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2d Session

SENATE

REPORT
No. 92-784

DEVELOPMENTS IN AGING: 1971 AND JANUARY-MARCH 1972

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 27, FEBRUARY 19, 1971

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

TOGETHER WITH

MINORITY AND INDIVIDUAL VIEWS

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LETTER OF TRANSMITTAL

MAY 2, 1972.

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

DEAR MR. PRESIDENT: As required under Senate Resolution 27, dated February 19, 1971, I am submitting to you the annual report of the Senate Special Committee on Aging.

This report has been delayed this year to include a report on developments that have occurred during the first 4 months in 1972 Among those developments are several actions taken to implement recommendations made at the White House Conference on Aging in December 1971, or—as in the case of the President's message, "Making Recommendations for Action on Behalf of Older Americans" of March 23, 1972—to comment on proposals for action.

Senate Resolution 251, passed unanimously by the Senate on March 6, 1972, gives the committee new authority to continue tasks of inquiry and evaluation into issues of direct importance to older Americans, who—as indicated by the 1970 Census findings—now number approximately 20 million, or about one-tenth of our population. The committee has a special task during this year: it should do all possible to show the need for implementation of major White House conference recommendations and it should assist in all efforts at implementation.

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,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 27, 92D CONGRESS, 2D SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 29, 1972.

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

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

SEC. 3. (a) For purposes of this resolution, the committee is authorized from February 1, 1971, through February 29, 1972, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to hold hearings, (3) to sit and act at any time or place during the sessions, recesses, and adjournment periods of the Senate, (4) to require by subpena or otherwise the attendance of witnesses and the production of correspondence, books, papers, and documents, (5) to administer oaths, (6) to take testimony orally or by deposition, (7) to employ personnel, (8) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel, information, and facilities of any such department or agency, and (9) to procure the temporary services (not in excess of one year) or intermittent services of individual consultants, or organizations thereof, in the same manner and under the same conditions as a standing committee of the Senate may procure such services under section 202(i) of the Legislative Reorganization Act of 1946.

(b) The minority shall receive fair consideration in the appointment of staff personnel pursuant to this resolution. Such personnel assigned to the minority shall be accorded equitable treatment with respect to the fixing of salary rates, the assignment of facilities, and the accessibility of committee records.

SEC. 4. The expenses of the committee under this resolution shall not exceed $380,000, of which amount not to exceed $17,000 shall be available for the procurement of the services of individual consultants or organizations thereof.

SEC. 5. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than February 29, 1972. The committee shall cease to exist at the close of business on February 29, 1972.

SEC. 6. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

PREFACE

"Momentum" was the magic word before and during the White House Conference on Aging, now five months behind us.

Delegates were assured that their voices would be heard, and that their recommendations would be heeded.

The dynamics of a White House Conference—and the prospect of a Presidential campaign year—were said to guarantee action on immediate and long-range needs of Older Americans.

At last, "Towards a National Policy on Aging" would become a pattern of action rather than a slogan for talk at a Conference.

There *has* been momentum since the Conference.

But it has been expressed almost entirely through Congressional initiatives.

Administration action has usually been *re*action to such initiatives, sometimes grudging.

Or—its spokesmen have come to Capitol Hill to speak against reforms such as realistic Social Security increases and a genuinely effective Federal agency on aging.

Long-awaited, the President's Message[1] on Aging of March 23 proved little more than a summation of the Executive Branch bent for "game plansmanship," long on promises and dismally deficient in substance.

It is not enough to offer proposals without commitment.

It is not enough to seek to pre-empt an issue by weaving it into a "grand design" that somehow is never implemented.

To say that the President's Message was a disappointment is an understatement.

To say that there is still time for policy reversals, however, is to express more than forlorn hope.

After all, the President must realize that his so-called comprehensive strategy is pathetically unresponsive to the strong and clear recommendations of the White House Conference.

The President must perceive that hopes for bipartisan action on aging will deteriorate rapidly if the Administration plays a crafty tactical game instead of fashioning a credible action program.

And the President should realize that many participants in the Conference—including the Conference Chairman, Dr. Arthur Flemming—regarded the Conference as a prelude to triumph over the problems that now blight the lives of many millions of Americans in or near retirement. That hope of triumph should not be transformed into despair or resentment.

[1] Full text of the President's Message appears on pp. 283–308. Earlier addresses by Democratic and Republican Senators on *The State of the Aging* appear on pp. 317–388.

For these reasons, I believe the President will, as he hinted in his message, make other statements on aging within the next few months. I think that he should, in particular, pay attention to these issues:

Income.—Administration policy now calls only for a 5 percent increase in Social Security benefits, despite powerful congressional sentiment for an increase of 20 percent and other significant reforms. The President's Message makes the point that since 1969, Social Security cash benefits have been increased twice—by 15 percent in January 1970 and by 10 percent a year later—boosting Social Security payments by $10 billion. But the Message fails to mention that the Administration resisted these increases and even threatened a veto on one.

Dismal enough as the Administration's record on Social Security is, it can further be harmed by the cynical view that the Administration must hold down its "bid" on benefit levels until it determines what position Congress is taking. This position, expressed by a high-ranking member of the Executive Branch at a recent hearing [2] says in unmistakable terms that there is no Administration policy on retirement income; the goal is to get by with as little increase as possible. The Administration seems willing to settle for the 5 percent and the automatic cost-of-living adjustment mechanism. Many in Congress want "inflation-proof" benefits, too; but we want the escalator to rise from a more nearly adequate base.

A successor to AoA.—June 30 is only two months away, and it is on that date that present authority for the Older Americans Act will expire. Under that Act, an Administration on Aging has worked for almost six years to become the Federal "focal point" on aging. But in the view of almost everyone who has studied its record—including a Presidential Task Force reporting in 1970—the AoA has failed to live up to its Congressional mandate in large part because of HEW downgrading.

Several Congressional bills would make significant changes designed to upgrade AoA and to elevate the Federal effort called for in the Older Americans Act. One bill would remove AoA from its present position within the Social and Rehabilitation Service and place it under the direction of a new Assistant Secretary on Aging within the Department of Health, Education and Welfare.[3] The Administration, however, opposes establishment of an Assistant Secretaryship and other important provisions of the legislation. It would keep AoA right where it is now, under the thumb of SRS administrators whose prime commitment is to welfare services.

This position is maintained by the Executive Branch despite the increase in AoA funding levels to $100 million voted by the Congress

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[2] In response to a question by Senator Thomas Eagleton regarding the inadequacy of the Administration's "income strategy" for the elderly, Secretary of Health, Education, and Welfare, Elliot Richardson responded:

"It is obvious further, I think, that a Republican President could expect in many situations like this to be outbid no matter what he might propose, and, of course, this has happened again and again, and naturally we have to take that into account in the manner in which we deal with the evolving process between a given proposal originating on the congressional side and the eventual result of the legislative process." (Hearings before the Subcommittee on Aging of the Senate Labor and Public Welfare Committee; "The Older Americans Act"; March 23, 1972; hearings are not yet in print.)

[3] S. 3181, introduced by Senator Church, also calls for an Office on Aging in the Executive Office of the President. Additional details on that bill and on H.R. 12017, introduced by Representative John Brademas and others, appear on pp. 101–102.

in direct response to the White House Conference. The Congress has also passed a nutrition bill for the elderly—and it was adopted after nearly two years of Administration opposition—calling for $100 million the first year and $150 million the next year.

Now that the Congress has acted, the Administration says it is ready to build the nutrition program into the "new" AoA as a major component in its service delivery system.

We in Congress have heard for a long time about Administration plans to develop a "comprehensive service network," but that network is always described in the future tense.

We are now told that the nutrition program will help us to that goal. So will the new, higher funding levels for AoA.

But can we really have confidence in an agency which appears still to have stepchild status and a murky mission despite the many uses to which the Administration wishes to put its new funding?

Medicare and health costs.—As of July 1, Medicare enrollees will pay $5.80 a month for the physician's service (Part B) offered under that program. The President's Message urges that this premium be eliminated, and it would be difficult to disagree with this goal. It has, after all, been recommended by the Senate Committee on Aging, by advisory councils to the Social Security Administration, and by many individual legislators. But there is a hidden danger in the President's proposal: to pay for the loss of premium income, he may reduce benefits or draw from the Social Security trust fund rather than from general tax revenues. This could require an increase in the payroll tax or depletion of the trust fund. If the premium suspension is to yield real gains, it should not cause the loss of other Medicare or Social Security benefits.

When all is said and done, Medicare pays for only 42 percent of all health costs of the elderly. One of the startling points made by this committee report is that older Americans are paying in 1972 almost as much in out-of-pocket medical expenses as they were before Medicare became law in 1965. They are paying more than twice as much in out-of-pocket payments than persons under age 65.[4]

In the face of such facts, the President offers very little, taking away with one hand what he proffers with the other.

Pension reform.—Apparently the Administration is unaware that a Senate Subcommittee study has made a powerful case for major reforms in our private pension system.[5] Congressional interest in this area is now at a high level. The President's Message, however, calls for little more than a watered-down vesting scheme and a program to make it more convenient for high-income individuals to put aside savings for their own retirement income, by means of "tax breaks" as incentives. Here again, the President seems to be waiting to see what Congress will do.

Nursing home care.—The President's 8-point program for upgrading of long-term care in the United States has been described in early reports by this Committee as little more than a "policing" and "inspection" package. A comprehensive program for elevating standards and care has been developed by Senator Frank Moss of Utah, Chair-

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[4] For details on the finding and other issues related to health care, see pp. 23–30.

[5] A report, "Interim Report of Activities of the Private Welfare and Pension Plan Study, 1971," was issued by the Subcommittee on Labor, Senate Committee on Labor and Public Welfare on Feb. 22, 1972.

man of the Subcommittee on Long-Term Care for this Committee. Not only has the Administration failed to make a positive response to the Moss legislation; it has failed even to live up to regulations authorized by laws passed in 1969. In the meantime, nursing home costs continue to rise; patients and their families live with the fear or reality of victimization; and reputable institutions suffer from guilt by association.

Minorities.—Only the barest mention is made in the President's Message of those older Americans who suffer the multiple jeopardy which occurs when one is old, a member of a minority group, and—as is the case for nearly 50 percent of elders in such groups—living in poverty. And yet, the White House Conference had special sessions for Aging and Aged Blacks, the Asian-American Elderly, the Elderly Indian, and the Spanish-speaking Elderly. If the Administration had paid any attention at all to the statements and recommendations made by participants at these sessions, the President's Message would have had far more to say in this area. There is no Administration plan to raise *all* older Americans out of poverty. There is no statement by the Administration that it will take steps to make programs more responsive to elderly members of minority groups. There is no reply to criticisms that the Executive Branch tolerates an appalling dearth of research data about older members of minority groups. Of all the examples of unconcern provided in the President's Message, his indifferent attitude toward minorities is perhaps the most disturbing.

Service opportunities.—Speaking in December at the White House Conference on Aging, the President had kind words to say about programs which give older Americans an opportunity to serve others. He said that Federal programs to provide such opportunities have proven "remarkably successful at the demonstration level," and that they should now be established "on a broader, national basis."

Did this mean that the Administration would withdraw its opposition to Congressional proposals to establish a national senior service program? Did this mean that the President would, in his Message on Aging, provide details on a plan for a "broader, national basis?"

Not at all. The Message called simply for more of the same: demonstration at pitifully low levels of funding.

Property tax.—Here again, what was said in December did not produce much by March. At the White House Conference, the President promised a study and relief. In his Message, he still promised study and was not clear at all about what form the relief could take.

Housing.—White House conferees emphatically supported Federal action to increase the production of units for the elderly to a minimum of 120,000 a year, to establish the position of Assistant Secretary on Housing for the Elderly in the Department of Housing and Urban Development, and to improve the availability and quality of services for tenants in publicly supported housing of many kinds. The President's Message makes much of the fact that guidelines on subsidized rental housing for the elderly have recently been published, even though these guidelines were at least a year overdue. He offers no overall goals; he does not withdraw Administration opposition to an Assistant Secretaryship and he proposes only more research to investi-

gate one of the most immediate of problems: the effects of crime and street violence on elderly residents in housing projects.

