Federal administration and supervision as well as establish formal and informal cooperative arrangements with and between States.
9. Establish a medicaid fraud and abuse unit in HEW.
10. Require States to maintain specific organizational units for the prevention, detection, and investigation of fraud and abuse in their health care programs.
11. Combine the Medical Assistance Advisory Council with the Health Insurance Benefits Advisory Council into a single body to facilitate coordination and communication in the two principal Federal health care financing programs.

16. Other Areas of Actual and Potential Abuse in Medicare and Medicaid

Concern has been expressed by many existing health care institutions and others over the tremendous growth in chain operation and construction of medical facilities and their acquisition of related companies.

Certainly, no case can or should be made solely because of size against an organization which limits its activity to a number (even a large number) of a single type of health care facility—such as skilled nursing homes. In such instances, where the chain operates beds which are needed in a community and without the presence of conflicts of interest, opportunities exist for significant economies and efficiency in the provision of necessary health care. The problems arise with respect to the overpromoted chains consisting of conglomerations of various types of health care facilities and services where, in the final analysis, the Government, in the main, is expected to recognize for reimbursement inflated prices paid by those chains in their eagerness to expand and demonstrate growth, presumably in order to generate demand for their stock.

Other hospitals and skilled nursing homes are being built or proposed for communities where existing facilities are adequate to serve the needs of those areas. In most instances, this construction is not subject to approval of areawide planning agencies and if prior experience is any yardstick, if a bed is available, it will be filled.

In the above instances, bona fide competition does not occur with respect to whether one facility is more efficient and economical than another. What competition does exist is for scarce health manpower and patients—both generating further upward pressure on already high costs.

In the competition for paying patients, several of the largest chains, deliberately follow a policy of selling stock to local physicians as a means of assuring that the new facility will get paying patients. Unquestionably, many physicians, who have an ownership interest in a facility, are not motivated by that interest in their treatment of patients. Nonetheless, there is always the appearance of a potential or implicit conflict-of-interest in physician ownership of a health care facility or service in which he treats his patients in terms of admissions policy, the range and frequency of services supplied, and dates of patient discharge.

There is a requirement in title 19 of the Social Security Act that States maintain a current list of owners of interests of 10 percent or more in skilled nursing homes. The staff requested those lists, and then, on a sample basis due to the massive amount of material received, cross-checked on physician-owners of nursing homes who had also received payments of $25,000 or more from medicare in 1968. A number of these physicians with financial interests in skilled nursing homes and in some cases proprietary hospitals as well showed unusual amounts and patterns of charges. In particular the frequency of visits to institutionalized patients and the aggregate amounts billed for such visits as well as for injections and laboratory services indicate an obvious need for thorough followup.

In addition to efforts to have unusually high cost bases recognized for purposes of medicare reimbursement, some chains (as well as some consulting firms who own stock in institutions for which they consult) have also sought acceptance as reimbursable costs of unusually high salary, franchise fee, percentage of gross-income, and purchases from related organization arrangements. Social Security has recently stepped up its efforts to detect and prevent abuse in those areas and that activity is certainly justified and worth while.

Another area of concern which has implications, not only for medicare and medicaid, but also for the tax collector, involves a trend toward changing the status of a proprietary health care facility to that of a "nonprofit" institution. For example, a group of physicians who own a proprietary hospital with a depreciated replacement cost of $2 million might claim a "fair market value" of $4 million (inclusion of goodwill, etc.) and sell it for that sum to a nonprofit organization which they in fact control. The purchase price is to be paid from the excess of cash flow over expenses of the hospital. Prior to the transfer of ownership, the hospital may have had average net income of $200,000 subject to ordinary tax. That $200,000 excess of income over expenses now becomes tax free and can be applied toward payment of the inflated $4 million purchase price (along with other items of cash flow such as depreciation) where, in large part, it becomes subject to capital gains tax rates rather than ordinary income rates.

A principal problem in these situations is that, under existing law, it is debatable whether the Internal Revenue Service can deny tax-exempt status to nonprofit hospitals or nursing homes engaging in transactions of this type, particularly where there is allegedly arm's-length dealing.

It is suggested that the committee consider requesting the Department of the Treasury to submit such legislative proposals or other recommendations as may be deemed necessary to avoid abuse of tax-exempt status and capital gains treatment in the sale or exchange of health care facilities. Particularly, the Treasury should suggest means of valuing such facilities which do not possess manipulative potential.

With respect to asset valuations for purposes of reimbursement under medicare and medicaid, the staff has recommended earlier in this report that "goodwill" not be recognized as an element of cost where a transfer of ownership occurs. Further, depreciation expense should be recognized only on the same basis as in the tax laws—straight-line historical cost.

17. Reporting of Medical Payments to Tax Collector

Until very recently, insurance companies (including those participating in medicare), many Blue Cross-Blue Shield organizations, State agencies participating in the medicaid program, and employers and unions having self-insured or self-administered health plans did not file information returns with the Internal Revenue Service when they made payments to (or with respect to) doctors, dentists, and other suppliers of medical and health care services and goods on behalf of individuals.

On November 13, 1969, largely in response to views previously expressed during hearings before the Committee on Finance (Hearings on Medicare and Medicaid, July 1 and 2, 1969), the Internal Revenue Service revoked its prior policy and announced that henceforth information returns would be required with respect to payments aggregating $600 or more made to a doctor or other provider. Payments made to corporations (including professional service corporations set up by doctors for tax purposes) were specifically excepted from this reporting requirement.

No doubt this change in attitude by the Internal Revenue Service and the publication of its new position requiring information returns with respect to medical payments made to doctors and other providers prompted the conferees on the Tax

Reform Act to omit a Senate amendment added to the bill by the Committee on Finance before the Service position was reversed. This Senate amendment called for detailed reporting of medical payments, including payments made to an insured person, either in reimbursement for payments he had made to a doctor or other provider, or with respect to services performed by the doctor or other provider.

The staff believes the present requirements of the Internal Revenue Service leave much to be desired. As already noted, they do not cover payments made to corporations. Nor do they cover the so-called indirect payments—those payments made to the insured who receives the amount, either as reimbursement for payment he has already made, or who presumably will use the proceeds in settlement of an unpaid bill. The staff views this shortcoming of the present reporting requirement as a substantial defect which can lead to massive shifts in billing practices by doctors and other providers of health care services seeking to avoid having their payments reported to the tax collector. Such a shift could also have serious implications with respect to the patient who may be unable to pay his doctor first and then seek reimbursement under his health insurance policy.

Another important defect in the new reporting requirements concerns the inability of the Internal Revenue Service to require the payer to furnish the doctor or other provider of medical services, goods, or supplies with a copy of the information return or similar statement. We believe it is important that the doctor or other provider be informed of the amount reported to the Internal Revenue Service as having been paid with respect to services he rendered or goods and supplies he furnished.

Yet another defect in the new reporting requirements is their failure to impose a reporting responsibility upon payees acting as conduits and who, in fact, merely transfer the insurance proceeds to the taxpayer actually rendering the services. For example, many clinics or associations of doctors may designate a single doctor to receive payment for services rendered by all the doctors in the clinic or association. The same could be true of doctors who join together in a professional service corporation for the practice of medicine. The staff believes the information required under the new Internal Revenue Service requirement will not be very useful as an enforcement device because IRS cannot know which doctor received what portion of a consolidated group payment.

Unfortunately, these defects largely reflect shortcomings in the statue itself, and few if any of them can be corrected by further administrative action.

Probably the most serious shortcoming of the present reporting requirement, however, concerns whether it is supported by the present law. The applicable statute (section 6041 of the Internal Revenue Code) requires "all persons engaged in a trade or business and making payments in the course of such trade or business" to render a true and accurate return reporting payments to another person aggregating $600 or more during the year. It has been argued that payments paid by an insurance company to or on behalf of a private citizen for health care goods and services are not encompassed by this language. Rather it is argued that the insurance company, in such cases, merely acts as the agent of the private citizen. And, pursuing the analogy, since the private citizen is not required to report payments he makes to his doctor for services rendered to him, neither is the insurance company.

The Internal Revenue Service position with respect to this question is stated as follows in the Revenue Ruling announcing the new reporting requirement:

> Payments of fees under the plans, programs, or policies here considered to doctors or other suppliers of health care services are made in the course of the trade or business of the persons making the payment. Accordingly, it is held that such persons are required to file forms 1099 with respect to such payments made directly to doctors or other suppliers. (Revenue Ruling 69–595—Nov. 13, 1969.)

The staff has already observed that the new reporting requirement fails to require reports of indirect payments (those made to a private person to be repaid, to a doctor or other provider). At this point we express the fear that the controversy described in the two immediately preceding paragraphs could develop into litigation which might place the validity of the present reporting requirement in doubt for years to come.

With payer of dividends and interest now required to report payments to a person aggregating $10 or more during the year (with additional statements required of nominees identifying the principal to whom they repaid the amounts)

the present reporting requirements with respect to medical payments seems particularly inadequate. In the opinion of the staff the committee should consider again the sort of comprehensive amendment it added to the Tax Reform Act. That amendment corrects and overcomes the defects in the new administrative reporting requirement and would provide the Internal Revenue Service with information vastly more useful to it in enforcing the tax laws of the Nation.

ITEM 2. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS OF THE SENATE FINANCE COMMITTEE STAFF RECOMMENDATIONS FOR CHANGES IN MEDICARE AND MEDICAID

In this document the Department of Health, Education, and Welfare presents general comments on the major recommendations made by the Staff in its Report, *Medicare and Medicaid, Problems, Issues and Alternatives.*

REIMBURSEMENT OF INSTITUTIONS PROVIDING MEDICAL CARE

The Staff suggests changing the law so as to limit Medicare reimbursement to an institution's customary charges to the general public (as in S. 1195) when such charges are less than cost.

We agree. This proposal is similar to one of the proposals in the Administration's cost effectiveness amendments submitted last July. There are a few situations in which heavily endowed institutions actually charge the general public considerably less than their cost and in such circumstances we believe that the Government should not pay full cost but should limit reimbursement to charges.

The Staff suggests that depreciation and interest on loans not be allowed in the case of major expenditures where the expenditure was specifically disapproved by the appropriate planning agency (as provided in S. 1195).

We agree. This recommendation for a change in the law is the same as one of the Administration's cost effectiveness proposals submitted last July. This is approximately the same provision that passed in the Senate in the 1967 amendments but was dropped in conference.

We believe that this change in law is necessary to support the planning efforts of States and localities where under present law reimbursement of cost may on occasion undermine such efforts.

The Staff suggests that except in unusual situations the law should be changed to limit Medicare recognition of increases in hospital costs in any area of the country to the annual percentage increase in the Medical Care Price Index for that geographic or metropolitan area (as provided in S. 1195).

We believe that a much more fundamental change is needed in the law so that the reimbursement of institutions can be shifted from retroactive reimbursement on a cost basis to an incentive formula based upon a target rate for the coming year. Under this new approach institutions would share in savings they make as a result of more economical and effective management. In designing such prospective rates one would naturally consider the past actual cost of the institution as well as what could be expected in the way of medical care price increases in general in that particular geographic or metropolitan area. However, we do not believe than any method of payment based on cost reimbursement limited by a price index would enlist fully the ingenuity of institutional managers and policy-makers toward more effective and efficient management. As long as they stay under the average increases as reflected by the Medical Care Price Index, further improvement in operations would merely reduce their reimbursement. We believe they need an economic incentive providing that reductions in cost will result in greater income to the institutions. It should be noted that the Staff report also indicates that the Staff is searching for an incentive system for institutional reimbursement such as we are proposing.

The Staff also suggests that payment for care provided in one institution be limited to not more than a reasonable difference above cost for comparable care and services in a similar but less expensive institution in the same area. This would be an important factor to consider in setting prospective rates and we would agree that such additional legislative authority would be desirable under the present retroactive cost provisions.

To encourage prompt final settlement of accounts with institutions the Staff recommends that blame be assessed for delay and that institutions be charged interest where the delay is their fault and the Government pay interest if it is determined that the delay is the Government's fault.

The process of reimbursement involves paying the institution currently on an estimated basis, the submission of cost reports at the end of an accounting period by the institution to its intermediatry (a private insurance company or Blue Cross), a desk review of the cost report by the intermediary with tentative adjustments from the previous reimbursement based on the interim rate, and finally, adjustment if necessary based upon actual audit performed by the intermediary.

Under present policy, if an institution fails to submit its cost report more than 90 days after the close of its accounting period (for good cause 30 days more may be granted), its interim payment is reduced by 20 percent. This has been an effective device for speeding up the submission of the cost reports which can then be reviewed by the intermediaries and tentative adjustments made. Overall differences between the reimbursement figures following the review of the cost reports and final settlements based upon formal audit are not large.

Frequently the delay in the final settlement is the result of an appeal by the institution of a relatively small item of difference on which the institution disagrees with the auditors. Assessing blame in these situations would seem to be a nearly impossible and a complicating part of the process and perhaps one which would undermine the right of the institution to question an audit. We believe that this process has been substantially improved and that the suggestion of the Staff would not lead to additional improvement but, on the contrary, would create problems.

We are currently experimenting with the possibility of using audits provided by the institutions rather than requiring separate audits by the intermediaries. This procedure will result in quicker action in some instances. As the Staff Report suggests we are developing common cost reports with other programs to avoid duplicate work on the part of the provider.

The Staff suggests that where approved capital needs cannot otherwise be met the existing reimbursement formula might be modified to allow capital assets to be depreciated in one-half the time ordinarily accepted where the expenditure can be expected to contribute substantially to efficiency.

We will give further study to the practicality of this suggestion. At the present time we have issued notice of a regulation change (asking for comment from interested parties) which would remove in all cases the opportunity to take accelerated depreciation. Our action in this respect was prompted by some of the same considerations which led the staff in other parts of the Report to show concern about the effect of accelerated depreciation on reimbursement practices and to recommend that the opportunity for accelerated depreciation be removed. However, if accelerated depreciation could be retained in limited circumstances it might be desirable to do so. The reservation that we have on the specific suggestion of the staff is the difficulty of making the kind of determination they propose that the expenditure would "substantially contribute to efficiency," since the expenditure may be part of a large total of many capital expenditures adding to the services of the institution. For example, the proposal might mean that any new construction that included labor saving elements would be subject in some part to accelerated depreciation. Another possibility for granting accelerated depreciation is that this advantage might be tied to approval by a planning agency.

The Staff suggests that the intent of the law be clarified by the Congress as to whether Medicaid should follow the same hospital reimbursement formula as Medicare.

We agree. Since present law requires in the same statute that both programs reimburse hospitals for the cost of providing services to the beneficiaries of the respective programs, we have thought the words of the statute ought to be given the same meaning in each program. If any change is made, it should be kept in mind that if States are allowed to define "reasonable costs" within only general guidelines established by the Federal Government, the result in many instances will be that the reimbursement for Medicaid patients would be less than cost. A case can be made for different treatment between the two programs because of the tradition of medical care being furnished at less than cost to people who meet a test of need as in the Medicaid program or to allow for experiments by States with a variety of approaches. If differences are alowed, but within regulated limits, some approaches could be barred by regulations should they turn out to have unsatisfactory results. However, in considering this issue one needs to recognize that most hospitals would have to shift cost to other patients if

the Medicaid programs are going to pay less than cost for their patients. With Medicare paying only cost for its own patients and Medicaid paying less than cost for its patients, the result could well be a considerable escalation in charges to people protected by private commercial insurance and Blue Cross as well as to those patients who pay their own way.

The Staff proposes that Medicare reimbursement have an overriding limitation related to the proportion of average actual Medicare occupancy to total beds available in the institution.

Intermediaries are required to eliminate from cost determinations any excess of nursing or staffing costs that arises from having standby personnel greater than are needed to take care of patients on hand. Moreover, interim rates are not permitted to exceed published charges.

We believe that our proposal in the Health Cost Effectiveness Amendments that would limit reimbursement to published charges when lower than cost (and would thus govern the final settlements as well as the interim rates) together with a continuation of the present instruction would largely take care of the problem of excessive reimbursement for standby costs. The adoption of our broader proposal to provide authority to reimburse on the basis of a prospective rate would remedy the situation.

In any event, the situation pointed out in the Staff Report occurs infrequently and usually in connection with new institutions starting up. In our opinion the kind of limitation suggested by the Staff would be a considerable complication in the reimbursement process.

The Staff recommends that more refined accounting methods be used to eliminate the possibility that Medicare is paying part of the collection costs of non-Medicare bad debts.

Hospitals are required to attempt to collect Medicare bad debts. The collection process is generally only one part of the cost of total "front office administration" of a hospital that involves many other types of administrative and recordkeeping activities applying to all patients. At present costs are apportioned among departments before allocating costs between Medicare and non-Medicare patients. The distribution between Medicare and non-Medicare patients of general administrative costs occurs as part of the distribution of costs of routine and ancillary patient services to which the administrative costs are allocated.

It would greatly complicate hospital recordkeeping to apportion subactivities in administration between Medicare and non-Medicare and possibly make similar distinctions for other nonincome producing departments. Doing this would require statistics related to degree of use by Medicare patients. Charges provide a basis for allocation only in income producing departments. The question, then, is whether the degree of refinement and recordkeeping required to make additional cost allocations would constitute accounting "overkill" or, in fact, be worth the additional cost and burden to the hospitals and to the auditing system. We are giving the matter further attention.

The Staff suggests that appraisal procedures when facilities change hands should be tightened, and that depreciation should be allowable only on a straight-line basis as is now the case under the tax law.

As intermediaries and their auditors have gotten more experience, they have become more skilled at identifying cost reports that claim excessive reimbursement based on attempts to establish unreasonably high asset values.

As indicated in our earlier comments, a notice of changed regulations, with opportunity for comment, has been issued to deal with several matters related to depreciation and the fixing of asset values, involving particularly profit-making health facilities which are involved in changes in ownership.

Specifically, the revised regulations would: (a) eliminate the use of accelerated methods of depreciation except with respect to assets currently being depreciated on that basis; (b) extend present provisions under which gains or losses on sales of depreciable assets are taken into account in determining provider costs to apply to sales that take place within a year after a provider terminates participation in the program, and (c) provide for recovery of any amount paid toward depreciation of provider assets in excess of what would have been paid on a straight-line basis when a provider terminates or substantially reduces participation on the program.

Under present regulations, the fair market value—that is, the price that would be set in bona fide bargaining between well-informed buyers and sellers at the time of acquisition—provides the upper limit for valuing depreciable assets in

the hands of a new owner. Procedurally, it has been difficult in the case of some transfers to assure that the value placed on depreciable assets did not improperly include elements of goodwill. The fair market concept also provides the upper limit for valuing the other assets—including land and goodwill—that form the base for the return on equity capital to be allowed the new owner, and the base for determining whether loans to finance acquisition give rise to allowable interest. This limit was set in expectation that the fair market value of facilities would be a reasonable valuation of the assets of the facility. We have had, however, a number of cases where it was questionable whether the nominal price paid for depreciable assets or the facility as a whole reflected a reasonable valuation of its assets. The price paid sometimes includes securities—stocks, bonds—in addition to cash. It seems clear that amounts paid for health care facilities and assets in excess of reproduction costs cannot be considered a cost that is necessary for the delivery of services. Hence, the regulations would limit the cost basis recognized in determining the allowable amount of depreciation to the lower of the fair market value of the depreciable assets at the time of purchase or the current reproduction cost of such assets depreciated in accordance with the age of the assets at the date of the sale using straight-line depreciation.

Also, the revisions in the regulations would exclude from equity capital and the base on which interest may be allowed, amounts paid for facilities in excess of the value of the tangible assets determined under the limits applicable to the depreciable assets. This would generally prevent amounts paid for "goodwill" from being recognized in determining the return on equity capital and allowable interest.

PAYMENTS FOR PHYSICIANS' SERVICES

The Staff believes that the present statute should have been interpreted to mean that Medicare reimbursement for physician fees be limited to what a Blue Shield plan pays under its own most widely held contract (or even the average payments actually made under all the plan's basic contracts) regardless of whether the Blue Shield schedules anticipate that a substantial portion of the physicians' fees be paid directly by the subscriber. The Staff has a very fundamental proposal for change (see section following this) but in the meantime it offers as a stopgap measure the recommendation that all Blue Shield plans serving as Medicare carriers be required to limit the physician's charge recognized as "reasonable" to not more than the average payment actually paid for a given service or procedure under all of its basic surgical-medical subscriber contracts.

We disagree with the idea that present law can be interpreted as the Staff suggests it could. We do not believe that it was the intent of Congress that a reimbursement policy be developed that would require Medicare patients typically to pay their physicians substantial amounts in excess of the deductible and coinsurance. An analysis of one example which the Staff has used in illustrating this issue makes the result quite clear. In the most widely held Blue Shield plan in Alabama a payment for a cataract operation was limited to $75. However, there was no agreement by participating physicians to limit charges to $75 even for the lowest income subscribers of the Blue Shield plan. The physicians were generally expected to charge more. In practice, customary fees of physicians for this operation in Alabama are around $350. If the allowable charge under Medicare were limited to the fee allowed under the most widely held Alabama plan, physicians would on the average have submitted bills to their patients for $350 and Medicare would have paid, after the deductible, 80 percent of $75, or $60, and the patient would have had to pay the balance of $290. Thus, the beneficiary would have had less than 20 percent of his bill paid by Medicare and could hardly be expected to accept that result as fair or equitable.

On the other hand, in North Dakota where the most widely held Blue Shield plan is based on reimbursement of what physicians customarily charge, Medicare could have paid a full 80 percent of the maximum allowance of $375. Yet the older people in both Alabama and North Dakota would have each been paying the same $4 for their protection.

Under the Staff's "stopgap" recommendation it is stated that if, for example, Blue Shield in Massachusetts under all of its basic medical-surgical contracts actually paid an average of $250 for removal of cataract during 1968, Medicare would not recognize charges above $250 as reasonable for purposes of reimbursement. This proposal, too, could leave beneficiaries with substantial, additional liabilities to physicians in excess of the deductible and coinsurance although un-

der this approach the gap would not usually be as great as in the Alabama illustration. Many Blue Shield basic medical-surgical plans are significantly below prevailing fees and Blue Shield plans that offer programs for group coverage in competition with prevailing fee plans generally provide a supplementary type of "major medical coverage." The problem about wide variation also remains. Thus, the Staff's "stopgap" measure involves the same basic objections though to a lesser degree.

It should be noted also that for another compelling reason the Staff recommendation could not be taken literally. If the cognizable charge for physicians' services for purposes of reimbursement under Medicare were not to exceed carrier payments actually made, as stated, the Medicare payment would be a reduced amount less than the average payment of the carrier for the reason that after the allowable charge has been determined the Medicare payment represents only 80 percent of the charge after the annual deductible has been taken into account. Such a result clearly would not be contemplated by the Congress. For the same reason, we do not think the Staff's construction of section 1842(b)(3)(B) of the Social Security Act can be sustained. This provision requires that the Medicare charge shall be both reasonable and also ". . . not higher than the *charge* applicable for a comparable service and under comparable circumstances to the policyholders and subscribers of the carrier . . ." (italic supplied). The statute does not set up as the test of Medicare's reasonable payment the schedule or other *payment* made by the carrier in its own business. It sets up the *charge* applicable, which is the charge which the physician would actually make to his patients irrespective of what the carrier's liability might be.

Since this short-run recommendation applies only to States in which a Blue Shield plan is a carrier for Medicare, the same anomalous results would not only occur on an inter-plan basis, but more particularly between those States in which Blue Shield is the carrier and those States having commercial carriers. There would not be a uniform national policy offering Medicare beneficiaries wherever they live approximately the same treatment in relation to their liabilities for medical costs and the premium they have paid.

Not only do we feel that the results of the Staff interpretation would have been unreasonable but we do not believe that such an interpretation would have resulted in significant control over the cost of Medicare, at least for very long. If Medicare ceilings were tied to Blue Shield rates, there would have been considerable added pressure for Blue Shield plans to raise their rates substantially.

But even if such an approach could be considered desirable, our reading of the legislative history would not allow it. We believe it is clear from the law and from the legislative history that reasonable charges under Medicare were not to be limited to amounts paid by private insurers under their own plans when such payments were unrelated to the total liability of the patient and, on the contrary, were only in partial indemnity for what the patient would have to pay. Such plans are not comparable to the Medicare program, which was, generally speaking, designed, except for deductibles and coinsurance, to relieve patients of what they would otherwise have had to pay the physician.

Contrary to what the Staff Report indicates, we have required the carriers to use the charges they recognize as a basis of what they pay in their own business as a limitation on what they can pay under Medicare when circumstances are comparable. For example, most of the commercial companies in their own business set up a prevailing rate which results in the reduction of reimbursement of physicians' fees that exceed these prevailing levels. They are instructed to make sure that the prevailing levels in Medicare do not exceed the prevailing levels which they have established for their own business. Similarly, in Blue Shield plans, which are increasingly following the same approach, the same limitation is imposed and even in the fee-schedule approach of some Blue Shield plans when the schedules do in fact widely establish the upper limit of patient liability for payment, as in the Rochester plan, the fee schedules have been used as a limitation on allowable charges in Medicare.

We agree that controls are needed over the recognition by Medicare of increases in physicians' fees. During fiscal year 1969, the program recognized only a 3 percent increase in the general level of physicians' fees although nationwide the actual increases in physician fees were between 6 and 7 percent. At the present time, about 30 percent of all requests for payment of physician and supplier bills submitted under Medicare are reduced before payment, with a savings to the program of $155 million a year. However, we believe that it is very important

that what the program is willing to reimburse not be allowed to get too far out of line with what physicians are customarily charging, for the clear result would be a shift of program cost to the patient who would more frequently be charged the difference between the customary charge and the allowed charge. We are, therefore, watching very closely the rate of assignments under Medicare as we continue to apply a policy of limited recognition of fee increases.

Our present approach is what might be called a slowdown in the recognition of fee increases.

For the long run, we believe that it would be desirable for the law to be changed so that Medicare recognition of fee increases from year to year would be limited to an index made up of appropriate elements of wage and price indices. This would give us a much firmer base for control of fee escalation.

The Staff recommends a change in the law to provide for reimbursement for physicians' fees on the basis of a fee schedule which would limit payment to the amount estimated by regional advisory boards to be supportable by a $4 premium paid by the beneficiary and matched by the Government.

We do not agree. It is possible that at some time in the future it may be necessary to consider a fee schedule approach. However, any fee schedule established would need to be designed so that the payments provided are not far below what most physicians are regularly charging other patients or the result will in many cases be the shifting of program costs to the patients as indicated earlier.

Under the plan proposed by the Staff, it is clear that even the initial fee schedule would mean the program would meet about one-fifth less of what physicians are now charging their patients. Since there would be no procedure to increase the premium rates other than by changing the law this gap between what the program was willing to base its reimbursement on and what physicians are actually charging would grow. The effects are quite predictable. A quite limited number of physicians, particularly those with the least successful practices, would agree to provide services to all patients at the rates provided by the program. (This, of course, has been the experience with medical care provided by the public assistance programs where fees have been set considerably below what the majority of physicians charge their regular patients.) Other physicians would normally charge their patients the regular fees and the patient in turn would be reimbursed for only a limited part of the bill, and, as time passed, a declining part. In other words, the proposal holds little promise of controlling what physicians charge and what the patient has to pay but rather controls only what the program's liabilities are.

The Staff recommends that uniform definition of medical procedures and services be applied in the payment of benefits under Part B.

Accurate reports of services and standardization of nomenclature are, of course, extremely important in the health insurance field and we have had extensive discussions and made considerable progress with the carriers and with medical societies. The attainment of general acceptance among all physicians, carriers and programs of uniform definitions of procedures and services is a highly desirable goal and is one of the recommendations made by the Health Insurance Benefits Advisory Council in its first annual report to the Secretary in May of 1969. This, however, is not as easy a matter as one might think from the discussion included in the report. The problem is, of course, complicated by the many possibilities for "packaging" services and charges and, of course, use of standard definitions would require a great deal of cooperation from the medical profession in completing bills and supplying information on charges. However, we will be working toward greater standardization in the classification of the services covered by physicians' charges so that more meaningful comparisons can be made in determining reasonable charges and would welcome legislative support in this area.

PAYMENTS TO PHYSICIANS IN TEACHING HOSPITALS

The Staff recommends that payments for physicians' services to "institutional" patients in a teaching setting be immediately terminated pending the development of new congressional policy.

Aside from the question of whether it would be desirable to stop such payments, we do not believe the law as it now stands would allow such an action. We see no basis for refusal to pay for physicians' services rendered to patients in an institution on the grounds that the patient is receiving his care in a teaching setting, that he was treated there by a salaried physician having a title such as assistant professor, or that he did not personally select a particular physician prior to entering the hospital.

A clear understanding of what is involved here must take account of the fact that services in the so-called teaching hospitals of the Nation are provided in a variety of ways. Many physicians who assist with intern or resident programs are in private practice and serve the hospital or a medical school part-time as a member of the teaching staff. When such a doctor treats a patient, whether he admitted the patient or not, and whether he uses interns to assist or not, he renders a personal professional service to the patient. The great number of people who are taken unconscious to the nearest physician's office or hospital following an accident are in no position to make a choice of physician, but if a physician, other than an intern or resident in a hospital, treats them, they may expect to pay for his services. And hospital patients very often do not "hire" (and in fact may never consciously see) the radiologist and pathologist who attends them, but this will not mean that they will not be billed for the services.

It goes without saying that there are problems in this area. The Social Security Administration instruction that reimbursement be paid only for identifiable and personal services rendered by attending physicians has not been followed consistently and even where followed has not always been appropriately documented as required by regulations. However, particularly in the last six months, administration in this area has greatly improved. In any event, the immediate cessation of all payments does not seem justifiable.

The present provisions of the Medicare law were not specifically designed to meet all the types of situations that can arise. It is worth reviewing in some detail the current situation. The medical insurance provisions (Part B) of the Medicare program provide for payment to be made on a fee-for-service basis for physicians' services without regard to whether the patient is a teaching patient and without regard to whether he is a "private" patient or an "institutional" patient. As is stated on page 24 of the Report of the Committee on Ways and Means on the original legislation: "Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, *and other physicians* employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan." (Italics supplied.) However, Hospitals may be reimbursed under the hospital insurance provisions for costs they incur in compensating physicians for their teaching and administrative activities.

There are many hospitals in which a teaching physician may be responsible for institutional patients, and the services the teaching physician renders to these patients may be the same, slightly different, or very different in character from the services he renders to private patients. Thus, a sharp distinction cannot necessarily be drawn between the institutional patient and the private patient. Over the past several years increasing numbers of private patients have received care in teaching programs as institutional patients, so that the physician-patient relationship is often essentially the same for the patient who elects to get services from a physician designated in the hospital, as for the patient who chooses his own physician. Payment for physicians' services under the medical insurance program is permitted only where such a private physician-patient relationship exists. The regulations that set forth this policy state, in part, that:

> Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents and interns in the care of his patient *only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.* The carrying out by the physician of these responsibilities would be demonstrated by such actions as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission: confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress. [Italic supplied.]

The regulations go on to note that there will be situations where a patient will receive medical services from residents and interns and the benefit of physician supervision for which charge reimbursement cannot be made by Medicare; payment for these services may only be provided by reimbursing the hospital under the hospital insurance program for its costs in providing the services.

As noted in the Staff Report, it has been difficult to achieve effective and uniform application of the program's policies to the large number of widely varying teaching settings. In some cases, charges have been paid for services rendered in hospitals—especially charity hospitals—which clearly did not involve the degree of physician participation envisioned by the regulations. Bills from the teaching physicians of a number of institutions have been suspended in order to permit a review to determine whether their billing practices are consistent with the Medicare coverage criteria and, where necessary, to provide full assurance that future billings are correct and that past overpayments are liquidated. However, it may well also be appropriate to modify the Medicare reimbursement provisions so that they are more responsive to the unique practices and policies of some of the teaching institutions.

We do not concur in the view that there is generally no obligation on the part of the patient to pay the supervisory physician for medical services in the teaching setting if the services are personal to him. Not only are such payments required by the Medicare law but other third parties generally recognize an obligation to pay for physicians' services furnished to institutional patients although, as in the case of the services of other hospital-based physicians, payment is sometimes made by a hospital benefit plan such as Blue Cross and related to costs rather than, as in the case of Medicare, by a medical insurance plan.

Nor do we believe than an insured person's obligation to pay for the services he receives should be determined solely on the basis of whether he can pay that portion of the charge that is not met by his insurance or on whether uninsured, indigent patients in the same institution are expected to pay. It seems clear from the Medicare program's legislative history that Congress intended to provide protection for eligible aged persons requiring health services they cannot pay for except through insurance benefits. For example, section 1862(a)(3) of the law stipulates that services to indigents who are eligible under State-Federal public assistance programs should be paid for under Medicare. Obligation to pay a fee, we believe, should be determined by whether patients who are not indigent are required to pay for services they receive. We do not believe it was the intent of Congress that other patients or programs bear what are indeed undeniable costs of a service just because the physician happens to be a teacher.

The heaviest concentration of "institutional patients" are, of course, found in public hospitals. As already noted, if payment for physicians' services were to be barred on the basis that they are furnished "free" to institutional patients, a strong incentive would be provided for Medicare patients to be sent to non-Government hospitals, where Medicare rather than the State or local government would pay the bill, even though the patient may prefer to go to the public hospital. The cost to Medicare of care in the voluntary or private hospital is generally higher than in the public hospital.

This is not to say that it might not be desirable to make some legislation modifications in the present provisions. For example, there is the question of whether it is appropriate to pay a volunteer physician from the community his customary fee for services he donates to a hospital even where the services he renders to a teaching patient are essentially of the same character as his services to his other patients. Also, the present law may be too restrictive in not providing reimbursement for the teaching and supervisory activities of physicians who are compensated by some source other than the hospital—e.g., an affiliated medical school or medical group.

LARGE PAYMENTS TO HEALTH CARE PRACTITIONERS

The Staff recommends that carriers and State Medicaid administrators be required to regularly compile and evaluate basic payments profile information with respect to each health practitioner.

We agree and have required Medicare carriers to institute postpayment controls that depict individual physician patterns and consist, at a minimum, of the following:

1. Ratios of total number of services (line items) provided to total number of beneficiaries served.

2. Ratios of lab services, x-rays, PT treatments, and injections to number of beneficiaries served.
3. Ratios of office, home, hospital, ECF, and nursing home visits to number of beneficiaries served.
4. Total payments on assignment to physician.
5. Total payments to beneficiaries per physician.

Standards for a post-payment surveillance system for Medicaid administrative agencies have been developed and steps for implementation are under way. In some States and with respect to some fiscal agents dealing with the Medicaid program for the State, the implementation of these changes will involve considerable cost and time, because it requires either basic systems changes or additions to the capability of the present systems to maintain provider profiles and to conduct surveillance by computer methods.

The staff suggests that it would be helpful to enlist the support of professional organizations in dealing with problems of possible program abuse.

We agree. This is a requirement that was part of the original contract with carriers, and from the very start, carriers, medical societies, and the Medicare program have been working to assure effective identification and resolution of situations of possible abuse.

The Staff recommends that each State Medicaid administrator be regularly provided Medicare payments profile data with respect to physicians practicing in that State.

We agree. We have been furnishing such information to State Medicaid administrators on basis of *ad hoc* decisions on its release. Our regulations on confidentiality have now been revised to permit release of such information to all State Medicaid administrators on a regular basis.

INCENTIVE REIMBURSEMENT METHODS FOR HOSPITALS, EXTENDED CARE FACILITIES AND PHYSICIANS UNDER MEDICARE

We are recommending a change in the law which goes in the same direction as this recommendation as discussed on page 2.

CERTIFICATION OF EXTENDED CARE FACILITIES

The Staff recommends that certification of facilities with deficiencies—other than those of an insignificant and minor nature—be prohibited.

Much depends on what is meant by deficiencies of an insignificant and minor nature in the above recommendation.

It is correct, as the report points out, that a temporary conditional certification was granted to 250 ECF's that were not initially able to meet the charge nurse requirement. This certification was granted, however, only after the Secretary was given assurance by the State Health Department that no hazard was involved and efforts were being made to correct the deficiency. These certifications were terminated in April 1968.

At the present time it is possible to certify for participation in Medicare an institution that is in substantial compliance and is making progress toward full compliance. This means that all statutory conditions for compliance must be met and that the deficiencies in failing to meet the regulatory requirements established by the Secretary must not be of a type that would endanger the health and safety of the patient, e.g., the facility does not have available to it the periodic services of a qualified dietitian, but its food service personnel are experienced, effectively trained and supervised, and are performing in a satisfactory manner. We believe it is quite essential, particularly in rural areas and particularly in the beginning of the program, that institutions be allowed to come into full compliance gradually as long as they substantially meet the conditions of participation. Out of some 20,000 nursing homes in the country, only some 6,000 have applied for extended care participation, and only 5,600 have been approved. Eight hundred have dropped out or have been dropped involuntarily. The same certification concept is applied to hospitals. If one had applied all the details of full compliance at the very beginning of the program, many areas of the country, particularly rural areas, would have been left without participating institutions. The problem was one of establishing high standards, certifying participation for those who substantially met the standards, and exerting pressure for improvement as compared with leaving large parts of the country without coverage of the services that the program was proposed to cover.

If the Department were to adopt the suggestion of the staff, it would face the following alternatives: (a) deny facilities any time frame within which they can be moving towards the goals embodied in the standards, and require them in a single step, to come into full, rather than substantial, compliance with essentially all of the demanding standards and factors now embodied in the conditions of participation and deny coverage of extended care services for beneficiaries in many parts of the country; or (b) relax the conditions of participation to the extent necessary to assure the availability of services to beneficiaries. We do not believe that either alternative is acceptable. We believe that both availability of approved extended care services and pressure toward the highest health and safety standards must be maintained.