Additional examples of unresponsiveness—as well as examination of those few substantial proposals made in the Message—are provided on the pages of the following report, but one other point should be made in this personal commentary.

Many of the Congressional accomplishments mentioned in this preface resulted from bipartisan action—action taken at times over the intense opposition of the Administration.

This spirit of legislative concern—or call it momentum if you will—is now the leading force for action to implement recommendations made at the White House Conference on Aging.

We will continue our efforts, but we think that the Administration should do its share, as well. Innovative ideas should be tested against each other; dialogue should be frequent and it should be candid.

Until it offers a more persuasive and vigorous effort, the Executive Branch will continue to give the distinct impression that—when White House recommendations were made—it was not listening.

FRANK CHURCH,
Chairman, Special Committee on Aging.

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PART 3

MINORITY VIEWS

APPENDIXES

EVERY TENTH AMERICAN[1]

[BASED ON 1970 CENSUS FIGURES]

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, close to 20 million older individuals make up 10 percent of the total population—every 10th American. The largest concentrations of older persons—11 percent or more of a State's total population—occur in 12 States in the agricultural midwest, in New England, and in Florida. New York, California, Pennsylvania, and Illinois each have more than a million older people with Ohio, Texas, and Florida very close behind. By 1985, when the older population will have passed the 25 million mark, California and New York will each have more than 2 million persons aged 65 and over; Florida, Illinois, Ohio, Pennsylvania, and Texas will each have over a 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. Between 1960 and 1970, older Americans increased in number throughout the Nation by 21 percent, as compared with an 18 percent growth in the under 65 population. Greatest percentage growth (a third or more) occurred in Arizona, Florida, Nevada, Hawaii, and New Mexico. Florida had the highest proportion of older people in 1970, 14.5 percent of its total population, while New York had the largest actual number of older people, almost 2 million.

ON AGE. Most older Americans are under 75; half are under 73; a third are under 70. Almost 1.5 million are 85 or over.

ON HEALTH. Eighty-one percent get along well on their own. While only 14 percent have no chronic conditions, diseases, or impairments of any kind, the vast majority that do have such conditions still manage by themselves. Older individuals are subject to more disability, see physicians more often, and have more and longer hospital stays. In 1970, per capita health care costs for older Americans came to $791: $372 went for hospital care; $136 for physician services; $32 for other professional services; $84 for drugs; $129 for nursing home care; and $37 for miscellaneous

[1] Prepared by Herman B. Brotman, Assistant to the Commissioner (Statistics and Analysis), Administration on Aging, HEW, March 1972.

items. Of the total amount spent for health care, $534 of the bill was taken care of by public sources, but the elderly still had to pay $257 from their own limited incomes.

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

ON PERSONAL INCOME. Older persons have less than half the income of their younger counterparts. In 1970, half of the families headed by older persons had incomes of less than $5,053; the median income for older persons living alone or with nonrelatives was $1,951. Almost 5 million or over a quarter of the elderly live below the official poverty line; every fifth poor person in the United States is aged 65 or over. Many of these aged poor became poor on reaching 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 appropriate 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; 13 years for men but 16 years for women.

ON SEX. Most older individuals are women—over 11 million as compared to over 8 million men. For the total 65 and over population, there are about 139 women per 100 men; the ratio increases from 124 women per 100 men at ages 65 through 69 to 179 women per 100 men at 85 and over.

ON MARITAL STATUS. Most older men are married; most older women are widows. There are almost four times as many widows as widowers. Of the married older men, almost 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 65 or over in approximately 14,000 marriages; the remaining 2,000 older brides and almost 22,000 older grooms take under-65 partners.

ON EDUCATION. Almost half never completed elementary school. Close to 3 million older people are "functionally illiterate," having had no schooling or less than 5 years. Over 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 one in 20 lives in an institution. Most older men (about two-thirds) live in families that include the spouse but only a 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.

ON MOBILITY. In the year ending March 1970, 8.6 percent (1.7 million) of all older people moved from one house to another: 6 percent moved to another house in the same county, 1.6 percent moved to a different county in the same State, and only 1 percent moved across a State line.

ON VOTING. In the 1970 elections, 57 percent of the older population actually voted; they accounted for 17 percent of all the votes cast.

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REPORT
No. 92-784

DEVELOPMENTS IN AGING: 1971 AND JANUARY-MARCH 1972

———————.—Ordered to be printed

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

REPORT

[Pursuant to S. Res. 27, 92d Cong.]

PART ONE

WORK PROGRAM FOR A DECADE: WHITE HOUSE CONFERENCE ON AGING RECOMMENDATIONS AND THE BEGINNING OF IMPLEMENTATION

INTRODUCTION

White House Conferences come and go. This year's compilation of recommendations can become next year's forgotten cause.

On November 28, 1971, 3,400 delegates to the White House Conference on Aging* began 4 days of deliberations and summing-up.

Their report now serves as the outline of a work program for a decade. It fulfills at least three objectives sought by those who supported the Conference:

—It issued an unmistakable call for action. Delegates—young and old, government officials, housewives, businessmen, educators, and many who had previously known very little about aging—discovered a common mood of impatience and concern. Many earlier calls for action were amplified.

*For official details on the structure, objectives and upshot of the Conference, see appendix 1, item 20, p. 276, a report prepared by the White House Conference staff at the request of the Senate Special Committee on Aging.

—The Conference, for a time at least, centered national attention upon the elderly. Newspapers and other media provided accounts, not only of needs among older Americans, but also of their hopes and accomplishments.

—And the Conference unleashed a response which has resulted in several significant congressional initiatives and a searching re-evaluation of present efforts by all levels of government.

To the Senate Special Committee on Aging, the Conference had special significance because (1) members of the committee had drafted the legislation that led to the call for the Conference, and (2) so many of the Conference recommendations—particularly those related to income, housing, improved medical care at less cost, long-term care, and governmental organization—were strikingly similar to proposals made by this committee within recent months or even earlier.

Even so, the Conference has not yet left an indelible mark upon this Nation. It has not yet produced a sense of inevitability for adoption of its major goals.

In short, the Conference is over and process of implementation has yet to reach full power.

Early Initiatives

Early response to the White House Conference was centered largely around opportunities caused by tactical situations in the Congress.

A supplementary appropriations bill was amended in the Senate one day after the White House Conference concluded. It provided a new $100 million funding level for the Administration on Aging, an agency for which the Executive Branch had sought only $29.5 million early in 1971.

A long-debated Nutrition for the Elderly Bill was passed in the Senate during the Conference and cleared by the House a few weeks later. This bill had been opposed by the administration. It provides for funding of $100 million the first year and $150 million the next.

Since present authority expires on June 30, the Older Americans Act was the subject of early attention by Committees in both Houses. However, an administration bill to extend the Act was not submitted until March 20, well after House hearings had begun.

The potentially historic H.R. 1—the House-passed bill to provide reforms in Social Security, Medicare, Medicaid, and welfare—was given powerful impetus in the Senate by the Conference in certain of its thrusts. One of the most significant developments in early 1972 was a major effort in both Houses to amend H.R. 1 to provide a 20-percent increase in Social Security benefits in a way which, it was said, would maintain actuarial integrity while causing only minor upward payroll tax adjustments.

Senate consideration of an omnibus housing bill was broadened in March to include amendments for improved federally assisted housing for older Americans and—in one case—to rescue a notably popular and productive direct loan program. At the same time, the Senate passed an amendment to establish the position of Assistant Secretary for Housing for the Elderly within the Department of Housing and Urban Development. At this writing, a House Committee is considering similar, and other, actions related to housing for the elderly.

Actions came on other Congressional fronts. House approval was given to an amendment providing earmarked funding for projects serving older Americans under Office of Economic Opportunity programs. Progress was made on legislation to broaden the national research effort on the biological and social aspects of aging. A heavy schedule of hearings and executive sessions was established by congressional units concerned about aging. In addition, members of both Houses introduced well over 200 bills or resolutions related to aging between November 30, 1971 and April 1, 1972.

One of the most important developments in Congress was the bipartisan nature of efforts made before and after the White House Conference. Members of both political parties joined forces in both Houses to fight—early in 1971—for higher funding levels for the Administration on Aging and research related to the elderly. Many of the other actions described briefly in this introduction, and in more detail later in this report, could not have succeeded without united efforts from both sides of the aisle in both Houses.

The President's Message [1]

As delivered to the Congress on March 23, the President's message was described as an outline of the "comprehensive strategy which this administration had developed for bridging the new generation gap and enhancing the dignity and independence of older Americans."

Nonetheless, the President did not close the door on possible additions or changes. He called the message "an important step" in fulfilling his pledge "to make 1972 a year of action on behalf of older Americans." He promised to keep the "recommendations of the White House Conference at the top of our agenda, under continuing review."

And he also said:

> This message, then, does not represent the last word I will have to say on this important subject. It does, however, identify those administrative steps which we are taking immediately to help older Americans, along with a number of legislative initiatives which should be of highest priority on this year's congressional agenda.

Five major elements of the "comprehensive strategy" were identified:

> 1. "*Protecting the Income Position of the Elderly.*—This was to be accomplished primarily by enacting H.R. 1 as passed by the House, with a 5-percent increase in Social Security; by removing the monthly premium charge under Part B of Medicare; by offering tax incentives to encouraging private savings for pension income and also establishing a "50-year rule" for vesting of pensions; and by enacting revenue sharing proposals to reduce property taxes while continuing studies of more direct ways to achieve that goal.

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[1] The full text of this message appears on pp. 283–307. Texts of earlier Senate addresses made by Democratic and Republican members of the Senate Special Committee on Aging appear on pp. 317–388.

2. "*Upgrading the Quality of Nursing Home Care.*"—This was to be accomplished primarily by Federal assumption of State inspection of homes receiving Medicaid payment; provision of additional funds for training of nursing home personnel; and strengthening and expediting action on portions of an 8-point administration program announced in summer 1971; and by withholding funds from homes that do not meet Federal standards.

3. "*Helping Older Persons Live Dignified, Independent Lives In Their Own Homes or Residences—By Expanding and Reforming Service Programs.*"—This was to be achieved primarily by additional funding to the Administration on Aging; appropriating the amounts authorized by Congress for the nutrition program; extending the Older Americans Act for an indefinite period; rather than for a specified period of years; and creating a new, coordinated system of service delivery under the Older Americans Act.

4. "*To Expand Opportunities for Older Persons to Continue Their Involvement in the Life of our Country.*"—This was to be achieved primarily by some additional funding for demonstration programs already at work; by broadening of the Age Discrimination Act of 1967 to include State and local governments; and by administration cooperation with 130 national groups to stimulate volunteer action.

5. "*To Improve Federal Organization for Future Efforts.*"—This was to be achieved primarily by strengthening the Secretary of Health, Education, and Welfare's advisory committee on older Americans by providing it with permanent staff capability; by arranging for the Commissioner on Aging, in his capacity as chairman of the Advisory Committee, to report directly to the HEW Secretary; and by creating a Technical Advisory Committee on Aging Research in the HEW Secretary's office.

Immediate reaction within Congress to the President's Message was one of disappointment and concern. For example, Senator Frank Church, Chairman of the Senate Special Committee on Aging, said he was surprised that the President had failed to take advantage of the congressional push for a 20-percent Social Security benefit, that he had not asked for Medicare coverage of out-of-hospital prescription drugs, and that he had not asked that the Administration on Aging be removed from Social and Rehabilitation Service to a higher level within HEW. Similar comments were made by other Democratic members of the committee. Newspaper accounts indicated surprise at the limited number of new proposals and reiteration of old ones, made before the Conference and bearing little resemblance to major Conference recommendations.[2]

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[2] James P. Gannon, writing in the March 24 Wall Street Journal, began his article with these two paragraphs:

"WASHINGTON.—President Nixon sent Congress a list of proposals to aid aging Americans that was more remarkable for what it omitted than what it included.

"The President's special message to Congress on older Americans reiterated his support for various earlier proposals still pending and reviewed administrative moves to aid the elderly, but contained surprisingly little in new initiatives. The President promised to keep thinking about some earlier promises made to the elderly at last year's White House Conference on the Aging."