The Staff recommends that the law concerning a distinct part of an institution certified as an extended care facility be interpreted to limit a distinct part somewhat more than at present.

We agree. The development of policies along the lines suggested by the staff is under way. Extended care facilities that are participating or wish to participate have now had time to become acquanited with the Medicare requirements and to make plans for adjustments of this type.

INSTITUTIONAL UTILIZATION REVIEW MECHANISM

The report recommends that we require the staff of the utilization review committee of a participating hospital to be drawn from physicians associated with other hospitals and require utilization review plans for extended care facilities to be organized outside the institution.

Utilization review conducted by responsible committees of the organized medical staffs of hospitals is still a relatively new concept but has made great progress in recent years, particularly in the larger hospitals of the Nation. Medicare provided a substantial impetus and turned what was essentially an educational concept into a review device. It is important to encourage and further perfect the mechanisms of peer review within institutions, and we believe that the experience to date, at least in the larger institutions, warrants building on patterns consistent with the requirement of present law, rather than to institute a dramatic change of the kind recommended by the Staff. Indeed, adoption of the recommendation across the board would present formidable conceptual and procedural difficulties which could offset the hoped-for increase in objectivity. The extra drain on scarce physician time, a lack of institutionally-based discipline around which to carry out the activities in the hospital, and confusion regarding scope of responsibility are some of the more basic problems in organizing a committee of physicians not immediately associated with the institution.

The formation of utilization review committees is particularly difficult for small institutions or institutions not having an organized medical staff willing to assume the duties. It can readily be seen, for example, that, in rural areas where only a few physicians are available, requiring them to travel considerable distances regularly and to work on the review of utilization in other hospitals than the ones they use would have severe drawbacks. Nonetheless, there is room for additional experimentation with variations on utilization review and some changes that are desirable could possibly be worked out, especially with respect to very small hospitals and with respect to extended care facilities generally. Changes of this type, which would provide for medical society participation, or State health department assistance to institute reviews on a community-wide basis, as the Staff Report proposes for extended care facilities, would be desirable. We would recommend here an approach which provides sufficient leeway to permit various types of demonstrations of the general principle so that further experience may be gained with respect to utilization review in the types of facilities where, because of ownership or for other reasons, the adequacy of present review may be doubted.

The Staff recommends that we require intermediaries to employ local, regional, and possibly national utilization criteria in evaluating the provision of institutional services.

The Staff Report comments upon the considerable experience which is emerging that results in more successful application by the intermediaries of length of stay criteria. We have made good progress in communicating to intermediaries agreed-upon concepts and better methodology for their claims screening. We are now studying the possibility of utilizing, nationally or on an area-by-area basis,

length of stay criteria as one means of making it possible to screen out claims potentially involving noncovered days of institutional stay. Claims screening of this nature may be related more to claims review by intermediaries than to utilization review in facilities, the latter having an objective more of improving services than of rejecting claims. However, it is possible that with the development and communication of fairly objective clinical criteria, the utilization review committees at least at the larger institutions could also be involved in the selection of certain types of cases that would be presumptively covered or noncovered for certain lengths of stay.

The Staff recommends that we consider the use of diagnostic and length-of-stay criteria to identify cases which can, upon transfer from a hospital, be given automatic eligibility for some days of extended care.

This recommendation touches on an area which we have been exploring and on which we hope to be able to make recommendations for legislative modifications.

The Staff recommends that homemaker benefits be provided, on a demonstration basis, as an alternative to more costly institutional care.

Medicare now pays for the services of home health aides under certain circumstances. However, the provision of homemaker benefits involves serious problems. For one thing, it would be very difficult to draw the line between the benefits intended and other kinds of domestic help. This would make it very difficult to estimate or control the cost of such a benefit. However, we support the recommendation to cover homemaker benefits on a demonstration basis. We also believe it would be preferable to make these benefits more widely available on a test basis to persons whose health, in the absence of the service at home, would require them to be institutionalized.

MEDICARE FISCAL INTERMEDIARIES

The staff recommends that the law be changed so that institutions no longer nominate intermediaries but rather that they be designated by the Secretary as he now selects carriers under Part B.

We have been mindful from the outset of the program of the possibility of certain providers using this right of nomination as a device for obtaining more favorable treatment from the intermediary. We have informed intermediaries that offering such inducements would not be tolerated and we have taken appropriate and prompt administrative action whenever we have had any indication of such action. We have also established the policy that a provider may not change intermediaries without good and sufficient reasons that are directly related to the efficient and effective administration of the Medicare program. On the other hand, there are advantages to allowing the provider the right to nominate the intermediary that it feels it is best able to work with and disadvantages to disturbing existing effective provider-intermediary relationships without clear evidence that such a change is necessary.

The Staff recommends that the Social Security Administration in its contract with Blue Cross Association reserve the right to select as local intermediaries only the Blue Cross plans which are capable of proper and efficient performance.

We agree. One of our proposed contract modifications would clarify the Secretary's right not to concur in the renewal of the subcontracts with Blue Cross plans. It would be made clear that individual plans could be excluded from program participation at the beginning of each contract term even when the prime contract with BCA remained intact.

The Staff recommends more direct dealing between the Social Security Administration regional offices and local Blue Cross plans as compared with routing matters through the national Blue Cross Association.

The need to provide BHI regional offices direct access to individual plans on significant issues is being met under the present contract. Moreover, clarification of regional office-plan liaison will be an objective of the SSA in renegotiating the BCA contract.

MEDICARE CARRIERS

The Staff recommends that there ought to be fewer carriers and changes made that would foster genuine competition for appointment to the job of Medicare agent.

The Bureau of Health Insurance has worked diligently throughout the first difficult years of Medicare implementation to advise and assist carriers in han-

dling the tremendous impact of initial workloads, to establish the procedures and policies necessary to assure sound operations for the long run and to establish clear standards of performance which would make it possible to evaluate carrier operations. There was little basis in the initial period to "weed out" inefficient carriers, but over time, as contracts have been renewed or modified, we have begun a selection process that is intended to move in the direction of a gradual reduction in the number of carriers and the enlargement of their areas. However, there are serious problems involved in making these shifts. A carrier that has performed well in a given area may not have the capability or inclination to serve in the area to be vacated by a poorer performer; a carrier that is efficient at its present level of Medicare operations may not have the capacity to perform efficiently at the higher level of Medicare operations that would result from its assuming the areas of poorer performers; and, of course, any major realignment of carrier areas would involve a substantial loss of operating efficiency during the transition period. In addition, the working relationships that have been established with providers, physicians, medical suppliers and health care organizations that would have to be severed and reestablished represent an investment and a resulting replacement cost of considerable magnitude.

THE QUALITY OF ADMINISTRATION OF MEDICARE

The Staff suggests the need for improvement in the quality of information supplied to and requested of carriers and intermediaries.

It is always possible to improve almost any operation. However, we were quite pleased actually at the reaction of the intermediaries and carriers to the questionnaire sent out by the Staff asking them to evaluate the quality of instruction and other material they receive. The results are that 76 of the organizations said the material was good and 36 said it was fair and only 6 said it was poor.

The Staff suggests that data necessary to evaluate program administration be given highest priority and be placed under control of BHI and that data useful for cost estimation be given only a slightly lower priority and be placed under control of the Actuary.

We have been reexamining our system for collecting and providing the program data required for administrative and cost estimation purposes. We will bear in mind the suggestions of the Staff in this reexamination. However, the highest priority is presently given to the production of program evaluation and cost data and close liaison is presently maintained between the Bureau of Health Insurance, the Actuary, and the Office of Research and Statistics to assure that the data produced is geared to administrative and cost estimating needs.

The Staff suggests that research related to the impact of the program on beneficiaries and the health industry should have a lower priority than data for administrative evaluation and cost estimation and should be carried out by the Office of Research and Statistics.

We have been operating in this fashion since the start of the program.

The Staff suggests that contractors be relieved of as much data gathering and reporting as possible.

We have been mindful of the need to avoid placing unnecessary data gathering and reporting burdens on Medicare contractors. At the same time, it must be recognized that our responsibility to secure the information needed for monitoring administration, estimating costs and evaluating the impact of the program must be fulfilled. The problem is to gather the necessary data while minimizing the administrative cost of doing so. We have been working hard to attain this result and will continue our efforts in the future.

In this connection, it should be noted that much of the data that contractors are required to report are byproducts of contractor operations which are often computerized. It should also be noted that much of the data requested by the Staff in preparation of its report would have been unavailable if extensive data and reporting requirements had not been imposed from the outset of the program.

MEDICARE FINANCING

The Staff recommends that future increases in the earnings base be reserved for program improvements and not used to meet increasing program costs.

The costs of benefits now provided by the law in the hospital program, of course, increase as wages rise. There seems to be no very good reason why one wouldn't use the income from increasing payrolls to meet these increasing costs. It does not

seem wise for the Congress to commit itself to not using the money that becomes available from a rising base to meet present costs because the Congress might wish to broaden benefits when the cost of such a broadening is unpredictable. Rather, it would seem more prudent to take this increase in the base into account in considering the financing of the program.

It seems certain that the earnings base will rise under conditions of rising earnings. The maximum earnings base has been kept up to date since 1950 with regular *ad hoc* increases. Unless this practice continues in the future, the cast benefit side of the program deteriorates in relative protection. If earnings increased without earnings base adjustments over the 25-year period used in the hospital insurance cost estimates, the cash benefits would offer largely flat rate protection with little relationship to earnings.

It is true that from 1965 on the cost estimates have assumed a level earnings base but we do not believe that this is a desirable procedure and will be furnishing estimates on both bases in the next Trustees Report. We will recommend that the estimates based on a rising earnings base be used to set the contribution rates for the program.

MEDICAID ADMINISTRATION

The Staff recommends that appropriate legislative, or administrative action by the Department of Health, Education, and Welfare, be taken to prevent payments to intermediate care facilities at the same or higher rates than those made to skilled nursing homes in the same area.

We agree. A legislative proposal is being developed by the Department to achieve the objective stated in this recommendation.

The Staff recommends that the Medical Services Administration must provide dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as Medicaid is to be soundly administered.

We agree. The Department has already recognized that the Medical Services Administration has been suffering from severe staff malnutrition and has begun to correct the situation. We have just appointed a new Commissioner for Medicaid, Howard N. Newman, an able medical care administrator. We are confident that he will provide dynamic and innovative leadership. We are also adding to MSA's staff a considerable number of highly qualified people who will bring the necessary expertise to bear on Medicaid's complex problems.

The Staff recommends that consideration be given to mandating use of fee schedules for payment of health care practitioners under Medicaid.

We believe that policies with respect to fee schedules under Medicaid should be worked out in the context of the possible changes in Medicare reimbursement of physicians discussed earlier under the heading, "Payments for Physicians' Services."

The Staff recommends that drugs be provided on substantially the same basis which would have been established under the provisions of the Medicaid amendment adopted by the Senate in 1967.

We agree. It is our belief that adoption of this recommendation will indeed save substantial sums of money.

The Staff recommends that the States be required to adopt procedures for prior independent professional approval of elective surgery, dental care (except for minor procedures), eye care, and hearing aids.

We agree that prior authorization is a useful adjunct to the control of utilization. The Ad Hoc Advisory Committee on Payments to Individual Practitioners Under Title XIX recommended to the Secretary (The Haughton Report) that "prior authorization requirements should be made a part of the utilization review mechanism," and apply to certain nonemergency services, dental services, hearing aids, eyeglasses, psychiatric care, and nursing home placements.

To the extent that prior authorization procedures do not inhibit and needlessly interfere with needed medical services they may serve to curtail unnecessary services.

One should not overlook the administrative burden that prior authorization places on the title XIX agency and guard against a too rigid or a too lenient application.

Ideally, as the Haughton recommendation concludes, prior authorization should be a spin-off of a successful utilization review mechanism.

The staff recommends that the States require the designation of a "primary physician" by recipients in areas or cases where abuse of physician services by

recipients is detected or where that type of costly overutilization is widespread.

We agree that patient designation of a "primary physician" may deter costly "Doctor-Shopping" by recipients of public assistance. In the California Cannery Workers Program of Automated Multiphasic Health Testing, such a designation is reported to have worked well. However, the State agency must establish a way of designating a physician for a patient if the patient is unable to find one for himself.

Basic to the concept of the "primary physician" is the ability of the title XIX agency to identify recipient overutilization patterns. This is particularly difficult in a constantly changing recipient universe.

As pointed out in the Committee's report, accommodation is required to the "free choice" principle.

It should be pointed out, also, that the same problem exists in outpatient clinics of large hospitals. In the clinic setting a remedy has been found in the form of a skeleton health record which the patient is required to carry with him. A similar device can be used outside a hospital.

The Staff recommends that the States be required to furnish each recipient with a notice and explanation of health care paid in his behalf by the program.

A policy regulation dealing with information reporting requirements has been drafted. Now being cleared, the policy requires that States establish a basis for verifying with recipients whether services billed by providers were actually received. The Staff's recommendation will be considered in this connection.

The Staff recommends that the making of vendor payments under Medicaid to independent collection and bill discount agencies be prohibited.

We agree that there is a need for streamlining administration and processing of title XIX claims so that providers can be paid promptly. Assuming that independent collection and bill discount agencies now operate legally, legislation will be required to prohibit States from making vendor payments to such agencies from title XIX program funds.

The Staff recommends that the claims control system used by a State Medicaid system (or by its fiscal agent) should be specifically approved by the Department of Health, Education, and Welfare and if not approved, specific fiscal penalties should be invoked.

We are fully in favor of establishing Federal standards and requiring Departmental approval of State Medicaid claims control systems to assure program integrity.

However, the proposed imposition of specific penalties for unacceptable procedures will create numerous administrative problems.

Rather than imposing penalties on States which in most instances are doing their best under the constraints of inadequate administrative funds and insufficient technical and professional staff, we prefer to offer them technical consultation and financial incentive as the Department has proposed. We are considering the recommendations of the Department's Task Force on Medicaid and Related Programs for increased Federal matching for administration to be made available to States whose management information system and claims processing procedures meet prescribed criteria. Upgrading existing claims control systems will require appreciable State effort in both manpower and funds.

In addition, a model State claims payment system that places special emphasis on provider surveillance and review of recipient utilization has been designed by a management consultant firm under contract to the Department.

Aimed at preventing and curbing fraud, abuse and overutilization, this model will be made available to States along with appropriate Federal technical and consultant staff needed to help them implement it. The Department has also contracted for an improved Federal reporting system capable of providing MSA with critical data on a more timely basis.

The Department's initiatives should vastly improve the claims control systems. Adding legislative authority to provide States with financial incentives to adopt the model systems developed would facilitate all these efforts.

The Staff recommends that Federal administration and supervision of the Medicaid program be strengthened in the following ways:

1. Consultants with expertise in the fields of claims review and fiscal and professional controls should be made available by the Federal Government to assist any State which requests such assistance. Such personnel could function as a team to assist States in establishing basic operating control programs.

2. Regulations and guidelines should be reviewed and issued on a timely basis.
3. Expanded activity to assure that States are fully complying with the congressional intent respecting the provisions of the Medicaid statute.
4. Special efforts to establish a system of routine and expeditious exchange of information and experience on a formal and informal basis among State Medicaid agencies.

We agree. The items listed in this recommendation are among MSA's top priorities for action as the organization is strengthened and reorganized.

The proposed organization structure includes a Division of Technical Assistance which will employ experts qualified to assist States with specific aspects of the program, or will contract with management consultant firms to provide assistance beyond its capability.

The writing and dissemination of policy, regulations, and guidelines has top priority and will be expedited as additional staff is employed.

Efforts already under way in SRS regional offices to monitor compliance with Federal regulations on a quarterly basis will be intensified. Regional offices will also assume greater responsibility for on-site reviews of State programs thereby increasing our ability to review them more frequently.

We have recently completed studies for a "ready to go" surveillance and utilization review system for State agency use. The design is now ready to be tested in selected States on a demonstration basis. We are also redesigning the system used for State reporting to allow better program control at the Federal level. Both these efforts should lead to systems that will enable one State to learn from the experiences of another. As our information resource grows, we will develop technical assistance techniques and communications channels to assure nationwide dissemination of effective and innovational activities.

The Staff recommends that Medicaid fraud and abuse unit should be established in the Department of Health, Education, and Welfare.

We agree with the objectives of the recommendations and will make every effort to coordinate the activities of the Medical Services Administration with those of the Social Security Administration in the detection of fraud and abuse.

The Medical Services Administration has published an interim regulation in the *Federal Register* and is preparing final policy on the subject. The regulation requires all provider claims forms to contain a statement indicating that State and Federal funds are involved and that false claims or statements can be prosecuted under State and Federal law. The regulation also requires the State Medicaid agency to report to the Social and Rehabilitation Service every case of suspected fraud that has been referred to law enforcement officials and the ultimate outcome of the referral.

The Staff recommends that all States be required to maintain specific organizational units for the prevention, detection, and investigation of abuse and fraud in their health care programs.

We agree. The policy on fraud published as an interim regulation requires that a State plan "(1) Provide that the State agency will establish and maintain (i) methods and criteria for identifying situations in which a question of fraud in the program may exist, and (ii) procedures developed in cooperation with State legal authorities for referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced. The definition of fraud for purposes of this section will be determined in accordance with State law; (2) Provide for methods of investivation of situations in which there is a question of fraud that do not infringe on the legal rights of persons involved and are consistent with principles recognized as affording due process of law; (3) Provide that the State agency will designate positions that are responsible for referring situations involving suspected fraud to the proper authorities."

Federal financial participation in the claims-payment process is now at the rate of 50 percent. The rate of such participation in the utilization review activities is at 50 percent or 75 percent depending upon the level of professional participation. We see no reason for the detection of fraud being reimbursed at a higher level and therefore do not concur with the recommendation that matching be at 90 percent for personnel engaged in such activities.

The Staff recommends that the Medical Assistance Council be terminated and its functions combined with those of the Health Insurance Benefits Advisory Council.

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We do not agree with this recommendation although we agree that many of the comments made about areas of commonality between the two programs. There are, however, basic and fundamental differences in the programs that would make a single, combined council less effective for each program.

We recognize the need for coordination of program activity and program regulations wherever possible and are achieving it by closer staff coordination within the Department. There has just been established in the Office of the Assistant Secretary for Health and Scientific Affairs a post of Deputy Assistant Secretary for Health Services, one of whose functions it is to provide guidance and program coordination for all Department programs concerned with financing, organizing, and delivering of health and medical care services.

In conclusion, the services each of the separate councils offers the two programs are extremely valuable; we believe their help would be diluted rather than strengthened if the two groups were combined.

Appendix 6

MATERIAL RELATED TO LONG-TERM CARE

DEFAULT ON NURSING HOME CODE

[From "Hospital Practice," Dec. 1969]

On January 1, 1969, the United States government defaulted on a deadline. Under a federal law passed almost a year before, the Department of Health, Education, and Welfare had been committed by Congress to upgrade the quality of nursing home care paid for under Medicaid. It was a move of significance to the practice of medicine in and out of hospitals. If the physician cannot trust the nursing home, he may retain the patient in the hospital or admit him there for want of an alternative. The hospital then comes under pressure to do the work of a nursing home.

The missed deadline and the months of turmoil and indecision that followed were symptomatic of the chronic inability of HEW, at the vortex of various interest groups, to cope swiftly with the needs of the indigent and medically indigent patient. In late June, tentative regulations appeared, were denounced as a betrayal of Congress' mandate, and virtually repudiated by an ad hoc HEW advisory panel. As of late October, fresh regulations still had not been issued.

The law in question, actually an amendment to the Social Security Act, was the work of Sen. Frank Moss (D-Utah), who for years had chaired hearings into the needs of long-term patients. He concluded that federal money for welfare nursing home care was abetting a ruse: in the name of "skilled care," it was paying for unskilled care, or worse—neglect and abuse. The Moss amendment represented his insistence that skilled homes in Medicaid be *medical* institutions.

Few quarreled openly with this. Issues arose over who would pay for it and how. The industry, predominantly proprietary, had begun by the early 1960's to sense and meet a growing public demand for quality. But the industry also included obsolete, economically marginal homes that could neither afford to renovate nor to hire better staff. They had little hope of transforming themselves into medically oriented allies of the hospital. Many were plagued by huge loans and speculation, Sen. Moss found, and could only survive at the expense of the medical needs of patients.

Some 12,000 of the nation's 14,000 nursing homes are vendors of care to Medicaid. Nearly 500,000 patients are cared for annually at an estimated $1 billion in state and federal Medicaid funds. That all of these patients need skilled services is open to question. That the ones who do are in homes providing skilled services also is open to question. However, it is a fact that Medicaid only pays homes under the rubric of "skilled" care. The definition of that care is the crux of the Moss amendment as well as the thread of survival for many homes. It has been estimated that moderately high standards would drive 6,000 homes out of Medicaid and into a recently created category of "intermediate care," which is not part of Medicaid. Payment to homes in the intermediate category, which a state can elect to establish, would be less than in Medicaid.

Medicaid payments set by states have been criticized by the industry as often unrealistic to support skilled care. That so-called skilled homes can profit on low state payments—the national average is $10 a day—may be evidence of extraordinarily able management, or it may indicate that standards are not being met. Low-standard homes defend themselves by saying that states get as much as they pay for.

State legislatures tend to resist federally imposed higher standards for political and economic reasons. Nursing homes often carry considerable weight in state capitols, and state welfare departments typically get budgets and staff too small to police quality of care. Often state supervision of construction, sanitation, and professional activities is fragmented, and administration is chaotic.

Infusing more federal dollars into such a situation, Sen. Moss concluded, was absurd. Under Medicaid's predecessor, the Kerr-Mills program, states got more federal dollars, kept total medical welfare spending the same, and released state dollars for duty elsewhere. Introduced in 1966. Medicaid had safeguards against this maneuver. But from the first, HEW's attempts to upgrade care were met by industry and state resistance. In 1966 and 1967, HEW found it could make only slow headway even in equating Medicaid standards with Medicare's themselves none too high.

This was the setting of the Moss admendment. In the following chronicle of frustrations surrounding its implementation, the focus is on the licensed practical nurse as charge nurse. Other provisions, equally important, have to be ignored here. Often the LPN is the only professional-type staff member in the nursing home, particularly at night.

The act containing the Moss amendment was signed by President Johnson in January 1968. The amendment required, among other things, that a Medicaid skilled nursing home keep an organized nursing service directed by a full-time RN. The service had to include "sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week."

Detailed specifications were left to HEW's newly formed Medical Services Administration under Commissioner Francis Land. This Indiana practitioner, a former official of the American Academy of General Practice, was considered by "quality" exponents as a laissez-faire protagonist whose views conflicted with the Moss mandate. Dr. Land, who was eased out of the job in mid-1969 with official expressions of regret, told HOSPITAL PRACTICE Congress never gave him the staffing to administer Medicaid properly; he had 80 people, he said, for tasks requiring hundreds. But the staff he had, he said, was fine.

Working under him was Frank Frantz, who had headed the Moss investigations and came to HEW specifically to lead the implementation of the Moss amendment, with the personal blessing of HEW Secretary Wilbur Cohen. Also in the picture was Harold G. Smith, a former Louisiana Nursing Home Association official who was well known to the staff of the U.S. Senate Finance Committee chaired by Louisiana's Russell Long. That committee has responsibility for Medicare and Medicaid legislation. At the same time that he served MSA part time, Mr. Smith was a consultant to the American Nursing Home Association which represented 7,000 nursing homes, mostly proprietary and mostly Medicaid vendors of care. Dr. Land defended his choice by saying Mr. Smith was a valued expert in both the welfare and nursing home fields, and he knew of no experts who did not appear to have some conflict of interest.

The casting at M S A seemed to predestine difficulties in writing the specifications. Indeed, it was hard to divorce standards development from chronic politicking by the industry for higher reimbursement and by the states for more federal money or looser controls.

An issue that never got settled concerned purported shortages of "unwaivered" I P N's as charge nurses. Were shortages due to low pay, poor working conditions, and the dim image of nursing homes professionally? Were shortages local or national? The questions bore on the issue of what level of nurse staffing was required by the Moss amendment. Earlier Medicaid regulations had obligated homes to have an R N as director of nursing service and charge nurse over one shift and at least an L P N in charge of the other two shifts. The L P N was required to be a graduate of a state-approved school of practical nursing, not one licensed by waiver of such training. The proviso for unwaivered L P N's was subject to repeated grace periods as states and industry pleaded shortages. But nobody had hard figures, for state agency statistics did not distinguish among L P N's by waiver status. In mid-1969, M S A acknowledged that hard figures still were lacking and some observers claimed that if any shortages of graduate L P N's existed, they were purely local.

In 1968 there was enough belief in a shortage to prompt the industry and P H S to begin devising a short-term curriculum for upgrading waivered L P N's. But partly because federal officials dallied, the attempt disintegrated. Dr. Land said he had appealed to H E W top brass for action, but in vain. Meanwhile, the grace period for waivered L P N's was extended to January 1, 1969.

In December 1968, the distillate of months of conferencing was laid before experts of the nursing home, hospital, and medical fields—among others—at an Atlanta meeting. The draft standards, primarily the work of Mr. Frantz

and his staff, were presented for discussion. Having been reviewed by Mr. Smith, the draft was no surprise to ANHA, which oppossed it. But it was described as "precisely" in line with the Moss Amendment by Sister Mary Ambrosette, president of the American College of Nursing Home Administrators and a member of the American Association of Homes for the Aging.

The draft's key specifics included a ratio of total nursing personnel hours per patient day and a formula for charge-nurse staffing. This called for two charge nurses per shift if 90 to 150 patients were to be covered, one of the two having to be an RN. For shifts with fewer patients, at least an unwaivered LPN as charge nurse was proposed, the standard for Medicare. The draft exceeded Medicare standards for extended care, which permit a charge LPN to cover any number of patients.

After comments on the draft were received at MSA, its proposals were cut back. The hours—patient day ratio was dropped. A draft with the charge nurse formula intact was brought to Secretary Cohen on January 7, a scant two weeks before the incoming Republican administration was to take over. Mr. Cohen was aware of Medicare officials' stand that Medicaid should not have higher standards than applied to extended-care facilities, many of which also served Medicaid. He instructed Dr. Land to bring Medicaid up to the Medicare level temporarily but to postpone until January 1, 1972, the effective date of higher standards.

Another draft was prepared and taken on January 10 by Dr. Land to his superior in the Social Rehabilitation Service, Joseph H. Meyers. Mr. Meyers asked that the draft be boiled down and, in particular, he criticized the key section on nurse staffing as too long and inexact; actually, it was a direct copy of the Medicare standard. But he said, some months later, that he asked Dr. Land to make only editorial revisions and not to change substance.

Dr. Land, however, did order changes in substance. In a recent interview he commented to HOSPITAL PRACTICE that Mr. Meyers' rejection of the draft had given him time to reassess the situation and that he changed course because of persuasive arguments by state officials. The January 10 draft was, anyway, only a "trial balloon," he said. On January 13, he relieved Mr. Frantz of his duties on standards and named a new group to draft a revision. It was quickly superseded; on January 15, Dr. Land named still another group, which included Mr. Smith and was chaired by Thomas Laughlin, Dr. Land's deputy. This group prepared a document that was circulated for comment the next day (January 16). Members of an MSA advisory group to whom it was shown reportedly reacted in shock and confusion, one calling it a sellout of the Moss amendment. The response was the preparation of another draft, which further diluted standards.

In this revision, dated January 17, one shift was allowed to be in the charge of "a member of the nursing personnel staff, qualified by training and experience"; in other words, a night shift could be left in the charge of a waivered LPN, a nurses aide, or an orderly. The draft set July 1, 1971—still another grace period—as the deadline for Medicaid homes to have fully qualified nursing around the clock. As this draft was contested within HEW, January closed with another round of draft writing and still another group of writers.

The agony of revision, a growing embarrassment at HEW, ended in late June with publication of regulations that would become effective after a 30-day period for comment. Proposed in the regulations was a grace period through mid-1970 on charge-nurse qualifications. This was too much for Sen. Moss. In announcing hearings for July 31, he declared: "We are left with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes 'properly supervised nursing services' on the afternoon and night shifts."

Testifying for ANHA at the Moss hearings, Mrs. Eleanor Baird endorsed the intent of the proposed standards but expressed "grave concern and strong reservations about the ability of the states to implement them—unless adequate lead time is provided." She foresaw that the standards would raise costs that could prove prohibitive in some states. The practical result would be that states would be encouraged—"in fact, forced"—to seek a lesser degree of nursing service than patients really needed, she said.

Speaking for the National Council of Senior Citizens, William R. Hutton said the regulations, when compared to the Moss amendments, show "that the interests of nursing home industry have been accommodated and the aged have been sold short."

For the American Nurses' Association, Miss Mary E. Shaughnessy declared that standards should be set according to services that are to be provided, not on the basis of availability of qualified personnel. The Rev. William T. Eggers, president of the American Association of Homes for the Aging, said his group knew of no national shortage of qualified LPN's. Facilities that cannot qualify as skilled nursing homes for personnel or other deficiency should be called by another name and reimbursed at a lower level until they can make the grade.

Dr. Land, who had resigned the previous week, was not at the hearing. Representing MSA, Mr. Laughlin quoted a Senate Finance Committee report on the Moss amendment as saying states should not be expected to impose "unrealistic" requirements on nursing homes. He also said that grace periods were necessary because H E W had never provided enough money for a training program to overcome a shortage of fully qualified L P N's. Mr. Smith, who had withdrawn as an MSA advisor to become a full-time ANHA advisor, told Sen. Moss that he gave advice to the best of his ability, that HEW knew of his other consultancy, that he had supported the Moss amendment in 1967, and that "I did not seek to impose my will on HEW."

In an unusual move, HEW had named a task force to review the regulations. The record of the Moss hearings was sent to the panel, including members from the top rungs of ANHA, AAHA, organized labor, senior citizens' councils, and state medical-welfare units. The chairman was Mrs. Charline J. Birkins of the Colorado Department of Social Services.

On August 19, her group made recommendations that indicated the January 10 draft. They recommended narrowing the grace period for certain waivered LPN's but not for others, Waivered LPN's who became charge nurses after July 1, 1967 should be barred as charge nurses until they get the necessary training, they recommended. In addition, in a recommendation harking back to the tough December 1968 draft, they urged HEW to develop a staffing formula necessary to quality care.

In October, while HEW was still trying to devise an upgrading program for LPN's, HEW was circulating drafts of regulations embodying the Birkins recommendations. These were expected to be issued in November.

How can one explain the procrastination that afflicted implementation of the Moss amendment? Mr. Meyers told HOSPITAL PRACTICE: "It was a question of balancing realities with ideals." At the administrative level occupied by Mr. Meyers, Dr. Land, and Mr. Laughlin, this desire for balance resulted in the repeated making and unmaking of decisions. Above and below this level there apparently was eagerness for strong regulations: i.e., Congress provided the Moss amendment, MSA veterans of other fights for quality care like Mr. Frantz appeared able and willing to do the job. The administrative paralysis goes back to the pressures brought by the interest groups with whom the administrators must deal. The nursing home patient—in whose name Congress acted—is the abstraction. He isn't there in the corridors and offices of federal government.

Appendix 7

MATERIAL RELATED TO CONSUMER INTERESTS OF THE ELDERLY

ITEM 1: PRESS RELEASE, FROM BUREAU OF LABOR STATISTICS ON THREE BUDGETS FOR A RETIRED COUPLE, OCT. 23, 1969

THREE BUDGETS FOR A RETIRED COUPLE

In spring 1967, it cost a retired couple almost $2,700 to maintain the level of living specified in the lower budget, roughly $3,900 to live at the intermediate level, and about $6,000 to meet the requirements of the higher budget.

These findings are from "Measuring Retired Couples' Living Costs In Urban Areas," an article that will appear in the November issue of the *Monthly Labor Review*. A research bulletin—*Three Budgets for a Retired Couple in Urban Areas of the United States*—will be published later in 1969 by the U.S. Department of Labor's Bureau of Labor Statistics.

Rising prices between spring 1967 and spring 1969 have added about 9 percent to the cost of goods and services required to sustain the retired couples.

Lower and higher budgets for a retired couple are now available for the first time. The intermediate budget (formerly the moderate budget) is a sequel to the retired couple's budget, autumn 1966, which was published in June 1968.

The budgets have been developed to meet the needs of public assistance agencies, voluntary social and welfare agencies, businesses, labor unions, and individuals concerned with retirement planning.

The retired couple is defined as a husband, age 65 or over, and his wife, self-supporting, living independently in a separate dwelling, and enjoying reasonably good health.

The budgets are based on the manner of living and consumer choices of the 1960's. They permit the couple to maintain its health and well-being, and to participate in community activities. The goods and services were selected as follows: nutritional and health standards, as determined by experts, were used for the food-at-home and housing components. However, the selection among the various kinds of foods and housing arrangements were based on actual choices made by families as revealed by surveys of consumer expenditures. In the absence of standards, the choices reported in the BLS Survey of Consumer Expenditures were used for housefurnishings, household operation, clothing, personal care, reading, recreation, meals away from home, and alcoholic beverages.

The style of living provided by the lower budget differs from the intermediate and higher levels in this manner: A smaller proportion of couples own their homes, dwelling units lack air conditioning, couples rely more on public transportation, they perform more services for themselves, and they make greater use of free recreation facilities.

By contrast, the higher budget assumes the largest proportion of homeowners, provides new cars for some couples, allows more household appliances and equipment, and more paid services than at the intermediate level.

Also, a majority of the items common to the three budgets are in greater quantity and of better quality at each higher level of living.

Total budget costs in urban United States in spring 1967 averaged $2,671 at the lower level, $3,857 at the intermediate, and $6,039 at the higher.

Consumption items—food, housing, transportation, clothing, personal care, medical care, and other family consumption in the lower budget cost $2,556. In addition, an allowance for gifts and contributions amounted to $115.

The intermediate budget required $3,626 for consumption items plus $231 for gifts and contributions, while the higher budget needed $5,335 for goods and services and $398 for gifts and contributions. Additional allowances are made in the high budget of $71 for life insurance premiums and $235 for personal taxes.

Food

Total food costs at spring 1967 prices averaged $789 for the lower budget, $1,048 for the intermediate, and $1,285 for the higher.

Of total food costs in the lower budget, $735 was for food at home. Compared with the two higher budgets, the lower food allowance calls for larger quantities of potatoes, dry beans and peas, flour and cereal, and smaller quantities of meat, and poultry and fish.

The family also has an allowance of $54 which permits them to enjoy a restaurant meal about once a month.

In the intermediate budget, food for home consumption cost $937 and restaurant meals and snacks—$111. At the top level the couples required $1,115 for food consumed at home, and $170 for meals outside the home.

Housing

Urban U.S. housing costs ranged from $939 in the lower budget to $2,066 in the higher level. The middle group housing costs amounted to $1,330.

Shelter—the major expense in the housing total—required an average annual outlay of $704 for the lower budget, $849 for the intermediate, and $1,188 for the higher level. These amounts are based on the average costs for rented and owned dwellings.

Rental housing which had 2 or 3 rooms were specified for 40 percent of the couples at the lower level, 35 percent of the middle level, and 30 percent of the higher level couples. The renters' cost included rent plus estimated costs of fuel and utilities, where these were not part of the rent, and insurance on household effects.

The majority of the families at all budget levels lived in 5- or 6-room mortgage-free homes. Typical homeowner costs for these couples include taxes, insurance, fuel and utilities, and routine repair and maintenance charges. The higher budget provides for greater utility usage and a larger repair and maintenance allowance than the intermediate and lower budgets.

Transportation

Transportation costs stepped up from $191 at the lower budget level to $382 for the intermediate, and $682 for the higher. These allowances provide for ownership and operation of an automobile for some of the couples at each budget level—except for lower budget families in Boston, Chicago, New York, and Philadelphia who rely on public transit.

The budget level and city size determined whether couples owned an automobile and how much they patronized public transit. In the lower budget it was assumed that car owners bought 6-year-old cars, intermediate group owners bought 2-year-old cars as did 45 percent of the higher budget families. For the remaining 55 percent of the higher budget couples, the purchase of a new car was specified.

Clothing costs—replacement of the clothing, and materials and services—averaged $134 for the lower budget couple. The intermediate budget couple needed $234 and the higher $371, at spring 1967 prices.

The clothing allowances for husband and wife were about the same in the lower and intermediate budgets. At the higher level, however, the wife's allowance averaged about $20 more than the husband's.

Personal care costs moved from $83 for the lower budget to $123 for the intermediate, and to $178 for the higher budget. These costs constituted about 3 percent of the total family consumption for the three budgets.

Medical care

The lower budget couple required $294 to cover its total medical costs for a year. This was only $2 less than the intermediate budget couple's $296, and $5 less than the top level cost of $229. Although there is only a $5 difference between the lower and the higher allowances, in the lower budget medical costs accounted for 12 percent of total family consumption, compared with only 6 percent of family consumption for the higher budget.

The medical care costs include hospital and medical insurance provided by the Federal Medicare program. Also included in the costs are eye examinations and eye glasses, drugs, and a physical checkup for Medicare enrollees not using Medicare services within a year.

Other consumption

In the lower budget, "other consumption"—reading, recreation, tobacco, alcohol, and miscellaneous expenses—cost $126. For these same items, the intermediate budget required $213 while the higher budget totaled $454.

At the lower level, the largest single cost in "other consumption" was reading ($46), while at the intermediate and higher levels, cost for recreation—$81 and $256, respectively—accounted for the largest portions of the item.

Tobacco—cigars or pipes—and alcohol allowances are part of "other consumption" costs. No allowance was made for cigarettes in view of the findings of the U.S. Public Health Service concerning the effects of cigarette smoking on health.