Federal Outlays on Aging: A Fundamental Question

Another fundamental question concerns the President's assertion that "overall Federal spending for the elderly in fiscal year 1973 will be $50 billion." However, a closer look at these figures will reveal that about $48.5 billion—or nearly 97 percent of the administration's projected outlays—will be for Social Security, retirement, income supplement, and health programs. And a substantial proportion of these outlays are derived from payroll contributions by the elderly during their working lives.

It would be unfortunate indeed if such use of statistics created false impressions or precipitates a divisive controversy over spending priorities.

Equally significant, official spending figures cannot conceal the harsh facts of life for millions of older Americans:

—Nearly 5 million now live in poverty, and their numbers have actually increased by 100,000 from 1968 to 1970.
—If the "hidden" poor are counted, their numbers jump to 6.3 million.
—Retirement income averages less often half of the income of those still in the labor force.

The "Federal outlay" issue takes on an added dimension in 1972. If our Nation is to implement a new national policy on aging, it is absolutely essential to have thorough and accurate data which is in no way challenged by questions of credibility.

ADMINISTRATION'S LISTING OF BUDGET OUTLAYS FOR PROGRAMS SERVING OLDER AMERICANS

[In millions of dollars]

	Fiscal year		
	1971	1972	1973
Total all reported programs	39,178.3	44,031.8	49,616.0
Departments:			
Agriculture	341.9	410.4	467.9
Defense	408.1	470.6	517.9
HEW	31,779.2	35,752.3	40,655.4
Office of Education	2.5	2.6	2.3
Public Health Service	128.0	120.7	108.8
Social and Rehabilitative Services	2,842.7	3,234.1	3,661.3
Social Security Administration	28,826.0	32,395.0	36,883.0
Housing and Urban Development	274.2	363.3	426.6
Labor	33.3	40.2	37.0
Transportation	9.3	10.9	11.6
Independent agencies:			
ACTION	10.0	19.1	41.1
Civil Service Commission	1,882.0	2,138.9	2,469.5
Office of Economic Opportunity	95.1	94.0	87.7
Railroad Retirement Board	1,613.0	1,794.0	1,772.0
Veterans' Administration	2,712.2	2,938.1	3,129.3

Additional discussion of specific points from the President's Message appears later in this report.

As of April 10, little support had been expressed in the Congressional Record by Members of Congress for this message.

PROJECTION: SERIES X (ZERO POPULATION GROWTH AND ZERO NET IN-MIGRATION), 1980, 2000, AND 2020

Item	1980	2000	2020	Ultimate distribution
Numbers:				
All ages	223,302	255,745	279,533	----
Under 20	75,448	78,359	78,581	----
20 to 64	124,289	149,335	163,163	----
65+	23,565	28,051	37,789	----
Percent distribution:				
All ages	100.0	100.0	100.0	100.00
Under 20	33.8	30.6	28.1	27.02
20 to 64	55.7	58.4	58.4	56.94
65+	10.5	11.0	13.5	16.04
65+ sex distribution:				
Males	9,631	11,261	15,912	(6.77)
Femaes	13,934	16,788	21,878	(9.28)
Per 100 males	144.7	149.1	137.5	137.1
Dependency ratios:				
Under 20 plus 65+/20 to 64(100)	79.7	71.2	71.3	75.6
65+/20 to 64(100)	19.0	18.8	23.2	28.2

Note: Figures in parentheses represent percent.
Source of basic data: Bureau of the Census.

POPULATION, 1970, AND REVISED PROJECTIONS, 1985, 2000, AND 2015, UNDER VARIOUS ASSUMPTIONS [1]

[Numbers in thousands; 1970 data as of Apr. 1; projections as of July 1]

Item	1970 census	Series B [1]			Series C [1]			Series D [1]			Series E [1]		
		1985	2000	2015	1985	2000	2015	1985	2000	2015	1985	2000	2015
Numbers (all ages)	203,166	257,903	322,277	413,425	252,093	305,111	373,350	246,265	288,293	335,926	240,153	271,082	299,617
Under 18	69,653	89,472	113,934	149,869	83,662	100,749	123,678	77,834	87,930	99,994	71,722	74,915	77,896
18 to 64	113,463	142,914	179,504	228,422	142,914	175,523	214,538	142,914	171,524	200,798	142,914	167,328	186,587
65 plus	20,050	25,517	28,839	35,134	25,517	28,839	35,134	25,517	28,839	35,134	25,517	28,839	35,134
Percent distribution (all ages)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	34.3	34.7	35.4	36.2	33.2	33.0	33.1	31.6	30.5	29.8	29.9	27.6	26.0
18 to 64	55.8	55.4	55.7	55.3	56.7	57.5	57.5	58.0	59.5	59.8	59.5	61.8	62.3
65 plus	9.9	9.9	8.9	8.5	10.1	9.5	9.4	10.4	10.0	10.4	10.6	10.6	11.7
65+ sex distribution:													
Males	8,408	10,327	11,554	14,531	10,327	11,554	14,531	10,327	11,554	14,531	10,327	11,554	14,531
Females	11,642	15,189	17,285	20,603	15,189	17,285	20,603	15,189	17,285	20,603	15,189	17,285	20,603
Per 100 males	138.5	147.1	149.6	141.8	147.1	149.6	141.8	147.1	149.6	141.8	147.1	149.6	141.8
Dependency ratios:													
Under 18 plus 65+/18 to 64(100)	79.1	80.5	79.5	81.0	76.4	73.8	74.0	72.3	68.1	67.3	68.0	62.0	60.6
65+/18 to 64(100)	17.7	17.9	16.1	15.4	17.9	16.4	16.4	17.9	16.8	17.5	17.9	17 2	18.8
Total fertility rate: Children per 1,000 females		3,097	3,100	3,100	2,789	2,775	2,775	2,480	2,450	2,450	2,158	2,110	2,110

[1] Projections revised November 1971 to conform to 1970 census counts and to new assumptions on timing rates on fertility. All series use the same assumptions on net inmigration (400,000 per year) and a small improvement in death rates but differ in the assumptions on birth rates: Series A, which assumed a significant increase in birth rates, has been dropped; series B and C assume medium and small increases in birth rates, respectively; series D assumes a decrease in birth rate and approximates the actual experience in the recent past on the average; series E assumes a significant decrease in birth rate and reflects actual trends in data for mid 1971.

Source of basic data: Bureau of the Census: Administration on Aging.

The Long-Range

Inflation, generally inadequate Social Security benefits, and unresolved problems related to Medicare and Medicaid are among the most pressing problems for older Americans in 1972.

But many of the recommendations made at the White House Conference [3] point to the need for consideration of more long-range goals to be met in 1972.

First and foremost, as the next chapter makes clear, the Nation still has a long way to go in establishing a national retirement income policy based upon actions to provide livable economic security for older Americans.

Second, the failures of Medicare and Medicaid have been caused in no small degree by failures within our health service delivery system. Long-term care, in particular, suffers from over-dependence upon institutionalization. Much the same is true of home health care.

Third, it appears clear that major reorganization of the Federal structure related to programs on aging is essential. Contradictions and cloudy definitions of purpose now abound. Establishment of a new Advisory Council within one of the departments dealing with aging—as suggested by the administration—would be a minor reform, as would funding at larger levels for an agency—the Administration on Aging—which now is misplaced.

Fourth, even the White House Conference on Aging paid comparatively little attention to the long-range shelter needs of a population of older Americans which will increase, which will number more of its total among the "older" elderly, and which will have more mobility within the next decade. Considerably more attention should be given to projections of future housing demand and potential supply.

Fifth, thus far little organized attention has been given to the especially intense problems of older members of minority groups. Extensive efforts should be made in this area, if measurable progress is to be made during the 1970's.

Sixth, important as an "income strategy" may be—and certainly there can be little argument with the premise that higher income is more likely than other means to produce greater satisfaction and independence in ways of meeting need—services should not be overlooked. Much attention has been given by the Executive Branch within recent years to the development of a "comprehensive services strategy" that will somehow serve all age groups, including the elderly. Thus far, however, little progress has been made, even though the need for improved services has been demonstrated to be of special importance to the elderly. What is needed now is application on a broader scale of services to older Amer-

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[3] All citations from the White House Conference report are taken from "The 1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions, November 28–December 2." This report, distributed at the conclusion of the Conference, was reprinted as S. Doc. 92–53 at the request of the Senate Special Committee on Aging in December 1971. A later edition, offering additional information about the Conference and cross-references from related Sections and Special Concerns Sessions, was to be published by the White House Conference staff in April 1972.

icans in a way that they can gradually be built into the "master plan" which has proven so illusory thus far.

Seventh, the full economic and social consequences of earlier and earlier retirement—too frequently forced upon the employee—has not yet been thoroughly examined, and it should receive comprehensive and early attention. Employment—part-time or otherwise—should not be withdrawn from Americans simply because they reach an age arbitrarily set for retirement. Pilot programs have demonstrated that services for others provide great satisfaction and some income for those who wish to participate. Volunteer service offers other possibilities. Far more innovation is needed; and a national service program is overdue.

Eighth, to measure progress made on implementing the White House Conference recommendations of 1971, sub-conferences should be held at 2- or 3-year intervals during this decade. The first "Mini-White House Conference" should call specialists in retirement income to explore, in-depth, issues that of necessity received only limited attention at the White House Conference and during debate on H.R. 1. At the same time, another small group should be called to evaluate ground gained or lost in implementation of recommendations.[4]

Additional issues with immediate or long-range implications are discussed on the following pages. Congressional actions are compared with proposals made in the President's message, and suggestions are made for action.

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[4] S.J. Res. 212, introduced on March 3, 1972, by Senator Frank Church calls for a series of "four White House Issue-Oriented Sub-Conferences on Aging." At hearings held in February, Arthur Flemming, Chairman of the White House Conference on Aging and Special Consultant to the President on Aging, indicated his personal support of such a proposal.

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I. TOWARD A NATIONAL RETIREMENT INCOME POLICY

Inadequate retirement income continues to be the unresolved problem which intensifies so many other problems of millions of older Americans.

On that fundamental point, the Congress, the Administration, the White House Conference on Aging and—most certainly—the elderly are in emphatic agreement.

Chronic as the retirement income crisis may be, recent developments offer the hope that at last—and at least—a Federal floor will be put under minimum public payment levels.

A national policy on retirement income may therefore be in the making, and it should be based upon the following premises:

1. Because of its almost universal application, Social Security should be the prime component in any strategy for providing genuine economic security for the elderly.[1]

2. Major improvements are needed in private pension coverage to assure that its protection is more than just an illusory promise.

3. Any comprehensive income strategy must deal effectively with the mounting drains upon the elderly's limited budgets, such as rising health costs, soaring property taxes, and other inflationary pressures.

With poverty on the rise for older Americans,[2] the push for an effective national policy on retirement income has already gained considerable force. But fundamental questions still remain as to the "mix." Unresolved issues also exist with regard to the level of the "income floor" and how it should be financed. And in the midst of everything else are basic questions about the Social Security payroll tax and whether the middle-income and middle-aged should be expected to support an improved level of benefits solely through a regressive tax.

White House Conference Recommendations:

Undoubtedly the number one concern for the 3,400 delegates was the need for a national policy to establish an adequate and livable income in retirement. No fewer than 11 Sections or Special Concerns Sessions commented on this fundamental issue. In general, most Sections and Special Concerns Sessions recommended as a minimum measure of adequacy an income consistent with the Bureau of Labor Statistics intermediate budget for a retired couple (approximately $4,500 a year in the spring of 1970) with appropriate adjustments for single persons.

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[1] Approximately 93 percent of all persons reaching age 65 are eligible to receive Social Security benefits.

[2] From 1968 to 1970 poverty for persons 65 and older increased by 100,000—from 4.6 million to 4.7 million.