Living cost differences among cities

The new budgets provide a wide variety of total budget costs and comparative living cost indexes (tables 1–6) for major categories of consumer goods and services.

All indexes relate to costs for families established in the areas. They do not measure differences in costs associated with moving from one area to another, or costs incurred by recent arrivals in the community.

Within each budget, the intercity indexes reflect differences among areas in price levels, climatic or regional differences in the quantities and types of items required to provide the specified level of living, and differences in State and local taxes.

The annual cost of the lower budget in spring 1967 amounted to $3,110 in Honolulu and $2,334 in small Southern cities. In relative terms, with U.S. urban average costs equal to 100, this constitutes a range of 87 to 116, or 33 percent. For the other two budgets, Honolulu families spent $4,429 for the intermediate and $7,219 for the higher. In Small Southern cities, families averaged $3,222 for the middle budget and $4,827 for the higher.

Of the mainland cities, the lower and intermediate budgets total costs were highest in Hartford—$3,022 and $4,343, respectively. The highest cost mainland city for the higher budget was Boston—$7,198.

For all three budgets, food, rental shelter, and transportation were most expensive in Honolulu, medical care in Los Angeles, and clothing in Portland, Maine. The cost of homeownership was highest in New York for the lower and middle budgets and in Boston for the higher budget.

Publications

"Measuring Retired Couples' Living Costs in Urban Areas" appears in the November issue of the *Monthly Labor Review*. Single copy price 75 cents, annual subscription $9.

The *Three Budgets for a Retired Couple in Urban Areas of the United States 1967–68*, Bulletin No. 1570–6, will become available later in 1969.

Other published bulletins in the series are:

Bulletin 1570–1, *City Worker's Family Budget for a Moderate Living Standard, Autumn 1966*. Price 30 cents.

Bulletin 1570–2, *Revised Equivalence Scale* for estimating budget costs for families of different size, age, and type. Price 35 cents.

Bulletin 1570–3, *Pricing Procedures, Specifications and Average Prices, Autumn 1966*, used for the moderate standard of the city worker's budget. Price 75 cents.

Bulletin 1570–4. *Retired Couple's Budget for a Moderate Living Standard Autumn 1966*. Price 35 cents.

Bulletin 1570–5, *Three Standards of Living for an Urban Family of Four Persons*, Spring 1967. Price $1.00.

Publications can be purchased from the regional offices of the Bureau of Labor Statistics and the Superintendent of Documents, Washington, D.C. 20402.

TABLE 1.—ANNUAL COSTS OF A LOWER BUDGET FOR A RETIRED COUPLE,[1] SPRING 1967

Area	Total budget costs[2]			Cost of family consumption									
						Housing (shelter, housefurnishings, household operations)							
							Shelter						
	Renter and owner combined[3]	Renter families	Homeowner families	Total[3]	Food	Total housing[3]	Renter and owner combined[3]	Renter families[4]	Homeowner families[5]	Transportation[6]	Clothing and personal care	Medical care	Other family consumption
Urban United States	$2,671	$2,723	$2,636	$2,556	$789	$939	$704	$756	$669	$191	$217	$294	$126
Metropolitan areas[7]	2,730	2,785	2,694	2,613	796	991	746	801	710	172	221	298	135
Nonmetropolitan areas[8]	2,492	2,536	2,462	2,385	769	783	578	622	548	248	207	281	97
Northeast:													
Boston Mass	2,757	2,710	2,789	2,639	835	1,109	852	805	884	47	218	290	140
Buffalo N.Y	2,944	2,938	2,948	2,817	816	1,085	833	827	837	249	237	293	137
Hartford Conn	3,022	3,065	2,993	2,892	851	1,121	885	928	856	250	227	298	145
Lancaster Pa	2,704	2,702	2,705	2,588	827	919	689	687	690	210	216	289	127
New York-northeastern New Jersey	2,803	2,706	2,867	2,683	845	1,142	898	801	962	33	223	301	139
Philadelphia Pa.-N.J	2,620	2,588	2,641	2,508	837	983	744	712	765	47	214	290	137
Pittsburgh Pa	2,680	2,762	2,625	2,565	802	885	652	734	597	228	224	285	141
Portland Maine	2,778	2,766	2,786	2,659	802	967	710	698	718	216	237	287	150
Nonmetropolitan areas[8]	2,764	2,827	2,722	2,645	829	952	754	817	712	263	217	286	98
North central:													
Cedar Rapids, Iowa	2,778	2,862	2,722	2,659	783	1,006	755	839	699	226	228	289	127
Champaign-Urbana, Ill	2,818	2,916	2,753	2,697	794	1,053	812	910	747	219	217	295	119
Chicago, Ill.-northwestern Indiana	2,664	2,798	2,574	2,550	806	1,048	801	935	711	43	227	295	131
Cincinnati, Ohio-Ky.-Ind	2,595	2,660	2,551	2,483	783	858	625	690	581	224	204	278	136
Cleveland, Ohio	2,828	2,929	2,761	2,707	778	1,054	809	910	742	236	227	274	138
Dayton, Ohio	2,689	2,845	2,585	2,574	777	948	706	862	602	219	216	281	133
Detroit, Mich	2,656	2,846	2,529	2,542	804	849	607	797	480	236	228	286	139
Green Bay, Wis	2,663	2,655	2,668	2,549	755	930	682	674	687	221	224	292	127
Indianapolis, Ind	2,850	2,969	2,770	2,728	786	1,077	826	945	746	228	224	275	138
Kansas City, Mo.-Kans	2,691	2,810	2,611	2,576	799	894	647	766	567	239	220	295	129
Milwaukee, Wis	2,795	2,864	2,749	2,675	768	1,036	797	866	751	228	224	287	132
Minneapolis-St. Paul, Minn	2,775	2,849	2,726	2,656	775	1,012	772	846	723	232	228	276	133
St. Louis, Mo.-Ill	2,757	2,830	2,708	2,639	820	953	711	784	662	242	215	287	122
Wichita, Kans	2,709	2,818	2,637	2,593	799	936	684	793	612	230	214	286	128
Nonmetropolitan areas[8]	2,560	2,635	2,510	2,450	788	829	623	698	573	240	224	275	94

South:													
Atlanta, Ga	2,462	2,566	2,393	2,357	738	752	489	593	420	221	210	292	143
Austin, Tex	2,462	2,593	2,374	2,356	733	787	545	676	457	220	194	295	127
Baltimore, Md	2,616	2,736	2,536	2,504	729	896	641	761	561	238	214	293	134
Baton Rouge, La	2,422	2,542	2,342	2,318	742	714	476	596	396	239	206	285	132
Dallas, Tex	2,511	2,573	2,469	2,403	725	813	574	636	532	228	202	302	133
Durham, N.C	2,554	2,634	2,501	2,444	713	893	651	731	598	218	205	287	128
Houston, Tex	2,531	2,610	2,478	2,422	745	798	549	628	496	246	198	302	133
Nashville, Tenn	2,536	2,573	2,512	2,427	710	857	600	637	576	222	209	291	138
Orlando, Fla	2,572	2,780	2,434	2,462	706	925	673	881	535	213	198	290	130
Washington, D.C.-Md.-Va	2,802	3,014	2,661	2,682	775	1,015	772	984	631	243	221	291	137
Nonmetropolitan areas [8]	2,334	2,359	2,317	2,234	732	692	487	512	470	246	188	280	96
West:													
Bakersfield, Calif	2,650	2,714	2,607	2,536	781	854	612	676	569	243	216	318	124
Denver, Colo	2,710	2,723	2,701	2,594	797	922	671	684	662	225	230	296	124
Honolulu, Hawaii	3,110	3,455	2,880	2,976	985	1,066	762	1,107	532	272	215	293	145
Los Angeles-Long Beach, Calif	2,818	2,993	2,702	2,697	781	971	739	914	623	243	226	339	137
San Diego, Calif	2,736	2,836	2,669	2,619	763	948	708	808	641	238	208	325	137
San Francisco-Oakland, Calif	2,926	3,062	2,835	2,800	816	1,016	774	910	683	259	244	324	141
Seattle-Everett, Wash	2,971	3,102	2,884	2,843	851	1,051	787	918	700	257	239	309	136
Metropolitan areas [8]	2,703	2,734	2,683	2,587	819	881	663	694	643	264	227	292	104

[1] A husband age 65 or over and his wife.

[2] The total cost of the budget includes an allowance for gifts and contributions.

[3] The total represents the weighted average costs of renter and homeowner families. The weights in the lower budget were 40 percent for families living in rental dwellings; 60 percent for homeowners.

[4] Average contract rent plus the cost of required amounts of heating fuel, gas, electricity, water, specified equipment, and insurance on household contents.

[5] Taxes; insurance on house and contents; water, refuse disposal, heating fuel, gas, electricity, and specified equipment; and home repair and maintenance costs.

[6] The average costs of automobile owners and nonowners were weighted by the following proportions of families: Boston, Chicago, New York, Philadelphia, 100 percent for nonowners; all other metropolitan areas, 45 percent for car owners, 55 percent for nonowners; nonmetropolitan areas, 55 percent for car owners, 45 percent for nonowners.

[7] For a detailed description see the 1967 edition of Standard Metropolitan Statistical Areas, prepared by the Bureau of the Budget.

[8] Places with populations of 2,500 to 50,000.

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

TABLE 2.—ANNUAL COSTS OF AN INTERMEDIATE BUDGET FOR A RETIRED COUPLE,[1] SPRING 1967

Area	Total budget costs [2]			Cost of family consumption									
						Housing (shelter, housefurnishings, household operations)							
							Shelter						
	Renter and owner combined [3]	Renter families	Home-owner families	Total [3]	Food	Total housing [3]	Renter and owner combined [3]	Renter families [4]	Home-owner families [5]	Transportation [6]	Clothing and personal care	Medical care	Other family consumption
Urban United States	$3,857	$3,976	$3,793	$3,626	$1,048	$1,330	$849	$968	$785	$382	$357	$296	$213
Metropolitan areas [7]	3,997	4,124	3,928	3,757	1,064	1,425	904	1,031	836	378	362	300	228
Nonmetropolitan areas [8]	3,440	3,538	3,388	3,234	1,002	1,046	683	781	631	394	342	283	167
Northeast:													
Boston, Mass	4,258	4,276	4,248	4,003	1,142	1,621	1,075	1,093	1,065	360	354	292	234
Buffalo, N.Y	4,217	4,259	4,194	3,964	1,089	1,520	980	1,022	957	442	385	296	232
Hartford, Conn	4,343	4,464	4,278	4,083	1,173	1,557	1,035	1,156	970	445	366	300	242
Lancaster, Pa	3,925	4,005	3,882	3,690	1,136	1,302	819	899	776	392	348	291	221
New York-northeastern New Jersey	4,265	4,256	4,270	4,009	1,173	1,682	1,137	1,128	1,142	247	368	303	236
Philadelphia, Pa.-New Jersey	3,993	4,015	3,981	3,754	1,124	1,430	921	943	909	330	348	292	230
Pittsburgh, Pa	3,884	4,020	3,811	3,651	1,080	1,273	774	910	701	414	362	287	235
Portland, Maine	4,035	4,062	4,020	3,793	1,104	1,364	836	863	821	407	388	289	241
Nonmetropolitan areas [8]	3,828	3,957	3,759	3,598	1,117	1,256	887	1,016	818	410	361	288	167
North Central:													
Cedar Rapids, Iowa	4,019	4,146	3,950	3,778	1,007	1,479	924	1,051	855	409	370	292	221
Champaign-Urbana, Ill	4,053	4,208	3,969	3,810	1,042	1,506	993	1,148	909	397	356	297	212
Chicago, Ill.-northwestern Indiana	3,945	4,156	3,831	3,709	1,034	1,454	933	1,144	819	335	367	297	222
Cincinnati, Ohio-Kentucky-Indiana	3,765	3,888	3,699	3,539	1,021	1,269	763	886	697	402	337	281	229
Cleveland, Ohio	4,057	4,279	3,938	3,814	1,010	1,506	988	1,210	869	422	372	277	227
Dayton, Ohio	3,791	4,000	3,679	3,564	1,004	1,296	800	1,009	688	401	357	284	222
Detroit, Mich	3,870	4,133	3,728	3,638	1,060	1,265	726	989	584	424	370	288	231
Green Bay, Wis	3,825	3,812	3,832	3,596	974	1,337	840	827	847	411	362	295	217

Indianapolis, Ind	4,065	4,194	3,995	3,822	1,021	1,507	984	1,113	914	417	367	278	232
Kansas City, Mo.-Kans	3,881	4,051	3,789	3,648	1,032	1,302	771	941	679	434	359	298	223
Milwaukee, Wis	4,040	4,132	3,990	3,798	1,015	1,496	969	1,061	919	411	364	289	223
Minneapolis-St. Paul, Minn	3,972	4,107	3,899	3,734	1,014	1,425	910	1,045	837	419	366	279	231
St. Louis, Mo.-Illinois	3,974	4,096	3,909	3,736	1,073	1,379	861	983	796	436	350	289	209
Wichita, Kans	3,863	3,986	3,796	3,632	1,018	1,324	814	937	747	432	350	288	220
Nonmetropolitan areas [8]	3,555	3,682	3,468	3,342	1,003	1,142	766	893	697	382	370	278	167
South:													
Atlanta, Ga	3,593	3,804	3,479	3,378	995	1,103	597	808	483	403	348	294	235
Austin, Tex	3,574	3,801	3,451	3,360	972	1,155	678	905	555	405	320	297	211
Baltimore, Md	3,781	4,024	3,650	3,554	981	1,276	738	981	607	421	357	295	224
Baton Rouge, La	3,504	3,671	3,414	3,294	995	1,030	569	736	479	436	329	287	217
Dallas, Tex	3,655	3,801	3,577	3,436	978	1,188	710	856	632	411	335	304	220
Durham, N.C	3,667	3,789	3,601	3,447	952	1,249	776	898	710	404	339	289	214
Houston, Tex	3,679	3,796	3,616	3,459	1,003	1,170	674	790	611	440	326	304	216
Nashville, Tenn	3,702	3,835	3,631	3,480	949	1,254	752	885	681	408	347	293	229
Orlando, Fla	3,668	3,967	3,507	3,448	941	1,273	786	1,085	625	396	328	292	218
Washington, D.C.-Maryland-Virginia	3,995	4,228	3,870	3,756	1,045	1,393	849	1,082	724	431	370	294	223
Nonmetropolitan areas [8]	3,222	3,289	3,186	3,029	964	912	564	631	528	395	311	282	165
West:													
Bakersfield, Calif	3,815	3,948	3,744	3,586	1,001	1,267	765	898	694	431	355	321	211
Denver, Colo	3,887	3,994	3,829	3,654	1,035	1,318	795	902	737	419	372	297	213
Honolulu, Hawaii	4,429	4,922	4,163	4,164	1,267	1,530	939	1,432	673	476	352	295	244
Los Angeles-Long Beach, Calif	4,019	4,263	3,888	3,778	1,017	1,389	870	1,114	739	430	371	342	229
San Diego, Calif	3,853	4,001	3,774	3,622	995	1,310	810	958	731	419	342	328	228
San Francisco-Oakland, Calif	4,182	4,414	4,058	3,931	1,068	1,448	915	1,147	791	455	397	327	236
Seattle-Everett, Wash	4,273	4,484	4,159	4,017	1,107	1,522	942	1,153	828	458	385	311	234
Nonmetropolitan areas [8]	3,672	3,790	3,609	3,452	1,039	1,159	772	890	709	407	376	294	177

[1] A husband age 65 or over and his wife.
[2] The total cost of the budget includes an allowance for gifts and contributions.
[3] The total represents the weighted average costs of renter and homeowner families. The weights in the intermediate budget were 35 percent for families living in rental dwellings; 65 percent for homeowners.
[4] Average contract rent plus the cost of required amounts of heating fuel, gas, electricity, water, specified equipment, and insurance on household contents.
[5] Taxes; insurance on house and contents; water, refuse disposal, heating fuel, gas, electricity, and specified equipment; and home repair and maintenance cost.
[6] The average costs of automobile owners and nonowners were weighted by the following proportions of families: New York, 25 percent for car owners, 75 percent for nonowners; Boston, Chicago, Philadelphia, 40 percent for car owners, 60 percent for nonowners; all other metropolitan areas, 60 percent for car owners, 40 percent for nonowners; nonmetropolitan areas, 68 percent for car owners, 32 percent for nonowners.
[7] For a detailed description see the 1967 edition of "Standard Metropolitan Statistical Areas," prepared by the Bureau of the Budget.
[8] Places with populations of 2,500 to 50,000.