An enthusiastic endorsement of this concept was urged by the 304 delegates at the Income Section when they proposed:

> THE IMMEDIATE GOAL FOR OLDER PEOPLE IS THAT THEY SHOULD HAVE TOTAL CASH INCOME IN ACCORDANCE WITH THE "AMERICAN STANDARD OF LIVING."
>
> WE, THEREFORE, RECOMMEND THE ADOPTION NOW, AS THE MINIMUM STANDARD OF INCOME ADEQUACY, OF THE INTERMEDIATE BUDGET FOR AN ELDERLY COUPLE PREPARED BY THE BUREAU OF LABOR STATISTICS (NATIONALLY AVERAGING ABOUT $4,500 A YEAR IN SPRING 1970). THIS LEVEL MUST BE ADJUSTED ANNUALLY FOR CHANGES IN BOTH THE COST-OF-LIVING AND RISING NATIONAL STANDARDS OF LIVING.
>
> FOR SINGLE INDIVIDUALS THE MINIMUM ANNUAL TOTAL INCOME SHOULD BE SUFFICIENT TO MAINTAIN THE SAME STANDARD OF LIVING AS FOR COUPLES (NOT LESS THAN 75 PERCENT OF THE COUPLE'S BUDGET). FOR THE ELDERLY HANDICAPPED WITH HIGHER LIVING EXPENSES, THE BUDGET SHOULD BE APPROPRIATELY ADJUSTED.

For immediate action, the Employment and Retirement Section called for a 25 percent increase in Social Security benefits, with a $150 minimum monthly payment, to be financed in part by general revenues.

However, varying judgments existed as to what constitutes a livable income. To the aging and aged Blacks, it meant $6,000 for a single person and $9,000 for an aged couple. In urging a higher guaranteed annual income, the Aging Blacks Special Concerns Session said:

> IT IS RECOMMENDED THAT A MINIMUM GUARANTEED ANNUAL INCOME OF $6,000 FOR A SINGLE AGED PERSON AND $9,000 FOR AN AGED COUPLE BE ESTABLISHED, AND THAT APPROPRIATE COST-OF-LIVING INDICES BE ATTACHED, WITH THE AFOREMENTIONED FIGURES AS A BASE.
>
> ABOVE ALL, FIRST PRIORITY SHOULD BE GIVEN TO ESTABLISHING A SYSTEM PROVIDING AT LEAST A GUARANTEED, MODERATE INCOME TO ALL BLACK AGED. INCOME NEEDS EXCEED ALL OTHER PRIORITIES.

Whatever the level of the guaranteed annual income, there was widespread agreement that the supplementary payment system should be federally financed and administered.

Comprehensive and far reaching improvements were also vigorously urged for the private pension system which now covers 30 million workers. Widespread support was expressed for fundamental changes in 5 of the Sections and Special Concerns Sessions. The Income Section, for example, stated:

> SOCIAL SECURITY BENEFITS PROVIDE A BASIC PROTECTION WHICH SHOULD CONTINUE TO BE IMPROVED BUT WHICH CAN BE AUGMENTED THROUGH PRIVATE PENSION PLANS.

THE FEDERAL GOVERNMENT SHOULD TAKE ACTION TO ENCOURAGE BROADER COVERAGE UNDER PRIVATE PENSION PLANS AND INSURE RECEIPT OF BENEFITS BY WORKERS AND THEIR SURVIVORS. IT SHOULD REQUIRE EARLY VESTING AND/OR PORTABILITY, SURVIVOR BENEFITS, AND COMPLETE DISCLOSURE TO BENEFICIARIES OF ELIGIBILITY AND BENEFIT PROVISIONS OF THE PLANS. IN ADDITION, FEDERAL REQUIREMENTS SHOULD ASSURE FIDUCIARY RESPONSIBILITY, MINIMUM-FUNDING REQUIREMENTS AND PROTECTION THROUGH REINSURANCE, AND OTHER MEASURES, OF THE PROMISED BENEFITS.

Endorsing many of the same concepts, the Employment and Retirement Section recommended:

LEGISLATION MUST BE ENACTED AS SOON AS POSSIBLE REQUIRING EARLY VESTING, ADEQUATE FUNDING AND PORTABILITY OF PENSIONS AND TO PROVIDE FOR FEDERAL INSURANCE FOR PENSIONS.

A NATIONAL PENSION COMMISSION WITH A GOVERNING BOARD OF MANAGEMENT, LABOR, AND PUBLIC REPRESENTATIVES SHOULD BE ESTABLISHED TO STUDY WAYS OF ENCOURAGING THE EXPANSION AND THE IMPROVEMENT OF PRIVATE AND PUBLIC PENSION PLANS WITH PARTICULAR REFERENCE TO: FLEXIBLE RETIREMENT AGES, LIBERAL (EARLY) VESTING AND PORTABILITY, ADEQUATE FUNDING, MORE GENERAL COVERAGE, JOB REDESIGN AND FEDERAL INSURANCE OF PENSIONS.

FOR ALL MINORITIES, RURAL RESIDENTS, MIGRANTS, AND EMPLOYEES OF SMALL BUSINESS, CONGRESS SHOULD ENACT A COMPULSORY, UNIVERSAL AND NATIONAL PORTABLE PENSION PLAN ADMINISTERED THROUGH SOCIAL SECURITY (WITH TAX ADVANTAGES FOR THE EMPLOYER AND THE SELF-EMPLOYED) TO PROVIDE FOR THOSE NOT NORMALLY COVERED BY OTHER PENSION PLANS.

Another key issue, which received intensive attention, was the means of financing Social Security. To improve its financing, the Income Section proposed:

THE FINANCING OF THE SOCIAL SECURITY SYSTEM SHOULD INCLUDE A CONTRIBUTION FROM GENERAL REVENUES. THE WHOLE STRUCTURE OF PAYROLL TAXES SHOULD BE REVIEWED TO LIGHTEN THIS BURDEN ON LOW-INCOME WORKERS.

The position of disadvantaged groups under Social Security also received close attention, especially in the special concerns sessions. Benefits at an earlier age to compensate for life expectancy differentials were urged by the Aged Blacks and the Spanish-speaking Elderly. The Aged Blacks gave this assessment, from Special Concerns Sessions:

IT IS RECOMMENDED THAT THE MINIMUM AGE-ELIGIBILITY REQUIREMENT FOR PRIMARY BENEFICIARIES OF OASDHI (SOCIAL SECURITY) BE REDUCED BY 7 YEARS FOR BLACK MALES, SO AS TO REDUCE THE EXISTING RACIAL INEQUITIES.

Taking into account varying life expectancies because of occupational differences, the Spanish-speaking Elderly said:

> DUE TO THE LOWER LIFE EXPECTANCY OF THE SPANISH-SPEAKING ELDERLY, IT IS RECOMMENDED THAT FEDERAL LEGISLATION BE PASSED TO LOWER THE RETIREMENT AGE TO 55 FOR THE URBAN SPANISH-SPEAKING AND TO 45 FOR THE MIGRANT RURAL SPANISH-SPEAKING WORKER.

Another issue which received intensive scrutiny is the test which limits the earnings a Social Security beneficiary may receive without loss of benefits. The Income Section, for example, called for a $3,000 limitation with $1 in benefits withheld for each $2 of earnings above this exempt amount. Another alternative was urged by the Employment and Retirement Section which called for a retirement test to allow persons to receive Social Security benefits without reduction up to the point where the total of Social Security plus earnings equal $5,000. And other Sections and Special Concerns Sessions recommended that beneficiaries should be allowed unlimited earnings without the reduction of Social Security benefits.

Congressional Actions:

New and potentially far reaching actions were initiated in the House and Senate in 1971 and early 1972 to make major improvements in Social Security and Welfare. In June the House of Representatives approved a comprehensive Social Security-Welfare Reform bill, H.R. 1. Despite the need for further significant changes, H.R. 1 provides an important vehicle for making vital improvements in Social Security, Medicare, and Old Age Assistance.

Among the major reforms in the House-passed measure:[3]

—A new special minimum monthly benefit ranging from $75 to $150 for persons with long periods of covered employment;[4]
—Full benefits for widows, instead of only 82½ percent as under present law;
—Automatic adjustments to protect the elderly from rising prices;
—Liberalization of the existing earnings limitation;
—An age-62 computation point for men;
—Replacement of the Old Age Assistance with a new income supplement program to be administered by the Social Security Administration. Under the new program, there would be a guaranteed annual income of $1,560 for a single aged person—double the amount initially proposed by President Nixon in his welfare reform message.[5] For an elderly couple, the income standard would be $2,340 a year.

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[3] For a more detailed description of these legislative proposals, see "Summary of Legislative Actions Taken from January 1971 to April 1, 1972", p. 89.

[4] On March 27, the Senate Finance Committee tentatively agreed to authorize a new special minimum, ranging from $80 to $200 for persons with 18 to 30 years of covered employment. Under present law, the minimum monthly benefit is $70.40. The new special minimum, as approved by the Finance Committee, would be equal to $10 multiplied by the years of covered employment above 10 years.

[5] On April 5, the Senate Finance Committee approved the House-passed income standards of $130 for a single person and $195 for an aged couple. However, the Finance Committee agreed to disregard the first $50 of Social Security benefits and the first $50 of earnings. About two-thirds of present Old Age Assistance recipients also receive Social Security benefits. The effect of the Finance Committee action is to guarantee most elderly welfare recipients a monthly income of $180 ($245 for an aged couple who also receive Social Security benefits).

Mills-Church Proposal

But even more significant is the powerful momentum—generated in part by the White House Conference—for a Social Security increase far in excess of the 5 percent level in H.R. 1. A few weeks ago, Representative Wilbur Mills and Senator Frank Church introduced companion proposals [6] calling for a 20 percent across-the-board boost in benefits. Under this approach, monthly Social Security payments would be increased from $133 to $162 for the typical retired worker; from $222 to $269 for the average elderly couple; and from $114 to $153 for aged widows. Approximately 1.9 million Social Security recipients would be lifted out of poverty under this proposal, including 1.4 million aged.

Utilizing actuarial assumptions [7] recommended in 1971 by the Social Security Advisory Council, this sizable benefit increase could be achieved without endangering the Social Security trust fund and with only a modest increase in the payroll tax.

Of special significance, the new actuarial assumptions will permit financing a 20-percent increase and with a smaller rise in the contribution rate for more moderate-income and low-income workers for a greater period of time than that presently scheduled under H.R. 1.

Adequacy of Pension Coverage Challenged

Disturbing evidence about gaps and shortcomings in private pension coverage was revealed over the past year in a study undertaken by the Labor Subcommittee of the Labor and Public Welfare Committee. Particularly noteworthy was the finding that—for those who qualify—the median monthly payment for normal retirement is only $99 a month. For early retirement, it is $72 a month. And for disability payments, less than $50.

A staff analysis of 87 retirement plans showed, that out of 51 plans with no vesting or 11 or more years for vesting, only 5 percent of all participants who left their jobs since 1950 had collected any benefits. Of the remaining 36—with 10 years or less for vesting—16 percent received pensions. And many of the individuals who lost their benefits were long-term employees.

Preliminary findings [8] by the Subcommittee focus on six major problem areas: (1) Inadequate or nonexistent vesting, (2) impossibility of transferring earned credits from one job to another, (3) inadequate or nonexistent funding, (4) lack of reinsurance in the event of the termination of a plan, (5) lack of Federal fiduciary standards, and (6) lack of consolidated and efficient enforcement.

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[6] H.R. 13320, introduced by Representative Wilbur Mills on February 23, 1972; Amendment No. 999, introduced by Senator Franck Church on March 7, 1972.

[7] The Social Security Advisory Council proposed two basic changes in the actuarial assumptions for the Social Security program: (1) Current cost financing (reduction of Social Security trust funds to a level approximately equal to one year's benefit expenditures, instead of allowing unnecessarily large accumulations as would occur under the present system), and (2) an assumption that both benefits and wages will rise in the future as they have in the past. "Reports of the 1971 Advisory Council on Social Security", H. Doc. No. 92–80, April 5, 1971, see p. 64 and p. 68.

[8] "Interim Report of Activities of the Private Welfare and Pension Plan Study", Subcommittee on Labor of the Senate Labor and Public Welfare Committee, Feb. 22, 1972.

To combat this mounting problem, the Subcommittee report recommended early enactment of legislation which would establish minimum standards for vesting, funding, and reinsurance; a uniform standard of fiduciary responsibility; and improved communication of plan provisions to workers. Additionally, the report called for Federal guidelines for a program to develop portability and reciprocity among private pension plans and fixing responsibility in one agency for the regulation of all private pension plans.

Presidential Message:

Agreement upon the need for a comprehensive "income strategy" for older Americans has produced strong support in Congress, from the Administration, and the White House Conference on Aging. But fundamental questions still exist about goals for implementing this strategy.

In his Message on Aging, the President reaffirmed his support for giving priority attention to protecting the income position of the elderly. Heading his recommendations was "prompt" enactment of H.R. 1, which would authorize a 5 percent increase in Social Security benefits and a floor under the income of older Americans ($130 a month for a single aged person and $195 for an elderly couple, eventually rising to $150 for individuals and $200 for couples).

Additionally, H.R. 1 would liberalize the retirement test by increasing the earnings limitation from $1,680 to $2,000, with $1 in benefits withheld for each $2 of earnings above this amount. (For other provisions in H.R. 1, see p. 89.)

Additionally, the President urged enactment of legislation on the following fronts to supplement or protect the elderly's income position:

—Elimination of the premium charge for the elderly [9] for Part B (doctor's insurance) of Medicare.

—Improvements in private pension plans by requiring vesting, tax deductions to encourage independent savings toward retirement, and the establishment of fiduciary standards for the administration of pension plans.[10]

—Revenue sharing measures to help provide an opportunity for property tax relief.[11]

Moreover, the President stated that the administration would propose improvements in the military retirement system, including a one-time recomputation of retirement pay.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

The fundamental weakness of the presidential message on aging is that it fails to establish any realistic goals to provide a livable income for older Americans. No where is this more evident than in the administration's insistence on holding the line for a grossly inadequate 5 percent Social Security increase—an increase which

[9] For further discussion of the administration's proposal to eliminate the premium charge, see p. XI.

[10] For comments of the President's pension proposals, see p. XI.

[11] For further discussion of the administration's proposals to provide property tax relief for the elderly, see p. 20.

will not even keep pace with the cost-of-living. Moreover, the presidential message falls far short of the moving call for action at the White House Conference. And it will still leave millions of older Americans in poverty.

One of the great failings of our society today is the failure to establish a retirement income policy which provides genuine economic security. As a consequence nearly 6.5 million older Americans are now classified as poor or near poor.[12]

The net impact of these figures is that older Americans are more than twice as likely to be poor as younger Americans. One out of every four individuals 65 and older—in contrast to one in nine for younger persons—lives in poverty.

For elderly women, especially widows and others living alone, the situation is even more severe. Approximately 50 percent have incomes below the poverty threshold. And their median income is only slightly above $35 a week.

The Committee strongly recommends an all out attack to eliminate poverty once and for all for older Americans [13] and to allow them to share in the economic abundance which they have worked most of their lives to create. Moreover, the Committee urges effective congressional and executive action to implement the national retirement income policy of the White House Conference. As immediate steps for implementing these goals, the Committee urges:

- A 20-percent increase in Social Security benefits:
- Replacement of old age assistance with a new income supplement program which would eliminate poverty for all older Americans.

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[12] See table below:

POVERTY THRESHOLDS (POOR AND NEAR POOR [1]) OLDER UNRELATED INDIVIDUALS AND FAMILIES BY LOCATION AND SEX, 1970

[Weignted averages]

Location and sex	Unrelated individual 65 and over		2-person family (couple) head 65 and over	
	Poor	Near poor	Poor	Near poor
Total	$1,852	$2,315	$2,328	$2,910
Nonfarm	1,861	2,326	2,348	2,935
Male	1,879	2,349	2,349	2,936
Female	1,853	2,316	2,335	2,926
Farm	1,586	1,933	1,994	2,493
Male	1,597	1,996	1,996	2,495
Female	1,576	1,970	1,972	2,465

[1] Near-poor threshold is defined as 125 percent of the poor threshold.

[13] The Finance Committee proposal for welfare reform (see footnote 5 for further discussion) would still leave 2.4 million aged, blind and disabled persons in poverty. However, a proposal (Amendment No. 998) introduced by Senator Frank Church on March 7 would establish an income standard of $1,920 for a single aged person and $2,400 for an elderly couple. Moreover, these standards would be automatically adjusted to reflect changes in the cost-of-living. Under this proposal, it would be possible to eliminate poverty for all older Americans as well as for persons who now receive assistance payments for being blind or disabled.

- Major reforms in the Social Security program, including cost-of-living adjustments, substantial increases in minimum monthly benefits for persons with long periods of covered employment, full benefits for widows, liberalization of the retirement test, an age-62 computation point for men, and equitable treatment for families with working wives.
- A recognition by the Administration that the change in the actuarial assumptions for Social Security to reflect current cost financing and a rising wage assumption permits major increases in benefits without saddling today's workers with a heavy burden.
- Major reforms in private pension plans, including minimum standards for vesting, funding, and reinsurance: a uniform standard for fiduciary responsibility; and greater disclosure requirements; about the provisions in pension plans, plus an intensive effort to cover those not likely to be protected by existing plans.

Additionally, the commitee recommends that:

- Railroad retirement increases should be consistent with Social Security rises.
- Income limitations for veterans' pensions should be appropriately adjusted to reflect the proposed boosts in Social Security and railroad retirement benefits.
- The retirement income credit should be updated to provide Government annuitants with comparable relief as is received by Social Security beneficiaries.
- Tax relief measures [14] should be promptly enacted to provide urgent relief for overwhelmed aged homeowners and renters.

An intensive inquiry is also needed to consider long-range goals for Social Security and other retirement programs. To provide further insight for these long-term policy considerations, the committee will initiate a comprehensive study on "New Directions in Social Security".

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[14] For more detailed discussion of the Committee's recommendations for property tax relief for the elderly, see p. 22.

II. A NATIONAL ISSUE CONCERN: PROPERTY TAXES

Property taxes in 1971 hit an all time record high of more than $40 billion. In many communities, the tax bite has doubled, and in some cases tripled, during the past five or ten years. As a consequence many aged homeowners—after a lifetime of savings and self-sacrifice—are finding themselves financially depleted by this mounting burden. Large numbers are now forced to liquidate their assets or endure serious deprivation in order to pay for the local assessments on their homes.

In the typical urban household approximately 4 percent of the income is spent for property taxes. But in the case of the aged homeowner the burden is frequently much more substantial. Many older Americans are now turning over 20 to 40 percent of their limited incomes to the local assessor. In some cases their property taxes now exceed 50 percent of their retirement benefits. Evidence from one Midwestern State,[1] for example, revealed that more than 8,000 elderly homeowners who lived on less than $1,000 paid about 30 percent of their meager incomes for property taxes.

And in 1971 the property tax became deeply interwoven in many national, State and local issues with the landmark Serrano decision [2] which held that the financing of school systems should not be dependent on local wealth. With this potentially far-reaching decision, a whole host of vital questions have been raised with important implications for all age groups, including:

—How can widespread financial disparities among school districts be corrected to insure quality education, regardless where a student lives?

—What is the most equitable and effective means of financing public education in the United States? Should there be greater Federal financing? Or, should the States assume a larger role?

—How can the property tax be made less regressive?

—What can be done to provide relief from this crushing burden?

White House Conference Recommendations:

At the White House Conference on Aging, the issue of property tax relief—either in the form of a refund, rebate or other means—received very close and careful attention. In general, there was widespread and strong support for relief for aged homeowners and tenants. The Housing Section, for example, made a ringing call for either the Federal Government or States to "provide mechanisms to make possible local property tax relief for the elderly homeowner and renter." [3]

A similar recommendation was also endorsed in the Income Section.

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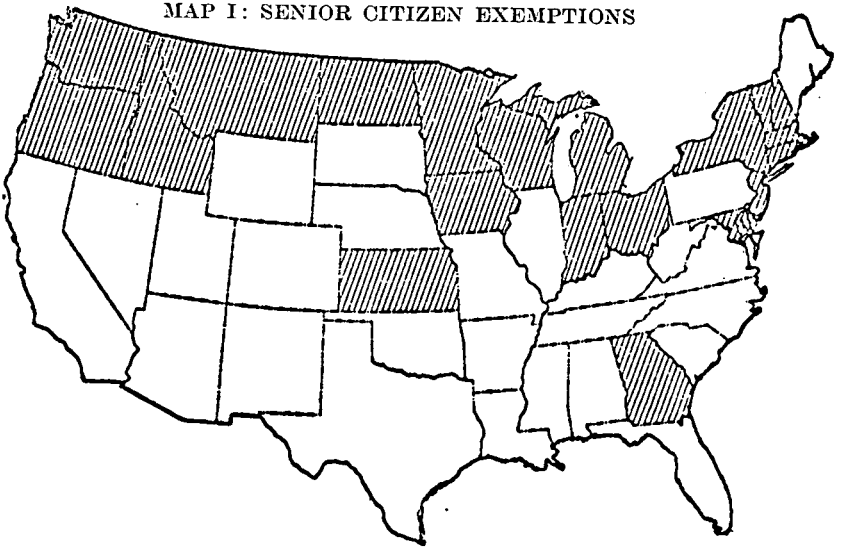
[1] "Economics of Aging: Toward a Full Share in Abundance", Part 4—Homeownership Aspects; Hearings before the Subcommittee on Housing for the Elderly of the Senate Special Committee on Aging; 91st Cong., 1st Sess., July 31-August 1, 1969; p. 769.

[2] In *Serrano* v. *Priest*, the California Supreme Court held that a State cannot set up any system of paying for public education which makes the amount of money available in any particular district, or for any particular child, depend upon local wealth. The California Supreme Court tentatively concluded that the State's public school financing system denies children equal protection because it produces substantial disparities among school districts in the amount of revenue available for education.

[3] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions." Dec. 1971, p. 13.

STATES AND LOCALITIES SHOULD BE ENCOURAGED TO REMIT PART OR ALL OF THE RESIDENTIAL PROPERTY TAXES ON HOUSING OCCUPIED BY OLDER PERSONS AS OWNERS OR TENANTS WHO QUALIFY ON THE BASIS OF AN APPROPRIATE MEASURE OF INCOME AND ASSETS. REMISSION IS TO BE ACHIEVED BY FEDERAL AND STATE GRANT PROGRAMS TO STATE AND LOCAL TAXING AUTHORITIES TO COMPENSATE FOR REDUCED REVENUES.[4]

MAP I: SENIOR CITIZEN EXEMPTIONS



INTERNATIONAL ASSOCIATION OF ASSESSING OFFICERS RESEARCH DEPARTMENT, JUNE 1971

Senior citizen exemptions have been enacted in the following states: Connecticut, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and Wisconsin.

Congressional Actions:

From 1967 to 1970 property taxes jumped by about 35 percent, nearly twice the average increase in the cost-of-living. And there appears to be no end in sight.

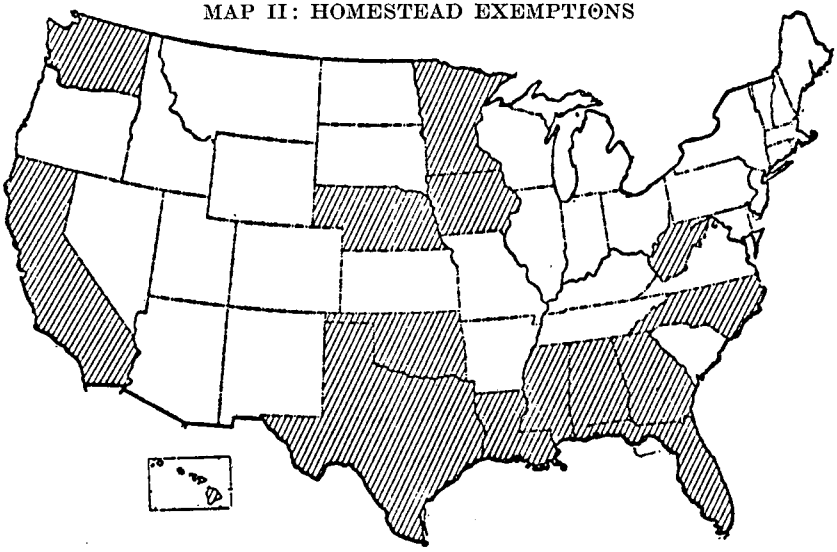
In response to this emerging problem, several bills were introduced in 1971 to develop mechanisms for providing property tax relief for the aged. One such example was the Housing for the Elderly Act (S. 1935)—sponsored by Senator Williams—which would establish an intergovernmental task force to report, at the earliest possible date, on several alternatives for providing (1) Federal assistance to States which grant tax relief for elderly homeowners and renters or (2) direct Federal relief to older Americans who pay a disproportionate share of their income for property taxes or rent.