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

TABLE 3.—ANNUAL COSTS OF A HIGHER BUDGET FOR A RETIRED COUPLE,[1] SPRING 1967

Area	Total budget costs[2]			Cost of family consumption										Personal taxes		
						Housing (shelter, housefurnishings, household operations)										
							Shelter									
	Renter and owner combined[3]	Renter families	Homeowner families	Total[3]	Food	Total housing[4]	Renter and owner combined[3]	Renter families[5]	Homeowner families[6]	Transportation[7]	Clothing and personal care	Medical care	Other family consumption	Renter and owner combined	Renter families	Homeowner families
Urban United States	$6,039	$6,350	$5,906	$5,335	$1,285	$2,066	$1,188	$1,449	$1,076	$682	$549	$299	$454	$235	$285	$214
Metropolitan areas[8]	6,342	6,701	6,187	5,571	1,305	2,232	1,287	1,588	1,158	697	545	303	489	284	342	258
Nonmetropolitan areas[9]	5,137	5,303	5,065	4,629	1,225	1,569	892	1,033	831	639	560	286	350	92	117	81
Northeast:																
Boston, Mass	7,198	7,312	7,149	6,217	1,375	2,840	1,823	1,916	1,783	675	526	295	506	446	467	437
Buffalo, N.Y	6,626	6,938	6,492	5,791	1,310	2,364	1,364	1,619	1,255	747	569	298	503	332	389	307
Hartford, Conn	6,860	7,244	6,695	6,002	1,432	2,433	1,461	1,784	1,322	760	545	303	529	339	400	313
Lancaster, Pa	6,027	6,141	5,977	5,304	1,371	1,955	1,048	1,144	1,006	670	527	294	487	256	274	248
New York-northeastern, New Jersey	6,917	7,079	6,849	6,012	1,418	2,609	1,618	1,750	1,562	617	550	304	514	385	415	273
Philadelphia, Pa.-N.J	6,372	6,827	6,176	5,557	1,365	2,284	1,324	1,703	1,161	591	519	295	503	329	405	296
Pittsburgh, Pa	6,078	6,333	5,968	5,338	1,311	1,990	1,058	1,272	966	699	537	290	511	271	312	253
Portland, Maine	6,069	5,980	6,107	5,380	1,319	1,995	1,035	959	1,067	693	575	292	506	217	204	223
Nonmetropolitan areas[9]	5,724	5,685	5,741	5,102	1,366	1,855	1,165	1,133	1,179	660	568	291	362	170	163	173
North Central:																
Cedar Rapids, Iowa	6,412	6,861	6,219	5,590	1,249	2,284	1,330	1,696	1,173	725	568	294	470	334	417	298
Champaign-Urbana, Ill	6,288	6,494	6,200	5,553	1,291	2,229	1,332	1,507	1,257	722	551	300	460	250	281	237
Chicago, Ill, northwestern Indiana	6,248	6,943	5,950	5,519	1,275	2,268	1,337	1,924	1,085	639	567	299	471	246	354	200
Cincinnati, Ohio, Kentucky, and Indiana	5,724	5,884	5,655	5,078	1,265	1,847	959	1,094	901	680	524	284	478	196	221	185
Cleveland, Ohio	6,234	6,544	6,101	5,489	1,236	2,219	1,288	1,551	1,176	714	574	279	467	264	311	243
Dayton, Ohio	6,030	6,582	5,794	5,307	1,225	2,099	1,192	1,656	994	672	554	287	470	256	344	218
Detroit, Mich	6,377	7,120	6,058	5,608	1,304	2,231	1,279	1,900	1,013	719	570	291	493	279	401	226
Green Bay, Wis	6,161	6,291	6,106	5,353	1,198	2,139	1,232	1,337	1,187	699	562	298	457	338	363	328
Indianapolis, Ind	6,304	6,377	6,272	5,553	1,264	2,231	1,309	1,370	1,283	713	568	281	496	266	278	260

Area																
Kansas City, Mo.-Kans	6,088	6,423	5,944	5,361	1,264	2,023	1,084	1,363	964	741	555	300	478	256	312	232
Milwaukee, Wis	6,305	6,496	6,224	5,460	1,264	2,172	1,268	1,422	1,202	698	561	292	473	366	403	351
Minneapolis-St. Paul, Minn	6,226	6,481	6,118	5,430	1,247	2,143	1,224	1,428	1,137	716	562	281	481	320	371	299
St. Louis, Mo.-Ill	6,031	6,094	6,003	5,317	1,334	1,953	1,042	1,095	1,019	758	542	292	438	246	256	241
Wichita, Kans	6,025	6,322	5,898	5,299	1,244	2,017	1,100	1,346	994	746	539	291	462	244	295	223
Nonmetropolitan areas [9]	5,265	5,314	5,244	4,726	1,227	1,658	974	1,016	956	617	595	281	348	115	122	112
South:																
Atlanta, Ga	5,475	5,948	5,272	4,908	1,224	1,689	788	1,192	615	689	535	297	474	130	199	100
Austin, Tex	5,515	5,872	5,362	4,940	1,188	1,758	905	1,210	775	727	495	299	473	135	187	112
Baltimore, Md	6,012	6,206	5,929	5,314	1,231	2,057	1,085	1,245	1,016	709	537	298	482	230	264	216
Baton Rouge, La	5,569	5,912	5,422	4,983	1,274	1,668	831	1,123	706	764	505	289	483	143	194	121
Dallas, Tex	5,949	6,664	5,641	5,284	1,226	2,010	1,149	1,757	888	731	517	306	494	200	307	153
Durham, N.C	5,560	5,734	5,485	4,932	1,169	1,774	908	1,051	846	708	518	291	472	189	220	176
Houston, Tex	5,995	6,741	5,674	5,320	1,243	2,019	1,123	1,756	851	780	501	306	471	207	320	158
Nashville, Tenn	5,728	6,000	5,611	5,110	1,161	1,932	1,027	1,258	927	720	531	295	471	166	207	149
Orlando, Fla	5,590	5,808	5,495	5,000	1,170	1,873	980	1,166	900	692	502	294	469	146	178	131
Washington, D.C.-Md.-Va	6,240	6,605	6,084	5,493	1,282	2,137	1,178	1,479	1,049	725	568	296	485	270	334	243
Nonmetropolitan areas [9]	4,827	5,089	4,714	4,388	1,177	1,410	754	979	658	642	527	284	348	40	77	23
West:																
Bakersfield, Calif	5,978	6,283	5,847	5,307	1,232	1,983	1,049	1,309	938	774	526	324	468	204	249	184
Denver Colo	6,154	6,565	5,978	5,444	1,324	2,100	1,150	1,494	1,003	710	546	300	464	233	300	204
Honolulu, Hawaii	7,219	8,072	6,853	6,204	1,594	2,436	1,344	2,030	1,050	815	521	298	540	481	648	409
Los Angeles-Long Beach, Calif	6,487	7,377	6,105	5,706	1,269	2,301	1,356	2,103	1,036	758	551	344	483	284	427	222
San Diego, Calif	6,127	6,548	5,947	5,425	1,230	2,147	1,216	1,574	1,063	732	507	332	477	226	289	199
San Francisco-Oakland, Calif	6,540	6,870	6,399	5,751	1,341	2,205	1,232	1,511	1,113	796	588	330	491	289	340	267
Seattle-Everett, Wash	6,497	6,725	6,399	5,717	1,367	2,192	1,177	1,370	1,094	793	568	314	483	282	317	267
Nonmetropolitan areas [9]	5,519	5,794	5,401	4,909	1,285	1,714	982	1,208	885	660	597	296	357	173	222	152

[1] A husband age 65 or over and his wife.
[2] The total cost of the budget includes an allowance for gifts and contributions.
[3] The total represents the weighted average costs of renter and homeowner families. The weights in the higher budget were 30 percent for families living in rental dwellings; 70 percent for homeowners.
[4] The total includes an allowance of $53 for lodging away from home city. The allowance is the same for all areas. This allowance is not shown separately or included in any of the housing subgroups.
[5] Average contract rent plus the cost of required amounts of heating fuel, gas, electricity, water, specified equipment, and insurance on household contents.
[6] Taxes; insurance on house and contents; water, refuse disposal, heating fuel, gas, electricity, and specified equipment; and home repair and maintenance costs.
[7] The average costs of automobile owners and nonowners were weighted by the following proportions of families: Boston, Chicago, New York, Philadelphia, 75 percent for car owners, 25 percent for nonowners; all other metropolitan and nonmetropolitan areas, 100 percent for car owners.
[8] For a detailed description see the 1967 edition of Standard Metropolitan Statistical Areas, prepared by the Bureau of the Budget.
[9] Places with populations of 2,500 to 50,000.

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

TABLE 4.—INDEXES OF COMPARATIVE COSTS BASED ON A LOWER LEVEL BUDGET FOR A RETIRED COUPLE [1] SPRING 1967

[U.S. urban average costs=100]

Area	Total budget costs			Cost of family consumption									
						Housing (shelter, house furnishings, household operation)							
							Shelter						
	Renter and owner combined [2]	Renter families	Homeowner families	Total [2]	Food	Total [3]	Renter and owner combined [4]	Renter families [5]	Homeowner families [6]	Transportation [7]	Clothing and personal care	Medical care	Other family consumption
Urban United States	100	100	100	100	100	100	100	100	100	100	100	100	100
Metropolitan areas [8]	102	102	102	102	101	106	106	106	106	90	102	101	108
Nonmetropolitan areas [9]	93	93	93	93	97	83	82	82	82	130	95	96	77
Northeast:													
Boston, Mass	103	100	106	103	106	118	121	106	132	25	100	99	111
Buffalo, N.Y	110	108	112	110	103	116	118	109	125	131	109	100	109
Hartford, Conn	113	113	114	113	108	119	126	123	128	131	105	101	115
Lancaster, Pa	101	99	103	101	105	98	98	91	103	110	99	98	101
New York-Northeastern N.J	105	99	109	105	107	122	127	06	144	17	103	102	111
Philadelphia, Pa.-N.J	98	95	100	98	106	105	106	94	114	24	99	98	109
Pittsburgh, Pa	100	101	100	100	102	94	93	97	89	120	103	97	112
Portland, Maine	104	102	106	104	102	103	101	92	107	113	109	98	119
Nonmetropolitan areas [9]	104	104	103	104	105	101	107	108	106	138	100	97	78
North Central:													
Cedar Rapids, Iowa	104	105	103	104	99	107	107	111	104	118	105	98	101
Champaign-Urbana, Ill	106	107	104	106	101	112	115	120	112	115	100	100	95
Chicago, Ill.-Northwestern Indiana	100	103	98	100	102	112	114	124	106	22	105	100	104

Cincinnati, Ohio-Kentucky-Indiana	97	98	97	97	99	91	89	91	87	117	94	95	108
Cleveland, Ohio	106	108	105	106	99	112	115	120	111	124	104	93	110
Dayton, Ohio	101	105	98	101	98	101	100	114	90	115	100	95	105
Detroit, Mich	99	104	96	99	102	90	86	105	72	124	105	97	111
Green Bay, Wis	100	98	101	100	96	99	97	89	103	116	103	99	101
Indianapolis, Ind	107	109	105	107	100	115	117	125	111	119	103	94	110
Kansas City, Mo.-Kansas	101	103	99	101	101	95	92	101	85	125	102	100	102
Milwaukee, Wis	105	105	104	105	97	110	113	115	112	119	103	98	105
Minneapolis-St. Paul, Minn	104	105	103	104	98	108	110	112	108	122	105	94	105
St. Louis, Mo.-Ill	103	104	103	103	104	102	101	104	99	127	99	98	97
Wichita, Kans	101	103	100	101	101	100	97	105	92	121	99	97	102
Nonmetropolitan areas [9]	96	97	95	96	100	88	88	92	86	126	103	94	75
South:													
Atlanta, Ga	92	94	91	92	94	80	69	78	63	116	97	99	114
Austin, Tex	92	95	90	92	93	84	77	89	68	116	89	100	101
Baltimore, Md	98	101	96	98	92	95	91	101	84	124	99	100	107
Baton Rouge, La	91	93	89	91	94	76	68	79	59	125	95	97	105
Dallas, Tex	94	94	94	94	92	87	81	84	80	119	93	103	105
Durham, N.C	96	97	95	96	90	95	92	97	89	115	94	98	102
Houston, Tex	95	96	94	95	94	85	78	83	74	129	91	103	105
Nashville, Tenn	95	94	95	95	90	91	85	84	86	116	96	99	110
Orlando, Fla	96	102	92	96	89	99	96	117	80	112	91	99	103
Washington, D.C.-Md.-Va	105	111	101	105	98	108	110	130	94	127	102	99	109
Nonmetropolitan areas [9]	87	87	88	87	93	74	69	68	70	129	87	95	77
West:													
Bakersfield, Calif	99	100	99	99	99	91	87	89	85	128	100	108	98
Denver, Colo	101	100	102	101	101	98	95	90	99	118	106	101	99
Honolulu, Hawaii	116	127	109	116	125	144	108	146	80	143	99	100	116
Los Angeles-Long Beach, Calif	106	110	103	106	99	103	105	121	93	127	104	115	109
San Diego, Calif	102	104	101	102	97	101	101	107	96	125	96	110	109
San Francisco-Oakland, Calif	110	112	108	110	103	108	110	120	102	136	112	110	112
Seattle-Everett, Wash	111	114	109	111	108	112	122	121	105	134	110	105	108
Nonmetropolitan areas [9]	101	100	102	101	104	94	94	92	96	138	140	99	83

See footnotes at end of table 6.

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TABLE 5.—INDEXES OF COMPARATIVE COSTS BASED ON AN INTERMEDIATE LEVEL BUDGET FOR A RETIRED COUPLE,[1] SPRING 1967

[U.S. urban average costs=100]

Area	Total budget costs			Cost of family consumption									
						Housing (shelter, housefurnishings, household operation)							
							Shelter						
	Renter and owner combined [2]	Renter families	Homeowner families	Total [2]	Food	Total [3]	Renter and owner combined [4]	Renter families [5]	Homeowner families [6]	Transportation [7]	Clothing and personal care	Medical care	Other family consumption
Urban United States	100	100	100	100	100	100	100	100	100	100	100	100	100
Metropolitan areas [8]	104	104	104	104	101	107	106	106	107	99	101	101	107
Nonmetropolitan areas [9]	89	89	89	89	96	79	81	81	80	103	96	96	78
Northeast:													
Boston, Mass	110	108	112	110	109	122	127	113	136	94	99	99	110
Buffalo, N.Y	109	107	111	109	104	114	115	106	122	116	108	100	109
Hartford, Conn	113	112	113	113	112	117	122	119	124	116	103	101	113
Lancaster, Pa	102	101	102	102	108	98	96	93	99	103	98	98	104
New York-Northeastern N.J	111	107	113	111	112	126	134	117	146	65	103	102	111
Philadelphia, Pa.-N.J	104	101	105	104	107	107	108	97	116	86	98	99	108
Pittsburgh, Pa	101	101	100	101	103	96	91	94	89	108	102	97	110
Portland, Maine	105	102	106	105	105	103	98	89	105	106	109	98	113
Nonmetropolitan areas [9]	99	100	99	99	107	94	105	105	104	107	101	97	79
North Central:													
Cedar Rapids, Iowa	104	104	104	104	96	111	109	108	109	107	104	98	104
Champaign-Urbana, Ill	105	106	105	105	99	113	117	119	116	104	100	100	100
Chicago, Ill.-Northwestern Ind	102	105	101	102	99	109	110	118	104	88	103	100	104

Cincinnati, Ohio-Ky.-Ind	98	98	98	98	97	95	90	91	89	105	95	95	107
Cleveland, Ohio	105	108	104	105	96	113	116	125	111	110	104	93	107
Dayton, Ohio	98	101	97	98	96	97	94	104	88	105	100	96	104
Detroit, Mich	100	104	98	100	101	95	85	102	74	111	104	97	109
Green Bay, Wis	99	96	101	99	93	100	99	85	108	108	102	99	102
Indianapolis, Ind	105	105	105	105	97	113	116	115	116	109	103	94	109
Kansas City, Mo.-Kans	101	102	100	101	99	98	91	97	87	113	101	100	105
Milwaukee, Wis	105	104	105	105	97	112	114	110	117	107	102	98	104
Minneapolis-St. Paul, Minn	103	103	103	103	97	107	107	108	107	110	103	94	108
St. Louis, Mo.-Ill	103	103	103	103	102	104	101	102	101	114	98	98	98
Wichita, Kans	100	100	100	100	97	99	96	97	95	113	98	97	108
Nonmetropolitan areas [9]	92	93	92	92	96	86	90	92	89	100	104	94	73
South:													
Atlanta, Ga	93	96	92	93	95	83	70	83	62	105	98	99	110
Austin, Tex	93	96	91	93	93	87	80	93	71	106	90	100	99
Baltimore, Md	98	101	96	98	94	96	87	101	77	110	100	100	105
Baton Rouge, La	91	92	90	91	95	77	67	76	61	114	92	97	102
Dallas, Tex	95	96	94	95	93	89	84	88	81	108	94	103	103
Durham, N.C	95	95	95	95	91	94	91	93	90	105	95	98	101
Houston, Tex	95	95	95	95	96	88	79	82	78	115	92	103	101
Nashville, Tenn	96	96	96	96	91	94	89	91	87	107	98	99	107
Orlando, Fla	95	100	92	95	90	96	93	112	80	104	92	99	103
Washington, D.C.-Md.-Va	104	106	102	104	100	105	100	112	92	113	104	99	105
Nonmetropolitan areas [9]	84	83	84	84	92	69	66	65	67	103	87	95	77
West:													
Bakersfield, Calif	99	99	99	99	96	95	90	93	88	113	100	108	99
Denver, Colo	101	100	101	101	99	99	94	93	94	110	104	100	100
Honolulu, Hawaii	115	124	110	115	121	115	110	148	86	125	99	100	114
Los Angeles-Long Beach, Calif	104	107	102	104	97	104	102	115	94	113	104	115	108
San Diego, Calif	100	101	99	100	95	99	95	99	93	110	96	111	107
San Francisco-Oakland, Calif	108	111	107	108	102	109	108	119	101	119	111	110	111
Seattle-Everett, Wash	111	113	110	111	106	114	111	119	106	120	108	105	110
Nonmetropolitan areas [9]	95	95	95	95	99	87	91	92	90	106	106	99	83

See footnotes at end of table 6.

TABLE 6.—INDEXES OF COMPARATIVE COSTS BASED ON A HIGHER LEVEL BUDGET FOR A RETIRED COUPLE [1], SPRING 1967

[U.S. Urban Average Costs=100]

Area	Total budget costs			Cost of family consumption									
						Housing (shelter, housefurnishings, household operation)							
							Shelter						
	Renter and owner combined [2]	Renter families	Homeowner families	Total [2]	Food	Total [3]	Renter and owner combined [4]	Renter families [5]	Homeowner families [6]	Transportation [7]	Clothing and personal care	Medical care	Other family consumption
Urban United States	100	100	100	100	100	100	100	100	100	100	100	100	100
Metropolitan areas [8]	105	106	105	104	102	108	108	110	108	102	99	101	108
Nonmetropolitan areas [9]	85	83	86	87	95	76	75	71	77	94	102	96	77
Northeast:													
Boston, Mass	119	115	121	117	107	137	153	132	166	99	96	99	111
Buffalo, N.Y	110	109	110	109	102	114	115	112	117	109	104	100	111
Hartford, Conn	114	114	113	112	111	118	123	123	123	111	99	102	116
Lancaster, Pa	100	97	101	99	107	95	88	79	93	98	96	98	107
New York-Northeastern N.J	115	111	116	113	110	126	136	121	145	90	100	102	113
Philadelphia, Pa.-N.J	105	107	105	104	106	111	111	118	108	87	95	99	111
Pittsburgh, Pa	101	100	101	100	102	96	89	88	90	102	98	97	112
Portland, Maine	100	94	103	101	103	97	87	66	99	102	105	98	111
Nonmetropolitan areas [9]	95	90	97	96	106	90	98	78	110	97	103	97	80
North Central:													
Cedar Rapids, Iowa	106	108	105	105	97	111	112	117	109	106	103	99	103
Champaign-Urbana, Ill	104	102	105	104	100	108	112	104	117	106	100	100	101
Chicago, Ill.-Northwestern, Ind	103	109	101	103	99	110	113	133	101	94	103	100	104
Cincinnati, Ohio-Ky.-Ind	95	93	96	95	98	89	81	76	84	100	95	95	105
Cleveland, Ohio	103	103	103	103	96	107	108	107	109	105	105	94	103
Dayton, Ohio	100	104	98	99	95	102	100	114	92	98	101	96	104
Detroit, Mich	106	112	103	105	101	108	108	131	94	105	104	98	109
Green Bay, Wis	102	99	103	100	93	104	104	92	110	102	102	100	101
Indianapolis, Ind	104	100	106	104	98	108	110	95	119	105	103	94	109
Kansas City, Mo.-Kans	101	101	101	100	98	98	91	94	90	109	101	101	105
Milwaukee, Wis	104	102	105	102	98	105	107	98	112	102	102	98	104
Minneapolis-St. Paul, Minn	103	102	104	102	97	104	103	98	106	105	102	94	106
St. Louis, Mo.-Ill	100	96	102	100	104	95	88	76	95	111	99	98	97
Wichita, Kans	100	100	100	99	97	98	93	93	92	109	98	98	102
Nonmetropolitan areas [9]	87	84	89	89	96	80	82	70	89	90	108	94	77

South:													
Atlanta, Ga	91	94	89	92	95	82	66	82	57	101	97	99	105
Austin, Tex	91	92	91	93	92	85	76	84	72	107	90	100	104
Baltimore, Md	100	98	100	100	96	100	91	86	94	104	98	100	106
Baton Rouge, La	92	93	92	93	99	81	70	78	66	112	92	97	106
Dallas, Tex	98	105	96	99	95	97	97	121	83	107	94	102	109
Durham, N.C	92	90	93	92	91	86	76	73	79	104	94	98	104
Houston, Tex	99	106	96	100	97	98	94	121	79	114	91	103	104
Nashville, Tenn	95	94	95	96	90	94	86	87	86	106	97	99	104
Orlando, Fla	93	91	93	94	91	91	82	80	84	101	92	99	103
Washington, D.C.-Md.-Va	103	104	103	103	100	103	99	102	97	106	103	99	107
Nonmetropolitan areas [9]	80	80	80	82	92	68	63	68	61	94	96	95	76
West:													
Bakersfield, Calif	99	99	99	99	96	96	88	90	87	113	96	108	103
Denver, Colo	102	103	101	102	103	102	97	103	93	104	99	100	102
Honolulu, Hawaii	120	127	116	116	124	118	113	140	98	119	95	100	119
Los Angeles-Long Beach, Calif	107	116	103	107	99	111	114	145	96	111	100	115	106
San Diego, Calif	101	103	101	102	96	104	102	109	99	107	92	111	105
San Francisco-Oakland, Calif	108	108	108	108	104	107	104	104	103	117	107	110	108
Seattle-Everett, Wash	108	106	108	107	106	106	99	95	102	116	103	105	106
Nonmetropolitan areas [9]	91	91	91	92	100	83	83	83	82	97	109	99	79

[1] The family consists of a retired husband and wife, age 65 years or over.