Additionally, Senator Thomas Eagleton introduced legislation (S. 1960) which would allow a tax credit up to $300 against property

[4] Page 17 of report cited in footnote 3.

taxes paid on an owner-occupied residence or against 25 percent of rent paid by a tenant. This proposal was limited to persons 65 and older with adjusted gross incomes not exceeding $6,500. S. 1960 was eventually adopted as an amendment to the Revenue Act by a vote of 65 to 19. But, the proposal was later deleted in Conference Committee.

MAP II: HOMESTEAD EXEMPTIONS



INTERNATIONAL ASSOCIATION OF ASSESSING OFFICERS RESEARCH DEPARTMENT, JUNE 1971

Homestead exemptions have been enacted in the following states: Alabama, California, Florida, Georgia, Hawaii, Iowa, Louisiana, Minnesota, Mississippi, Nebraska, North Carolina, Oklahoma, Texas, Washington, and West Virginia.

Presidential Message:

Calling the property tax "one of the most onerous of all taxes for older Americans",[5] President Nixon pledged to the White House Conference delegates that he would develop specific proposals to ease this crushing burden. Additionally, the President declared, "The time has come to stop talking about the impact of property taxes on older Americans and to act in their behalf, and in behalf of other citizens in similar circumstances." [6]

In his recent Message on Aging, the President announced a two-prong approach to cope with this problem. First, he reiterated his strong support for the concept of revenue sharing to provide States and local governments with the opportunity to grant property tax relief. Second, he indicated that he would draw upon the recommendations of his Commission on School Finance and the Advisory Commission on Inter-governmental Relations to place the educational system on a sounder financial basis.

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[5] P. 128 of report cited in footnote 3.
[6] P. 129 of report cited in footnote 3.

Commission on School Finance Report

In its 147-page report, the Commission on School Finance recommended in March that the States take over the major burden of paying for public schools. To achieve this, the Commission proposed that the Federal Government should provide the States with $4.6 billion to $7.8 billion over the next five years as an incentive for assuming part of the financing now being carried out by 17,500 school districts.

Critics of the Commission's proposals,[7] however, have contended that:

—The recommendations of the Commission on School Finance fall far short of the major commitment which is really needed if our Nation is serious about improving the means of financing our public school system, and yet protect the elderly from onerous property taxes.

—The basic thrust of the Commission report is to eliminate the sharp gaps between the amounts spent per child in rich and poor school districts, rather than to provide meaningful property tax relief.

Value Added Tax: A Growing Controversy

Another proposal under consideration by the Administration is the value-added tax, which would be comparable to a national sales tax on commodities and commercial services. Basically, it would be imposed at each stage of production until the item is sold.

During hearings conducted by the Joint Economic Committee, this proposal generated heated and lively debate. Advocates of the European VAT system argue that it is essentially a hidden tax which can raise substantial quantities of revenue to replace or provide a partial substitute for the property tax.

Critics of VAT claim, however, that it is regressive in the extreme because it would fall most heavily upon low- and moderate-income persons. Additionally, they contend that it would intensify inflationary pressures because the tax is passed along to the consumer in the form of higher prices.

A more appropriate alternative, they maintain, would be to close the massive tax loopholes which now cost the Government billions of dollars. And pressures for tax reform have intensified because 112 taxpayers with incomes of $200,000 or more escaped Federal income tax completely in 1970.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Recent investigations by the Senate Committee on Aging make it painfully clear that older Americans are being victimized by soaring property taxes. In most major cities in the United States, the vast majority of aged property owners can expect to pay at

[7] For examples of criticisms, see Mar. 12, 1972 New York Times, *A New Way to Foot the Bill*, by John Herbers.

least $300 for property taxes, and in many cases substantially more, for a medium-priced home.

Complicating everything else, there is clear and convincing evidence to suggest that many homeowners are shouldering too much of the load at the expense of preferential treatment for other interests. According to one leading authority,[8] an estimated $7 billion per year may be denied local communities because of special exemptions.

Moreover, the administration's proposed revenue sharing measures, in themselves, are unlikely to provide major property tax relief because any additional money released to the States is likely to be used for other pressing problems, such as increasing welfare costs, the demand for additional public services, and rising educational expenditures.

However, the burdens imposed by rising property taxes have now reached emergency proportions for the elderly and demand immediate attention.

The committee strongly urges early and favorable action on property tax relief measures which incorporate the following basic principles:

- Relief should be available to the aged tenant as well as the homeowner.
- Assistance should be limited to low- and moderate-income individuals.
- A "tier" or "step" system should be employed to provide the greatest relief for persons with the lowest incomes.
- Relief should be as direct as possible and without imposing cumbersome eligibility procedures.
- Relief may be in the form of a tax refund and for persons whose incomes are too small to file a tax return, a property tax rebate should be available.
- Property tax relief should be linked with property tax reform.
- Federal assistance should be available to States adopting tax relief measures based on these fundamental concepts.

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[8] Ralph Nader, see Mar. 5, 1971 Cong. Rec., p. E 2106.

III. HEALTH CARE: "A BASIC RIGHT"

Medicare, in the minds of many, meant the end of financial worry over medical costs for the Nation's elderly.

But the hard facts reveal that the performance of Medicare—essential as its protection may be—stands in need of far-reaching improvement.

Dramatic evidence of this is provided by recent figures showing that, when it comes to health expenditures, "per capita direct payments for the aged in fiscal 1966 (the year prior to Medicare) were only slightly greater than those in 1971 ($234 compared to $225)." [1]

In fact, in fiscal year 1970, out-of-pocket payments for people 65 and older were about the same as the *total* medical care expenditures of the average person under 65 and were much more than double the younger person's out-of-pocket payments.[2]

What these startling figures mean, quite simply, is that the elderly, despite Medicare, have been on an economic treadmill as far as health care costs are concerned.

And more hard facts point to hard times for the elderly in trying to meet medical expenses:

—Per capita health expenditures in fiscal year 1971 were $861 for persons 65 and older but only $250 for those under 65. And Medicare in fiscal year 1971 covered only 42 percent of the total health payments of the elderly.[3]

—A major Federal study of the Nation's health care costs, released August 5, 1971, forecasts that medical expenses will rise 50 percent in the first half of this decade to more than $100 billion.[4]

—The Administration's "New Economic Plan" is failing in its effort to put a lid on spiraling health care costs. Figures from the January 1972, Consumer Price Index confirm this. The CPI listing for medical care services indicated a 0.4 percent increase over the previous month. For the preceding three months, the CPI for medical care services had risen 0.9 percent. And the increase over the previous 12 months was an even 5 percent.[5]

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[1] Letter of March 7, 1972, to the U.S. Senate Special Committee on Aging, from Ida C. Merriam, Assistant Commissioner for Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare (in response to an inquiry from the Committee).

While the out-of-pocket payments have remained essentially the same, present expenditures would purchase much less medical care because of the sharp increase in medical costs. However, older Americans are receiving vastly more medical care than in 1966, which is being paid for by public programs (Medicare and Medicaid).

[2] Barbara S. Cooper and Mary F. McGee, "Medical Care Outlays for Three Age Groups: Young, Intermediate, and Aged," *Social Security Bulletin*, May, 1971, p. 10.

[3] Message from the President of the United States Transmitting Recommendations for Action on behalf of Older Americans, March 23, 1972, p. 10. (H. Doc. 92–268, 92d Cong., 2d Sess.). (All references to the President's message on aging are taken from this document).

[4] "A Study of National Health Insurance Proposals Introduced in the 91st Congress: A Supplementary Report to the Congress," Department of Health, Education, and Welfare, July, 1971, Appendices A and B, pp. 79–85. This study was called for by an amendment to Public Law 91–515 by Senator Claiborne Pell of Rhode Island, a member of the Special Committee on Aging.

[5] *Washington Report on Medicine and Health*, February 28, 1972, p. 3. The survey director of the HEW study cited in footnote 4 has stated that the predicted cost increases forecast in that report will run even higher if the national economy is not stabilized. (*Reforms That Can't Wait*, The Evening Star, Washington, D.C., September 7, 1971, p. A10).

So much for costs. What about programs and services? Are the elderly at least getting more return for the extra cash outlays they must make for medical care? The answer to this question appears to be, "Emphatically, No."

Programs and services are declining while health care costs are increasing. This crisis of "rising costs and reduced programs" was summarized by the Special Committee on Aging on the eve of the 1971 White House Conference on Aging: [6]

> Health care costs keep going up for all Americans. But for the older person the problem is compounded. He has only about half the income of those under age 65, but—even with Medicare—he pays more than twice as much for health services. He is doubly likely to have one or more chronic diseases than young people, and much of the care he needs is of the most expensive kind. And, while costs go up, services available under Medicare and Medicaid go down—a process which was accelerated considerably in 1971.

White House Conference Recommendations:

The recommendations of the White House Conference on Aging show a sharp awareness of the health care crisis facing America's elderly and the importance of solution if overall goals are to be achieved. The Income Section, for example, prefaced its specific recommendations—including the recommendation for a comprehensive national health security program for the total population—by stating: "This Nation can never attain a reasonable goal of income security so long as heavy and unpredictable health costs threaten incomes of the aged." [7]

Summed up, the recommendations of the Health Section were:

—The United States "must guarantee to all its older people health care as a basic right." Denying health care to the elderly by calling it a "privilege" and not a "right" is no longer acceptable or justified.

—Declaring that "Health care for the aging must be provided as an integral part of a coordinated system that provides comprehensive health services to the total population," the delegates recommended that, "A comprehensive health care plan for all persons should be legislated and financed through a National Health Plan."

—But, "Pending the achievement of such a National Health Plan," the delegates recommended that "the complete range of health care services for the elderly must be provided by expanding the legislation and financing of Medicare." [8] In addition, "Such ex-

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[6] "A Pre-White House Conference on Aging Summary of Developments and Data," U.S. Senate Special Committee on Aging, November 1971, p. 17. Chapter 2 of this report describes and documents in detail the problem of increasing costs and reduced services for the elderly in the health field in 1971.

[7] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions," reprinted by the U.S. Senate Special Committee on Aging, December 1971, p. 17. (All references to White House Conference on Aging recommendations are taken from this publication.)

[8] The Minority Report of the Section on Physical and Mental Health stated that "75 delegates opposed the Section's action eliminating the combination of Medicare and Medicaid expansion (through legislation and financing) as an alternate to expansion of Medicare only to achieve a comprehensive health care plan."

panded financing should be accomplished by means of a combination of Social Security Trust funds with a greatly expanded use of general revenues." The Medicare expansion should also "include elimination of deductibles, coinsurance, and copayment."

The Income Section, also urging the expansion of Medicare, specified that the range of services should include, at a minimum and without cost sharing, "out-of-hospital drugs, care of the eyes, ears, teeth, and feet (including eyeglasses, hearing-aids, dentures, etc.); and improved services for long-term care, and expanded and broadened services in the home and other alternatives to institutional care."

Several other central concerns marked the deliberations of the conferees.

First, alternatives to institutional care received repeated emphasis. The delegates declared that, "To be specifically responsive to the needs of the elderly, special attention must be given to the development of adequate, appropriate alternatives to institutional care." And a Special Concerns Session on "Homemaker-Home Health Aide Services" spelled out recommendations for developing this important resource to "provide many older persons the choice of maintaining independent living."

Second, much thought and attention were devoted to the crucial problem of mental health of the elderly. A key recommendation in this area came from the Special Concerns Session on "Mental Health Care Strategies and Aging," which called for the early establishment of a Presidential Commission on Mental Illness and the Elderly, with responsibility for implementing recommendations made at the White House Conference, and also charged, in general, with policymaking and oversight responsibilities in this long-neglected area.

Third, the Special Concerns Session on "Aging and Blindness," pointing out that "approximately half of the estimated 500,000 legally blind persons in the United States are 65 years of age or older," urged that high priority be given the question of how the visually handicapped "can be more effectively integrated and served by the ever-increasing number of special programs for older persons." In addition, it was recommended that Congress amend Medicare and Medicaid "to cover low vision aids when the need is certified by an ophthalmologist or an optometrist specializing in low vision treatment."

Congressional Actions:

In 1971 and early 1972 Congress was active in a number of areas affecting health care of the elderly. Some of the major thrusts are described below.

National Health Plans.—The House Ways and Means Committee held hearings in the fall of 1971 on more than a half-dozen proposals for a national health plan.[9] At the time this report goes to press, the Ways and Means Committee is expected to meet in executive session soon to draft its own legislation. Chairman Wilbur D. Mills of Arkansas expects these meetings to last six or seven weeks.[10]

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[9] Two of these proposals are discussed in Part two of this report at pp. 96–97.
[10] John Sibley, "Mills Proposes Own Health Plan," New York Times, Mar. 4, 1972, p. 19.

The Senate Finance Committee is scheduled to hold hearings on proposals for national health plans after it completes work on H.R. 1, the House-passed bill amending the Social Security Act.[11]

Although Chairman Mills has stated that he thinks passage of a national health plan by the House is possible in 1972,[12] the chances that Congress will complete action on such a plan this year appear slim.

H.R. 1.[13]—The House version of H.R. 1 has been undergoing a series of major and minor changes by the Senate Finance Committee. Many current estimates point to passage of the bill in some form by the summer of 1972.

H.R. 1 contains a number of key provisions related to health care of the elderly. On the positive side, Medicare coverage would be extended to disabled Social Security beneficiaries under age 65, provided they have been receiving disability benefits for at least two years.[14]

But the restrictive provisions of H.R. 1 are cause for great concern. The impact of these regressive features of H.R. 1 would be to reduce even further the medical services available to the elderly while adding to their health care costs. Briefly, H.R. 1, as passed by the House, contains these Medicare-Medicaid cutbacks:[15]

—The deductible under Medicare Part B supplementary medical insurance would be increased from the present $50 to $60.
—The elderly, under Medicare, would be subject to a $7.50 daily co-payment charge for each day in the hospital from the 31st to the 60th day.
—The existing provision requiring States to have comprehensive Medicaid programs by 1977 would be repealed.
—Maintenance of effort by the States would be required for only the basic Medicaid services.
—Cost sharing would be imposed on Medicaid recipients.
—In the attempt to promote more out-patient care under Medicaid, Federal matching funds for in-patient services would be cut back.

Cutbacks in Medicare and Medicaid.—The White House Conference on Aging delegates, as noted above, called for "expanding the legislation and financing of Medicare." The restrictive provisions of H.R. 1 point in the opposite direction. And so do announcements made by the Administration in 1971 increasing the out-of-pocket costs of Medicare enrollees.[16]

The Subcommittee on Health of the Elderly of the Special Committee on Aging held hearings in 1971 on "Cutbacks in Medicare and Medicaid Coverage." These hearings focused on the cutbacks in Medi-

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[11] Carroll Kilpatrick, "Nixon Urges Hill to Act on Health Plan," Washington Post, Mar. 3, 1972, p. 1.
[12] "Health Plan Outlined by Mills," Washington Post, Mar. 4, 1972, p. A17.
[13] H.R. 1 contains provisions that would change Medicare and Medicaid.
[14] The Special Committee on Aging opposes this 2-year requirement. See footnote 29, p. 29.
[15] For a more detailed description, see pp. 23–24 of the report cited in footnote 6. See, also, "Cutbacks in Medicare and Medicaid Coverage," U.S. Senate Special Committee on Aging, Parts 1, 2, and 3 (hearings held in 1971).
[16] These include announcements by HEW Secretary Elliot Richardson: (a) on Dec. 31, 1971, that, as of July 1, 1972, the monthly premium for Part B of Medicare would be increased to $5.80 and (b) on Oct. 1, 1971, that the deductibles for Medicare Part A Hospital Insurance would be increased to $68 as of Jan. 1, 1972.

care described above, as well as cutbacks in Medicaid, such as the co-payment schemes in California that were implemented with the approval of the Administration.[17]

Senator Edmund S. Muskie of Maine, Chairman of the Health Subcommittee, described the damaging effects of these cutbacks on the elderly:[18]

> Recent cost-cutting cutbacks and regulations have saved money, but at the price of denying urgently needed health care to our older citizens. By placing limits on care available and by increasing costs, we have merely decreased the health and happiness of our older people. Too often, the choice for them must be made between food and medicine.

HMO's.—Medicare has, since its enactment, been oriented primarily toward acute illness and "crisis medicine." Preventive medicine and health maintenance are being stressed in the current national dialogue on health care.

A bill introduced by Senator Edward M. Kennedy of Massachusetts, a member of the Senate Special Committee on Aging and also Chairman of the Health Subcommittee of the Senate Committee on Labor and Public Welfare, on March 13, 1972, would establish health maintenance organizations (HMO's) providing medical treatment to subscribers paying annual premiums in advance. In exchange for the premiums, subscribers would be entitled to comprehensive health care without co-payments and without a price tag on each service.

Although a number of pre-paid group plans are already in operation, the Kennedy Bill (S. 3327) would stimulate the nationwide expansion of such plans through incentives in the form of Federal grants, subsidies, and loans. Hearings on the bill were underway in the spring of 1972.

Home Health Care.—At a time when alternatives to institutional care are being discussed as a vital component of a revitalized health care system, the Special Committee on Aging has pointed to the alarming decline in one of the most potent alternatives, home health care. This situation is documented in a report to the Committee in April of 1972.[19]

In a preface to the report, Senator Frank Church of Idaho, Chairman of the Special Committee on Aging, and Senator Muskie warn that the decline of home health services is "hardly a promising trend at a time when the Nation is about to make major decisions on health care policy, including the question of national health insurance of one kind or another."[20]

The report does more than analyze the shortcomings in public policy in the home health field. As the Church-Muskie preface indicates, it also "points the way to an action program that can help remedy these deficiencies."[21]

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[17] See Part 1 of the hearings cited in footnote 15. The California cutbacks are also summarized at pp. 19–21 of the report cited in footnote 6.

[18] This quotation is from p. 2 of Part 1 of the hearings cited in footnote 15.

[19] "Home Health Services in the United States," U.S. Senate Special Committee on Aging, April 1972.

[20] See p. III of the report cited in footnote 19.

[21] See p. IV of the report cited in footnote 19.

The report called for both immediate and long-term approaches. Major recommendations included the following:

1. Interpreting and applying Medicare and Medicaid regulations "in order to stimulate, rather than restrict, utilization of home health services by allowing *full* implementation of the regulations as they are presently stated." [22]
2. Eliminating Medicare barriers to home health services, the most serious being institutionalization as a pre-condition for home health care under Part A and requirements for coinsurance payments under Part B.
3. Eliminating administrative policies requiring prior authorization and allowing retroactive denials of claims.
4. Providing for comprehensive home health services in all legislative proposals for national health care.

Mental Health.—A report by the Special Committee on Aging in November of 1971 concluded that "public policy in mental health care of the elderly is confused, riddled with contradictions and short-sighted limitations, and in need of intensive scrutiny geared to immediate and long-term action." [23]

The report called for the establishment of a Presidential Commission on Mental Illness and the Elderly American. The creation of such a Commission is proposed in S. 2922, introduced by Senator Muskie on December 1, 1971.

Presidential Message:

The President's message on aging, transmitted March 23, 1972, contained the following remarks and recommendations regarding health: [24]

—*Eliminating Medicare Part B Premiums.*—The President called for repeal of "the requirement that participants in Part B of Medicare must pay a monthly premium which is scheduled to reach $5.80 this July." [25]

—*Price Inflation.*—A promise was made to "continue the battle against price inflation, with special emphasis in the health care field." [26]

—*Enactment of H.R. 1.*—Congress was urged to "enact H.R. 1 as soon as possible." H.R. 1, as noted above, includes changes in Medicare and Medicaid.[27]

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

To the Special Committee on Aging, the basic weakness in the President's message on aging is its glaring neglect of health care

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[22] See p. 49 of the report cited in footnote 19.
[23] "Mental Health Care and the Elderly: Shortcomings in Public Policy," U.S. Senate Special Committee on Aging, November 1971, p. 3.
[24] The long-term care aspects of the President's message are discussed in the section of this report dealing with nursing homes.
[25] One comment should be included here regarding the President's proposal to eliminate Medicare Part B premiums. Although the message is not specific on this point, all past indications are that the Administration would pay for the loss of premium income by drawing from the Social Security trust fund as opposed to general revenues.
[26] For a comment on this "battle," seep. 23 of this report.
[27] For a discussion of H.R. 1, see p. 26 of this report.

needs and of the recommendations of the White House Conference on Aging. The simple truth is that the President almost totally ignores what the conferees said had to be done in the health field.

The Committee agrees with the White House Conference delegates, who told the Administration, the Congress, and the Nation what needed to be done and called for action.

The Committee's major findings and recommendations for action in the health field are set forth below:

1. We support the movement in the Nation and the Congress toward some form of national health plan. In our view, however, none of the current proposals for a national health plan deals effectively with either the problem of long-term illness among older people or the needs of older people for supportive health and social services in the community.[28] If a national health plan is to help the elderly in full measure, strong provisions to meet these needs must be incorporated.

2. H.R. 1, if properly amended, can serve as the vehicle for providing improved health care to the elderly while a national health plan is evolving:

- Some provisions in H.R. 1 are appropriate for enactment now, with little, if any, modification. These include emphasis on health maintenance organizations; coverage of the disabled under Medicare, modified to permit eligibility earlier in the disability;[29] and protection against retroactive denial of payment under Medicare.[30]
- But the undesirable provisions in H.R. 1—cutbacks in benefits under both Medicare and Medicaid [31]—should, as recommended by Senator Frank Church of Idaho, Chairman of the Special Committee on Aging, "be deleted or substantially altered by the Senate." [32]
- And major Medicare improvements can and should be achieved through amendments to H.R. 1, including, at least, coverage of out-of-hospital prescription drugs; combining Parts A and B; and eliminating the monthly premium charge for Part B through the use of additional general revenues.[33]

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[28] For a fuller discussion of these points, see pp. 24–25 of the report cited in footnote 6.

[29] H.R. 1 would extend Medicare coverage to disabled Social Security beneficiaries under age 65, provided they have been receiving disability benefits for at least two years. The Committee urges that Medicare benefits be made available earlier in the disability when timely medical care could increase the effort at rehabilitation.

[30] On May 11, 1971, Senator Frank Church of Idaho, Chairman of the Special Committee on Aging, introduced a bill (S. 1827) to protect against retroactive denial of payments under Medicare. A similar provision has been incorporated in H.R. 1.

[31] These are outlined at p. 26 of this report.

[32] This quotation is from testimony by Senator Church before the Senate Committee on Finance, as reprinted in the *Congressional Record*, February 14, 1972, p. S1605.

[33] The Committee recommends that financing be done through one-third contributions from employees, one-third from employers, and one-third from general revenues. This proposal is based on a recommendation in the 1971 Social Security Advisory Council report. For the typical retired worker, this change could mean almost the equivalent of a 5 percent increase in benefits.

3. Three areas seem especially promising to the Committee on Aging as "New Directions" in the health care field that can and should benefit the elderly:

- *HMO's.*—The Committee welcomes the current emphasis on preventive medicine and health maintenance in the national dialogue on health care. Health Maintenance Organizations (HMO's) are a promising means for redressing the present imbalance in favor of "crisis medicine." We recommend intensifying study of and experimentation with HMO's, with special attention to benefits for, and inclusion of, the elderly.[34]
- *Home Health Care.*—The present decline of home health services must be reversed immediately. And the full potential of this vital but neglected resource must be promoted and harnessed to serve the needs of the elderly. We recommend the development and expansion of home health services along the lines set forth in the Committee's recent report.[35] And we further recommend, as an immediate step to be taken now, that the present Medicare home health regulations be fully implemented and flexibly interpreted. This would maximize the law as it now stands and reverse the recent trend of restrictive interpretations in the home health area.
- *Mental Health.*—For too long mental health has been the stepchild of the health care field. And this is especially so in the case of mental illness and the eldery. As an important first step to help correct this situation, we recommend early passage of S. 2922, which would establish a Presidential Commission on Mental Illness and the Elderly American.