[2] The total represents the weighted average costs of renter and homeowner families. See the weights cited in footnote 4.

[3] The lower and intermediate budgets do not include an allowance for lodging away from home city, but the higher budget includes $53 for all areas. These costs are not shown separately or included in any of the housing subgroups.

[4] The average cost of shelter is weighted by the following proportions: Lower budget, 40 percent for renters, 60 percent for homeowners; intermediate budget, 35 percent for renters, 65 percent for homeowners; higher budget, 30 percent for renters, 70 percent for homeowners.

[5] Average contract rent plus the cost of required amounts of heating fuel, gas, electricity, water, specified equipment, and insurance on household contents.

[6] Taxes, insurance on house and contents, water, refuse disposal, heating fuel, gas, electricity, specified equipment and home repair and maintenance costs.

[7] The average costs to automobile owners and nonowners in the lower budget are weighted by the following proportions of families: New York, Boston, Chicago, and Philadelphia. 100 percent for nonowners; all other metropolitan areas, 45 percent for automobile owners, 55 percent for nonowners; nonmetropolitan areas, 55 percent for owners, 45 percent for nonowners. The intermediate budget proportions are: New York, 25 percent for owners, 75 percent for nonowners; Boston, Philadelphia and Chicago, 40 percent for owners, 60 percent for nonowners; all other metropolitan areas, 60 percent for owners, 40 percent for nonowners; nonmetropolitan areas, 68 percent for owners, and 32 percent for nonowners. The higher budget proportions are: New York, Boston, Philadelphia and Chicago, 75 percent for owners, 25 percent for nonowners; all other areas, 100 percent for automobile owners. Intermediate budget costs for automobile owners in autumn 1966 were revised prior to updating to spring 1967 cost levels.

[8] For a detailed description, see the 1967 edition of the "Standard Metropolitan Statistical Areas" prepared by the Bureau of the Budget.

[9] Places with population of 2,500 to 50,000.

INDEXES OF COMPARATIVE LIVING COSTS
URBAN RETIRED COUPLE
(lower budget, spring 1967)

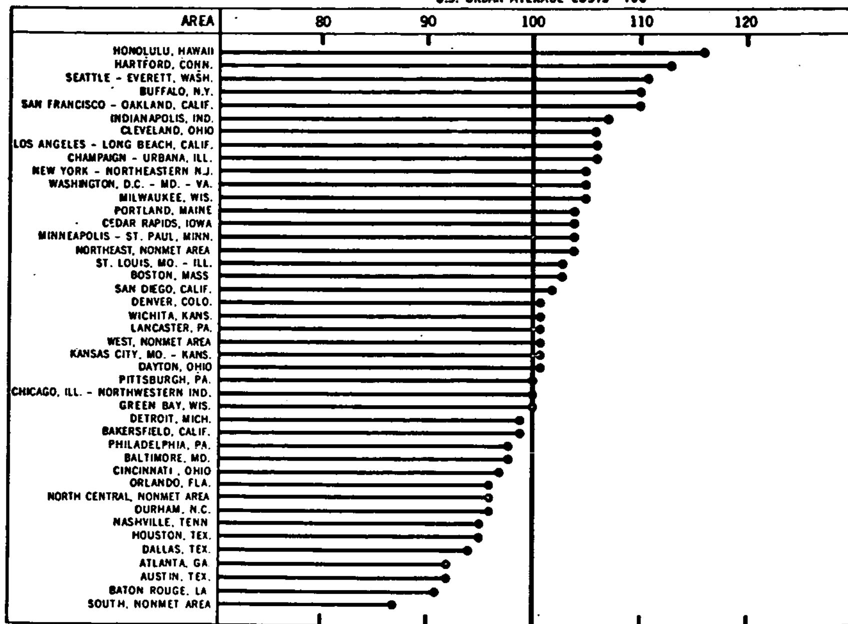

EXHIBIT 1

INDEXES OF COMPARATIVE LIVING COSTS

URBAN RETIRED COUPLE

(intermediate budget, spring 1967)

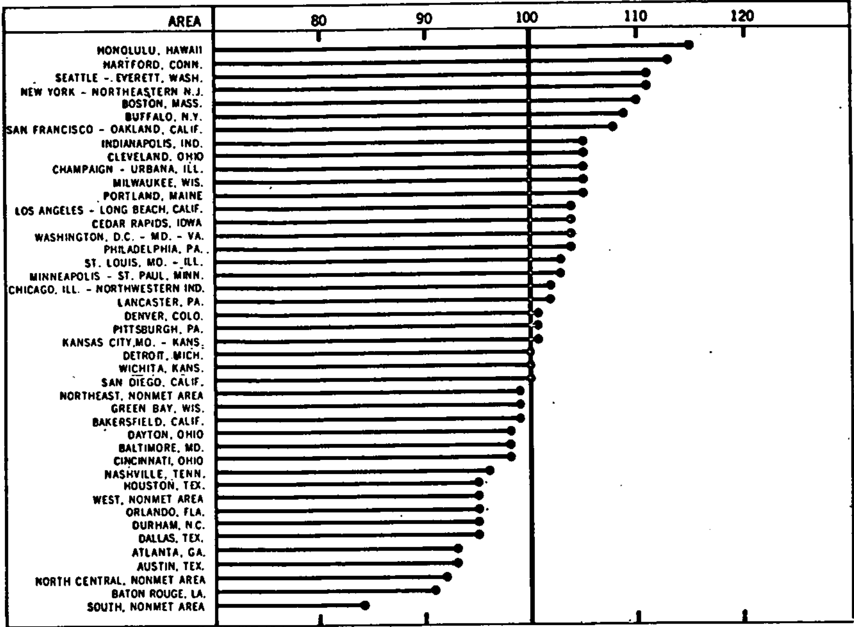

EXHIBIT 2

INDEXES OF COMPARATIVE LIVING COSTS
URBAN RETIRED COUPLE
(higher budget, spring 1967)

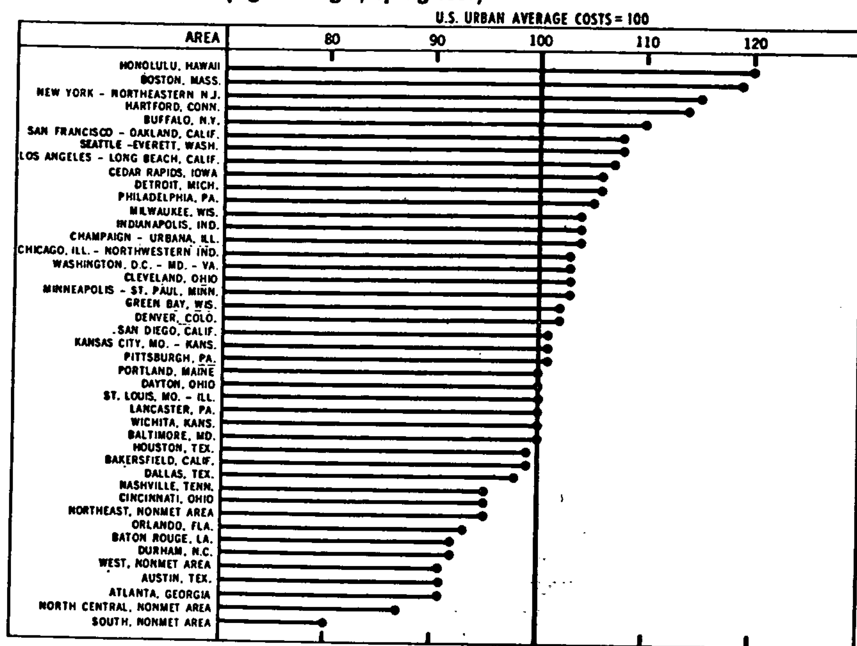

EXHIBIT 3

ITEM 2: RECOMMENDATIONS ON THE AGING MADE BY PANEL 4, SECTION II (NUTRITION OF VULNERABLE GROUPS), AT WHITE HOUSE CONFERENCE ON FOOD, NUTRITION, AND HEALTH, DECEMBER 1969

PREAMBLE

The present crisis among the aged demands immediate national action to relieve poverty, hunger, malnutrition and poor health. Furthermore, positive measures are required throughout life to retard the premature debilitating aspects of aging.

Certain priorities exist:

1. Provision of adequate income to the aging.
2. Provision of adequate nutrition to the aging.
3. Provision of adequate health services to the aging.
4. Federal, state and local funding to insure immediate implementation of (1), (2) and (3) above.
5. Prompt provision of substantial increases in federal funding for support of education, research and development in nutrition and gerontology.

RECOMMENDATION I: MEAL PURCHASE AND DELIVERY

The U.S. Government having acknowledged the right of every resident to adequate health and nutrition must now accept its obligation to provide the opportunity for adequate nutrition to every aged resident. Immediate attention must be given to developing a new system of food delivery based on modern technical capability by which meals supplying a substantial proportion of nutrient requirements can be distributed to the aged through restaurants, institutions and private homes when this is necessary. Regional, urban and cultural differences in the U.S. will require that a variety of systems may be necessary to accomplish this goal.

The Administration on Aging with the Department of HEW and the Department of Agriculture should begin at once to implement a variety of meal delivery systems in the following ways:

(1) Assemble a working party of scientists, industrialists and representative aged persons with experience in nutrition science, food preparation, food habits and meal service who will review existing experience with low cost meals, and meal delivery service.

(2) Undertake permanent funding programs of daily meal delivery service, initially consisting of at least one meal for all the aged needing this service and desiring it, in both urban and rural locations emphasizing the importance of the values of eating in group settings where possible. This service, as outlined in Recommendation III of this Panel, may be provided in restaurants, institutions or other suitable sites for the well aged or at home for the home bound.

(3) Develop a system of reimbursement with either food stamps or coupons or credit cards which will be acceptable to the recipients and efficient for the system, and which will retain freedom of choice for the user.

(4) Develop surveillance systems which will insure both the nutritional quality and the acceptability of the means. The single daily meal will furnish at least one-half of the daily Recommended Dietary Allowance of the Food and Nutrition Board of the National Research Council, and may include foods to be eaten at other times during the day. The remaining allowance especially of calories, may be obtained by the individual's initiative facilitated by income supplements and the revised food stamp program when necessary. The meal delivery system should extend to all areas as feasible systems are developed.

RECOMMENDATION II: INCREASED INCOME

Because diet quality and income are related, and because many older people do not have the income to provide adequate nutritious diets, immediate increases in the incomes of elderly people are a vital first step in freeing the aged from hunger and malnutrition.

Therefore it is recommended that:

(1) Social Security benefits be increased by fifty percent and the minimum benefit be raised from $55 to $120 monthly within the next two years, taking an additional five million people out of poverty and hunger.

(2) The public welfare system be completely revised to provide a federal welfare program with adequate payments based solely on need of the consumer and with federal financing and administration of welfare costs.

(3) The Federal Government assure all Americans the economic means for procuring the elements of optimum nutrition and health, and assure the distribution availability and utilization of adequate information, facilities and services.

(4) The Federal Government eliminate all barriers to adequate nutrition and health for all segments of the population, particularly those groups with special needs, e.g. the aged, the poor, the handicapped and minority groups, including those using languages other than English.

(5) While the Panel on Aging joins other Panels in endorsing a guaranteed annual income, we are concerned that older individuals, having contributed to and living within their Social Security benefits, may find their standard of living reduced. Therefore, we recommend that Social Security beneficiaries receive income in an amount at least of a level on parity with any implemented system of guaranteed annual income.

RECOMMENDATION III: FOOD STAMP PROGRAM

Supporting the position of Panel V–3 as stated in the Provisional Draft (page 4 on the Food Stamp Revision), and supporting the policy position of the President which urges revision of the food stamp program as an interim mechanism for implementing the procurement of food by the poor; and supporting the immediate enactment by Congress of S. 2014 and urging the entire White House Conference to press for its enactment.

The Panel on Aging makes the following additional recommendations:

(1) The food stamp program must be revised so that any individual or family receiving food stamps may purchase prepared meals with stamps. Restrictions in current legislation limiting eligibility for food stamps to those having "adequate cooking facilities" must be eliminated.

(2) Eligibility for food stamps must be established on the basis of self-declaration under clear, simple, uniform, and widely published Federal standards.

(3) Such standards must permit very low income persons and families to obtain stamps without cost. Those who purchase stamps must be permitted to purchase portions of their allotment at various times throughout the month.

(4) The Department of Health, Education and Welfare should initiate ongoing impact research to monitor and evaluate the effectiveness of the food stamp program in placing the resources for sound nutrition into the hands of all low-income Americans.

RECOMMENDATION IV. EDUCATION, RESEARCH AND DEVELOPMENT

It is recommended that

(1) The U.S. Government develop guidelines for a nutrition education program aimed at the elderly. This program should include an emphasis on physical activity and social interaction. These guidelines should give direction to mass media, voluntary and official agencies, advertising agencies and industry. To avoid preventable nutritional and health disabilities of aging, these guidelines should emphasize adequate nutrition education and practice throughout life.

(2) Educational programs for the elderly be developed by qualified personnel in the health, social and nutrition sciences, utilizing a variety of media. These programs should recognize educational reading levels, common language usage, and ethnic or cultural backgrounds, to provide a means of effective education and communication on all aspects of food supply, nutrition and health. These programs should include direct hand-out material, media programing and the training of indigenous Senior Citizens where possible as community workers in all service areas.

(3) Government funds be provided to augment training programs for preparation of professional and sub-professional workers in Nutrition and Gerontology.

(4) Surveys of institutionalized and noninstitutionalized aged be carried out with respect to their nutrition and health status and that these data be used to eliminate faulty diagnoses based on dietary deficiencies.

(5) Because of the mental health problems associated with the problems of social isolation and inadequate nutrition a National Commission for Mental Health of the Aged be established.

(6) Substantial funds be devoted to the support of basic and applied research as an investment for the future health and nutrition of the nation. Since effective action programs are based on research findings, immediate action must be based on the best information currently available. However, it must be recognized that continued research on the basic nature of aging and its relation to nutrition is essential for progress in the future.

RECOMMENDATION V: NATIONAL CODE OF STANDARDS

It is recommended that persons and agencies providing residential care or home health care for any number of the aged be required to supply adequate nutrition and health services for their clientele and that to help insure this, the federal government establish a national code of health, nutrition and personnel standards and use its powers to encourage each state to adopt and enforce this code.

RECOMMENDATION VI: HOUSING

An effective meal delivery service for the older citizen, accompanied by opportunity for socialbility, can be extended effectively on a workable neighborhood basis through the use of various facilities including particularly centers in housing developments located in strategic neighborhood areas.

It is recommended that

1. All Housing Programs for the elderly, no matter how financed or by whom sponsored, include meal service with proper nutrition, this recommendation to include those developments for the well elderly which also provide individual cooking facilities within their dwellings. Community spaces provided for such meal service be designed by or in cooperation with persons knowledgeable in food preparation and dining arrangements.
2. In order to reach older people in the surrounding neighborhood, this service be extended to older people in the neighborhood and that planning and funding for this outreach service be reflected in all future plans for possible extension or modernization of existing facilities.
3. That the Department of Housing and Urban Development include in its programs for Senior Citizens one that responds to the needs of the more frail elderly, those who cannot shop and prepare meals, but who are not ill and do not need more costly and less socially desirable medical facilities.
4. That the Federal Government fund construction of neighborhood centers for the elderly which can provide services peculiar to the needs of older persons
5. That research and demonstration programs jointly funded by the Department of Housing and Urban Development and the Administration on Aging be undertaken to bring about a closer relationship between housing design and construction and the services needed to round out a rewarding environment.

RECOMMENDATION VII: TRANSPORTATION

The older population in large part must depend on accessible and economic public transportation to reach services, including food services. Therefore, to overcome the effects of limited mobility, to assure continued access to the general community, to provide opportunity for a role in society benefitting their years and physical condition,

It is recommended that

The U.S. Department of Transportation, in conjunction with the Department of Health, Education and Welfare, its Administration on Aging, and the Department of Housing and Urban Development, seek ways of providing necessary transportation for the elderly and other disadvantaged groups who are not within reach of, or able to use normal public transportation (if it exists) in order to take advantage of nutrition, health and other services.

RECOMMENDATION VIII: PACKAGING AND LABELING

It is recommended that

(1) The U.S. Government establish a mechanism in collaboration with private industry for the development of economical, nutritious, easily prepared, attractive and readily stored new lines of food products. While these would satisfy certain packaging requirements of the elderly, they should be available to all residents regardless of age.

(2) Promotion of these new food products be accompanied by an education program geared to the needs of those seeking economical high quality nutrition.

(3) All packaged food products be labelled in clearly visible print with their nutrient contents translated into proportions of daily allowances of the four basic food groups.

(4) This labelling system not replace present ingredient labeling.

(5) The Federal Government launch a concentrated educational campaign against food fadism utilizing the new food lines, the education program and the proposed labelling system.

RECOMMENDATION IX: SOIL BANK UTILIZATION

Whereas many rural, landless, poor families, suffering from malnutrition, live adjacent to farmland held in the Federal Soil Bank;

It is recommended that: the Federal Soil Bank legislation be amended to entitle older persons to raise foods for personal consumption on soil bank land.

RECOMMENDATION X: FUNDING

It is recommended that

1. As a sincere expression of the national commitment to solving the problems of nutrition and poor health among the elderly, the President vigorously supports federal action to provide adequate funds for immediate and realistic implementation of all the aforementioned recommendations.
2. Evaluation designed to insure the efficient, effective utilization of these funds be incorporated into every program derived from these recommendations.

RECOMMENDATION XI: IMPLEMENTATION

It is recommended that

1. Action to implement each of the panel's recommendations be initiated immediately.
2. The President immediately establish a mechanism to give leadership to their effective development and to the continued monitoring of progress on each recommendation.
3. The forthcoming White House Conference on Aging (Nov. 1971) include a review and evaluation of progress on each of these recommendations as part of the responsibilities of a Panel on Nutrition with the objective of providing recommendations for further action.

Appendix 8

TESTIMONY ON MODEL CITIES PROGRAM BY GEORGE ROMNEY, SECRETARY, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

(Before the Subcommittee on Housing and Urban Affairs of the Senate Committee on Banking and Currency, June 6, 1969)

As you know, Mr. Chairman, I have approved the first seven Model Cities action programs for the cities of Seattle, Washington; Atlanta, Georgia; Waco, Texas; Detroit, Michigan; Huntsville, Alabama; Charlotte, North Carolina; and Smithville-DeKalb County, Tennessee. These approvals represent a total of about $42 million in Model Cities funds. This is the first program money being spent under Model Cities since the passage of the enabling legislation in late 1966.

By the end of this fiscal year, we expect to obligate over $200 million to about 40 cities for their first-year action programs. An additional $190 million should be obligated to another 35 cities before October 1st. The second round of 75 cities will be completing their planning phase this fall and winter.

That is where we are today. We arrived at this point after more than three months of intensive scrutiny of the Model Cities program as inherited by this Administration. I hope it will be helpful to the Committee if I discuss briefly our analysis of the program as we found it, and our recommendations for its future sound direction. Assistant Secretary Floyd Hyde is here to elaborate on my introductory remarks, and both Mr. Hyde and I will be pleased to respond to questions.

I have not found anyone who quarrels with the basic objectives of the Model Cities program. It seeks to coordinate the vast array of Federal, State, local and private programs; to concentrate the impact of these programs on the most needy urban neighborhoods; and to increase the capacity and flexibility of local governments by focusing responsibility for coordinated planning and implementation on elected local officials. These are sound objectives, and this Administration considers them of the highest priority.

The President made an early decision to determine whether or not the Model Cities program was in fact achieving these objectives. He established a subcommittee of the Council on Urban Affairs chaired by me to study the program and make recommendations for its future administration. The Secretaries of HEW, Labor, Commerce and Transportation served with me on the subcommittee.

Our committee found several areas in which the administration of the Model Cities program was deficient. Among them:

—Federal agencies have not responded quickly and in a coordinated way to local proposals reflecting specific local conditions.

—In developing their proposals, local authorities have been hindered by uncertainty as to the amounts and timing of funds that would be available from the Federal departments.

—Few effective attempts have been made to secure the involvement of the State governments.

—Federal guidelines have forced cities to set "model neighborhood" boundaries that often have been arbitrary, and that have created unnecessary divisions among Model Cities residents.

—HUD guidelines and administrative practices had not clearly established the principle that local elected officials have ultimate responsibility for program planning and implementation, including the responsibility for ensuring continuous and vigorous participation by citizens groups.

You will note, Mr. Chairman, that our analysis laid much of the blame for the program's halting and troubled progress at the feet of the Federal Government. I think this is highly significant, for it represents a long overdue recognition of

the fact that the Federal Government's well-intentioned efforts to help the cities have too often entangled responsible city officials in a web of confusing and contradictory Federal programs, regulations and bureaucracies. If we can make the Model Cities program work, we will have provided local government with an instrument to sort out and untangle Federal programs, and fit them together with local, State, and private efforts in a way that can reverse the steady deterioration of our cities.

Let me summarize the steps we are taking to improve the Model Cities program. These policy changes have been approved by the President, based on the analysis and recommendations of the Council on Urban Affairs.

1. The Council on Urban Affairs will assume direct responsibility for interdepartmental policy affecting Model Cities.
2. Secretaries of the departments involved will have personal supervision of their departments' funding of Model Cities proposals, and will reserve program funds specifically for that purpose. This will ensure the availability of departmental funds for Model Cities, and will give local authorities a better idea of the amount and kind of funds they can expect from the various departments for their Model Cities plans.
3. Administration of the program will be fed into the reorganization of the regional Federal offices, now under way. One effect of this will be to facilitate interdepartmental coordination at the regional level. In the past, variations among the Federal offices in program procedures, headquarters locations, and structures of authority, have handicapped well-intentioned Federal officials and confused local officials, thus seriously compromising the Model Cities program at the City level.
4. Greater efforts are under way to involve the State governments in the Model Cities program. Lack of State involvement has proven a critical deficiency because many of the Federal funds needed for Model Cities are administered through State agencies.

   Many of the things individual cities will be trying to do require State support. Moreover, we need to encourage States, just as we encourage cities, to organize and operate in a way which increases their capacity to serve all of their residents. The Department is already developing ways whereby existing programs, such as the 701 planning program, can be used to fund general staff support and coordination capacity in the State Governors' Offices. Some thirty States should be aided in this manner by the end of this fiscal year.

   Our aim is not to add another administrative layer between the cities and the Federal Government, but to make better use of the States' resources, experience and perspective. Model Cities is intended to be and will remain a local government program.
5. We are spelling out in clear terms that local government officials must exercise final control and responsibility for the content and administration of a local Model Cities program. This follows from the requirement in the Model Cities statute that HUD contract with local governments in making grants of supplemental funds. Our restatement of the city's role reaffirms that the city, as a party to the contract, has certain responsibilities, including the responsibility for assuring that Model Cities funds are wisely spent and that the statutory requirements for a local Model Cities program are and continue to be met. I should point out that among these statutory requirements is the requirement of "widespread citizen participation." Local government officials are responsible to HUD for satisfying this, as well as all other, statutory requirements affecting the local program. The emphasis on the city's ultimate responsibility for the program does not change our requirement for the active involvement at all stages of the program of residents of both the model neighborhood and the wider community.
6. The 10 per cent population restriction on the size of the target neighborhoods has been dropped. This guideline has been administered haphazardly in the past and has hindered progress at the local level. Eliminating this guideline does not mean that the program will be expanded within each city. Its purpose will remain that of focusing resources on particularly poor and blighted neighborhoods, but local officials will be given greater latitude in drawing boundaries which conform to local conditions. Let me emphasize the word "latitude." Initiation of boundary changes will be at the dis-

cretion of each individual city. The city will, however, be asked to show that new areas proposed for inclusion satisfy the statutory requirements of need and blight, and that it has the resources to achieve, as the statute further requires, a "substantial impact" on the problems of the enlarged model neighborhood without an increase in Model Cities supplemental funds. The city will also be asked to show that it has the capacity to coordinate and plan for the enlarged area. We anticipate that most cities will initially request only minor changes and adjustments, to include those small areas or groups which it makes no sense to exclude.

7. Local governments will be asked to establish clear priorities in developing their Model Cities proposals, and to strive for "comprehensiveness" only in the programs' five-year planning cycle. Many cities have interpreted Model Cities legislation and administrative guidelines requiring a local "comprehensive" plan of attack on blight and poverty in their target neighborhoods as requiring proposals to immediately attack every conceivable problem within these neighborhoods. This obviously would be unworkable. What is important is that city governments set clear priorities for attacking their problems so that they can make rapid and substantial progress toward solving their most urgent ones, rather than dissipating their resources in a vain effort to solve all. This Administration will completely scrutinize applications to eliminate unwise or unnecessary proposals.
8. Priority consideration will be given to those cities that successfully enlist the participation of private and voluntary organizations in their Model Cities plans. HUD will strongly encourage model cities to make maximum efforts to determine the availability of, and utilize the resources of, private enterprise and voluntary organizations. The statute itself requires model cities to make "the fullest utilization possible . . . of private initiative and enterprise." Of course, this does not mean that those cities which have tried and been unable to obtain widespread voluntary participation in their programs will be rejected. We expect that the increased flexibility in establishing program boundaries will make it easier for the voluntary organizations to contribute.

With these revisions, Mr. Chairman, we believe that the Model Cities program can help us to achieve two important goals—a more rational and creative Federal-State-local system, and city governments that are more flexible and responsive to the urgent needs of their citizens. We must realize that elimination of blight and poverty in our central cities cannot be accomplished overnight. It will be a hard and often frustrating struggle, but Model Cities does offer us the means of better using our present resources, and thus taking an important step in that direction.

Appendix 9

MATERIAL RELATED TO EMPLOYMENT AND SERVICE OPPORTUNITIES

ITEM 1: PENDING LEGISLATION

Older American Community Service Employment Act.—S. 3604 would authorize the Secretary of Labor to establish an Older American Community Service Employment program for low-income persons 55 years or older who have or would have difficulty in securing employment. The Secretary would be authorized to enter into agreements with nonprofit private organizations and State or local governments to pay up to 90 percent of the cost of community service employment projects. Full funding would be authorized for emergency projects or projects located in economically depressed areas. An authorization of $35,000,000 is provided for fiscal year 1971 and $60,000,000 for fiscal 1972.

A hearing was held by the Special Subcommittee on Aging of the Senate Labor and Public Welfare Committee on April 4, 1970, in Fall River, Massachusetts. Further hearings are planned to be held, but no definite date has been set at this time.

National Employ the Older Worker Week.—S.J. Res. 74, sponsored by Senators Randolph, Harrison Williams, Bible, Fannin, Fong, Kennedy, Miller, Mondale, Moss, Muskie, Yarborough, and Steven Young, would authorize and request the President to issue a proclamation designating the first full week in May as "National Employ the Older Worker Week." The Resolution was introduced on March 10, 1969, but no action was taken on it by the Senate Judiciary Committee. In his statement on February 6, 1970, to urge prompt action on this resolution, Senator Randolph stated:

> Underutilization of the older worker is probably costing our Nation billions of dollars in terms of lost production and services and added expenses for unemployment compensation and public assistance. More importantly, the impact on these individual in terms of frustration, despair, and the loss of the sense of dignity and status is incalculable.[1]

Middle-Aged and Older Workers Full Employment Act of 1968.—Introduced on October 10, 1968 by Senator Randolph of West Virginia and nine other sponsors, the bill would "provide a comprehensive program of employment services and opportunities for middle-aged and older Americans." (For analysis of major provisions, see p. 260, "Developments in Aging—1968.")

[1] Congressional Record, Feb. 6, 1969.

42-923 O—70——28

Appendix 10

MATERIAL RELATED TO VETERANS

ITEM 1: LEGISLATION ENACTED INTO LAW

Paraplegic Veterans.—Public Law 91–22 liberalizes the eligibility requirements that govern assistance to paraplegic veterans for special housing, and increases the maximum Federal grant for the purchase of a home equipped with special facilities from $10,000 to $12,500 and the maximum direct loan from $17,500 to $25,000.

Widows' Benefits.—Public Law 91–96 authorizes increases in the rates of dependency and indemnity compensation payable to widows and children of men who died in service or as a result of a service-connected disabiilty.

Nursing Home Care.—Public Law 91–102 eliminates the 6 month limitation at the Veterans' Administration expense for nursing home care for veterans with service-connected disabilities. Under the new law community nursing home care would be authorized for unlimited duration for such veterans.

Medical Services.—Public Law 91–102 authorizes complete medical services, including outpatient care; for a non-service-connected disability for a veteran totally disabled from a service-connected disability.

ITEM 2: PENDING LEGISLATION

Disregard Social Security Benefits.—On January 30, 1970, Senator Yarborough introduced S. 3359, which would disregard Social Security benefits in determining eligibility for or the amount of: (1) dependency and indemnity compensation for parents of deceased veterans and (2) non-service-connected pensions for veterans and widows of veterans. In discussing the 15 percent raise in Social Security benefits provided in the Tax Reform Act of 1969, he noted that it could have three possible effects on veterans pensions:

> First, in some cases, there will be no reduction in pension income since the increase in Social Security benefits will leave the veteran or his survivor in the same income bracket.
>
> Second, in some cases, the veteran's total income will rise despite a reduction in pension benefits. There the veteran or his survivor will receive an increase in his net income of less than 15 percent.
>
> Third, finally, in some cases the reduction in pension income will be greater than the 15-percent increase in social security benefits thus causing the veteran or his survivor to suffer a net loss in income.[1]

Talmadge-Cranston Proposal.—S. 3385, introduced on February 4, 1970, would (1) increase the income limitation under the veterans' non-service connected program from $2,000 to $2,300 for a veteran or widow with no dependents, and from $3,200 to $3,600 for a veteran or widow with dependents and (2) remove the present exclusion of 10 percent of Social Security and other income, and substitute a higher pension rate structure.

[1] *Congressional Record,* Jan. 30, 1969, pp. 908–909.

Appendix 11

COMMITTEE HEARINGS AND REPORTS

(One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Two asterisks indicate all supplies exhausted. Three asterisks indicate limited quantity, single copy available from committee supply.)

With a request for printed copies of documents, please enclose self-addressed label for *each* item desired.

Action for the Aged and Aging, Report No. 128, March 1961.**
Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.**
Developments in Aging, 1959–63, Report No. 8, February 1963.**
Developments in Aging, 1963–64, Report No. 124, March 1965.**
Developments in Aging, 1965, Report No. 1073, March 15, 1966.**
Developments in Aging, 1966, Report No. 169, February 1967.***
Developments in Aging, 1967, Report No. 1098, April 1968. (Cat. No. 90/2 :s, $1.25)
Developments in Aging, 1968, Report No. 91–119, March 1969. (Cat. No. 91/1 :119, $1.25)
Developments in Aging, 1969, Report No. 91–875, February 1970 (Cat. No. 91–2 : S. Rpt. 875, $1.75)
Mental Illness Among Older Americans, committee print, September 8, 1961.**
New Population Facts on Older Americans, 1960, a staff report, May 24, 1961.**
Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 10, 1962.**
Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.**
The Farmer and the President's Health Program, May 17, 1962.**
Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print report, June 15, 1962.**
State Action to Implement Medical Programs for the Aged, a staff report, June 8, 1961.**
Medical Assistance for the Aged, the Kerr-Mills Programs, 1960–63, committee print report, October 1963***
Health and Economic Conditions of the American Aged, a chart book, June 1961.**
A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 24, 1962.**
Statistics on Older People, Some Current Facts About the Nation's Older People, June 14, 1962.**
Basic Facts on the Health and Economic Status of Older Americans, June 2, 1961.**
Some Current Facts About the Nation's Older People, October 2, 1962.**
Housing for the Elderly, committee print report, August 31, 1962.***
The 1961 White House Conference on Aging, basic policy statements and recommendations, May 15, 1961.**
A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, June 1963.***
Blue Cross and Private Health Insurance Coverage of Older Americans, committee print report, July 1964.***
Increasing Employment Opportunities for the Elderly, committee print report, August 1964.***
Services for Senior Citizens, Report No. 1542, September 1964.***
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, a staff report, October 1964.**
Frauds and Deceptions Affecting the Elderly—Investigations, Findings and Recommendations: 1964, committee print report, December 1964.***
Extending Private Pension Coverage, committee print report, June 1965.***
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, a staff report, November 1965.***
War on Poverty as It Affects the Elderly, Report No. 1287, January 1966.***
Services to the Elderly on Public Assistance, committee print report, March, 1966.***
Health Insurance and Replated Provisions of Public Law 89–97, the Social Security Amendments of 1965, committee print, October 1965. (Y4:Ag4:H34/8, 35¢.)
Needs for Services Revealed by Operation Medicare Alert, committee print report, October 1966.***
Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 31, 1966.***
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print report, December 30, 1966.***
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[1] Working Paper incorporated into appendix of hearing.

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- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

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- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.
- Part 5. Los Angeles, Calif., December 5, 1962.
- Part 6. San Francisco, Calif., December 7, 1962.

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- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
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- Part 3. Los Angeles, Calif., February 17, 1965.***
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- Part 6. Boston, Mass., August 9, 1965.***
- Part 7. Portland, Maine, August 13, 1965.***

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[1] Working Paper incorporated into appendix of hearing.
[2] Price not determined at time of this printing.

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  Part 6. St. Joseph, Mo., December 11, 1961.
  Part 7. Hannibal, Mo., December 13, 1961.
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  Part 9. Daytona Beach, Fla., February 14, 1962.
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  Part 4. Las Vegas, Calif., October 25, 1961.
  Part 5. Eugene, Oreg., November 8, 1961.
  Part 6. Pocatello, Idaho, November 15, 1961.
  Part 7. Boise, Idaho, November 15, 1961.
  Part 8. Spokane, Wash., November 17, 1961.
  Part 9. Honolulu, Hawaii, November 27, 1961.
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  Part 11. Wailuku, Hawaii, November 30, 1961.

Part 12. Hilo, Hawaii, December 1, 1961.
Part 13. Kansas City, Mo., December 6, 1961.
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Part 3. Ogden, Utah, October 24, 1968—30¢.
Part 4. Syracuse, N.Y., December 9, 1968—45¢.
Part 5. Atlanta, Ga., December 11, 1968—40¢.
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[2] Price not determined at time of this printing.

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- Part 2. El Paso, Tex., December 18, 1968—50¢.
- Part 3. San Antonio, Tex., December 19, 1968—50¢.
- Part 4. Washington, D.C., January 14–15, 1969—65¢.
- Part 5. Washington, D.C., November 20–21, 1969.[2]

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- Part 2. Ann Arbor, Michigan, Consumer Aspects, June 9, 1969—60¢
- Part 3. Washington, D.C., Health Aspects, July 17 & 18, 1969—$1.00 *
- Part 4. Washington, D.C., Homeownership Aspects, July 31 & August 1, 1969—55¢
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- Part 6. Cape May, New Jersey, August 15, 1969 [2]
- Part 7. Washington, D.C., International Aspects, August 25, 1969 [2]
- Part 8. Washington, D.C., National Organizations, October 29, 1969 [2]
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- Part 2. St. Petersburg, Florida, January 9, 1970 [2]
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- Part 2. Majestic-Freeburn, Kentucky, September 12, 1969 [2]
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- Part 4. New Albany, Indiana, September 16, 1969 [2]
- Part 5. Greenwood, Mississippi, October 9, 1969 [2]
- Part 6. Little Rock, Arkansas, October 10, 1969 [2]
- Part 7. Emmett, Idaho, February 24, 1970 [2]
- Part 8. Boise, Idaho, February 24, 1970 [2]

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- "Older Americans Act Amendments of 1967—S. 951", June 12, 1967.**
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[2] Price not determined at time of this printing.

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