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[34] For a further discussion of Committee views on HMO's, see pp. 25–26 of the report cited in footnote 6.
[35] See report cited in footnote 19.

IV. NURSING HOMES: IMPETUS FOR REFORM

Despite years of intensifying criticism of Federal policies affecting the Nation's 23,000 nursing homes, long-term care was not specifically designated early for special attention at the White House Conference on Aging.

Only in mid-August was a 4-hour "Special Concerns" session added to the Conference agenda. Even during that brief period, conferees raised disturbing questions about the quality and future direction of long-term care in the United States.

Concern about the Nation's 23,000 nursing homes—as well as some hope for well-placed reform—arose primarily for the following reasons during 1971 and early 1972:

—President Nixon announced in mid-summer that he would begin an 8-point program dealing primarily with inspection and some training aspects of the problem.[1]

—Damaging evidence about shortcomings of nursing homes was presented at hearings by the Subcommittee on Long-Term Care of the Senate Committee on Aging,[2] by a Ralph Nader Task Force,[3] by a Government Accounting Office report along with newspaper and television exposés in several cities.

—Perhaps the most important force for reform was the escalating cost of long-term care. The Senate Finance Committee estimates that the extended care facilities program under Medicare had exceeded its projected estimates for 1970 ten times over. Total revenues for the nursing home industry are approximately $2.6 billion a year, and more than three-fourths come in the form of public payments of one kind or another.

Given this background of controversy most students of problems of aging welcomed the President's intervention and eagerly looked forward toward the implementation of his 8-point plan. In recent months these reforms have begun to draw fire from those who suggest they are directed at regulatory problems rather than being the genuine comprehensive approach to improving the system. The White House Conference recommendations lend considerable weight to this view of the problem.

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[1] For earlier criticism of the administration for failing to implement legislation enacted in 1967 for purposes similar to the President's 8-point plan, see p. 30 of "A Pre-White House Conference Summary of Developments and Data," (November 1971), and pp. 50–53 of "Developments in Aging: 1970" (March 1971), reports issued by the Senate Special Committee on Aging.

[2] *See*, in particular, "Trends in Long-Term Care," pts. 12 and 13. Chicago, Ill., Apr. 2 and 3, 1971, pts. 9, 10, on the Baltimore Salmonella epidemic, Aug. 19, 1970, Dec. 14, 1970.

[3] *See* "Trends in Long-Term Care," pt. 11 (Washington, D.C., Dec. 17, 1970) for testimony by Mr. Nader and members of his Task Force.

White House Conference Recommendations:

Limited to one 4-hour "Special Concerns" session the delegates to the Conference nevertheless adopted a number of important recommendations, including:

1. The federalization of long-term care aspects of the Medicaid program. (Medicaid is presently financed on a 50–50 Federal-State matching basis.) Federalization would mean that the Federal Government would assume all the costs, that it would establish a uniform minimum level of benefits and national minimum standards.
2. The discouragement of Medicare-type reimbursement; which reimburses for reasonable costs expended and the encouragement of prospective reimbursement with proper incentives to provide good patient care.
3. That HEW change its primary nursing home inspection emphasis from physical plant standards to patient care.
4. To encourage the physician to accept responsibility for patients in long-term care institutions, the coverage limitation of one physician visit per patient per month should be eliminated and physicians should be allowed to see patients as often as necessary.
5. That the provision of care and services for the aged should be removed from title 19 (Medicaid) and that all health care for the aged should be provided under an expanded title 18 (Medicare) program.
6. That there be established a Federal program for financing nursing home construction through long-term low interest loans.
7. Minority groups—Indians, Asian-Americans, Blacks—noted the paucity of nursing home programs available to their members asking for Federal programs to provide incentives for the construction, rehabilitation or upgrading nursing homes serving these groups. Spanish-speaking elderly expressed the strong desire to continue the tradition of living within the household and supportive services were suggested as a more appropriate method of serving their needs for long-term care.

Congressional Actions:

Three separate legislative packages before the Congress at this time deal with long-term care: The Social Security Amendments (H.R. 1) which have passed the House were expected to reach the Senate floor in late April or May; the proposals for some form of National Health Insurance; and the 20-bill program introduced by Senator Frank E. Moss. The Social Security Amendments will have far-reaching effects on Medicare and Medicaid but the primary thrust of this legislation is improvement of enforcement. Proposals for National Health Insurance, with the exception of Chronicare sponsored by the American Nursing Home Association, basically would rely on the present Medicare and Medicaid programs for long-term care. Accordingly, the Moss bills provide the most comprehensive approach to the multiple problems in the field of long-term care.

The Moss 20-Bill Legislative Package

Senator Frank E. Moss, Chairman of the Subcommittee on Long-Term Care in April enunciated what he called the five major problems in the field of long-term care. His 20-bill legislative package represents the Senator's legislative solutions to these problems. The problems were:

—*Lack of a clear policy with regard to the infirm elderly.*—The Senator suggested the absence of effective options for families who have kin in need of nursing services. The Moss bills would broaden the scope of Medicare to provide: up to 100 days of long-term care; expanded home health services, and homemaker senior citizen day-care centers and an experimental program of subsidizing the family to care for their elderly in their own homes.

—*Lax enforcement of standards by States and the Federal Government.*—Senator Moss has proposed several bills in addition to the new enforcement legislation in H.R. 1. The Moss bill would require all nursing homes receiving Federal funds to certify costs annually, would close loopholes in nursing home ownership disclosure laws, and make nursing home inspection reports public.

—*Reliance on untrained and inadequate personnel.*—The Moss plan would provide funds to schools of nursing to establish inservice training programs for aides and orderlies.

—*The absence of the physician from the nursing home setting.*—Moss bills would provide grants to medical schools to establish departments of geriatrics, would provide training for medical corpsmen from the armed services to serve as medical directors for nursing homes.

—*The existence of financial incentives in favor of poor care.*—Medicaid typically pays a flat rate of perhaps $14 a day for Medicaid patients. This amount is immediately cut back when the patient becomes ambulatory. The incentive is thus to keep the patient in bed. At the same time there is no accountability as each individual operator can decide for himself how much of the $14 to allocate to profit and how much to food and patient care. For the majority of nursing home operators who are conscientious, $14 a day is much below what is needed for proper care. But for the unscrupulous, $14 a day can be turned into a fortune.

The Senator's proposed solution is incentive reimbursement such as the Connecticut "point" system where nursing homes are in effect graded and placed into classes, A, B, and C. Starting from a base reflecting cost, a Class A nursing home might receive $18 a day and a Class B $17, et cetera. In short, the better the nursing home in terms not only of physical plant and capability but also in terms of patient care, the higher the rate of reimbursement.

H.R. 1

The House-passed Social Security bill, H.R. 1, offers by all odds the most comprehensive series of amendments to the Social Security Act

since the enactment of Medicare itself. In terms of long-term care, H.R. 1 means more enforcement tools, for example:

—To head off the alleged abuse of Medicare, physician's fees would be limited to 75 percent of actual and reasonable charges in a particular locality.

—Penalties of a year in jail and up to $10,000 fine will be provided for offering or accepting a kickback or falsifying a Medicare claim for payment.

—Establishment of the Office of Inspector General of Health Administration in the Department of HEW to insure efficiency, economy, and consonance with law.

Other provisions of H.R. 1 would merge titles 18 and 19 Medicare and Medicaid creating one unified set of nursing home standards; nursing home inspection reports would be made public; and consideration is being given to federalizing the long-term care portion of Medicaid.

National Health Insurance

The proposals for National Health Insurance with exception of Chronicare proposed by the American Nursing Home Association for the most part leave unaffected present programs of long-term care for the aged. This is true for the Administration proposal which basically would require employers to purchase private health insurance for their employees with the government subsidizing premiums for low income individuals.

The Javits bill adds a new title 20 to the Social Security Act to extend Medicare coverage to all Americans. The American Medical Association proposal utilizes voluntary health insurance providing protections against catastrophic illness. The Government would pay 100 percent of the premiums for the poor and those with higher incomes would be allowed to offset medical costs against their Federal income tax.

The Kennedy bill is important because it provides up to 120 days care in a nursing home for all Americans, superceding Medicare but leaving Medicaid basically intact to supplement.

The ANHA Chronicare proposal calls for nursing homes to contract with regional health administration units for prescribed negotiated services on a capitation basis.

Legislation as comprehensive as proposals for National Health Insurance usually takes several sessions of Congress to be fully considered and the present plans appear to be no exception.

The Presidential Message:

President Nixon expressed his determination to continue his 8-point plan to improve nursing homes and noted substantial progress toward making nursing homes "shining symbols of comfort and concern". For example:

—Some 450 out of the proposed 2,000 State nursing home inspectors have completed their 4-week federally sponsored training at three Universities.

—An Office of Nursing Home Affairs has been established in HEW to coordinate enforcement activities. Additionally, 142 new posi-

tions have been added to the Medical Services Administration to help enforce Medicaid standards.

—Reportedly, the short-term training program for nursing home personnel will train 20,000 persons in the current fiscal year; a comprehensive study of the issues in long-term care is underway; and an amendment has been adopted to H.R. 1 providing for the Federal Government to pay for 100 percent of the cost of Medicaid inspections which will continue to be conducted by the States.

—The 900 Social Security offices have been designated as "listening posts" to receive any complaints about nursing homes.

—38 out of the 39 States which were found to be out of compliance with Medicaid certification procedures have corrected deficiencies and all Medicaid nursing homes must be correctly certified by July 1, 1972.

Criticisms of the 8-Point Proposal

President Nixon's entry into the growing controversy surrounding nursing homes and the two Federal programs—Medicare and Medicaid—which together contributed 2 out of every 3 dollars in nursing home revenues, could be regarded only as constructive. In all fairness it must be indicated that there has been some progress in terms of implementing the Nixon plan. The plan, however, is properly subject to general and specific criticism.

In general terms the plan is enforcement-oriented and commits HEW to an aggressive role overseeing State enforcement procedures. The enforcement power, however, continues to be with the States and all of the threat to close substandard nursing homes amounts to little, for States still have responsibility for closing nursing homes. Few have been shut down. At the same time there is a distinct absence of programs to help nursing homes upgrade standards.

In specific terms the announcement that 450 State nursing home inspectors have completed a 4-week training program at one of three Universities should be helpful. However, very little has been said about what inspectors are taught in these classes and some critics have great concern about the Federal Government assuming costs for flying State inspectors to 3 universities in various parts of the country to attend classes. The alternative of on-site instruction of State inspectors with traveling Federal instructors seems to be more intelligent and less expensive.

Creation of the Office of Nursing Home Affairs in the bureaucratic jungle of HEW is definitely constructive and the same is hoped for the addition of the 142 new positions.

Short-term training programs for nursing home personnel are perhaps the most potentially beneficial part of the whole Nixon plan. The plan calls for the short-term (3 days) training for 20,000 this year and 21,000 next year. In an industry which has better than 500,000 employees, the bulk of them being untrained aides and orderlies, it is clear the training program is far short of what is needed.

The designation of the 900 Social Security offices as listening posts to investigate and receive nursing home complaints even as an interim gesture is unfortunate. Interim plans tend to become final. Many stu-

dents of nursing home problems believe that State investigative units vested with proper authority and independent of State government would be the most effective formula. As a second choice, units attached to each Governor's office isolated from most of the exigencies of State government is offered.

The portion of the President's plan that has drawn the most fire is the crackdown on substandard nursing homes. At the recent White House Conference, Secretary Richardson announced that 39 States were out of compliance with State standards and threatened to withdraw Federal funds if States were not in compliance by February 1.

In order to be in compliance States simply had to write a letter to the Secretary of intention to comply. The new deadline of July 1 requires only that all nursing homes receiving Medicaid funds be certified according to Federal rather than State standards. This has been a requirement of the law since the Medicaid program began but in practice, States have been content to have one inspection yearly qualifying a nursing home according to State law and upon qualification certifying it automatically for Medicaid without a second look.

The reality is that few nursing homes have been closed or will be or that few have felt any pressure for reform because of the Nixon initiatives. HEW's inspections (few as they are) are directed at paper analyses and procedures rather than at people and patient care. HEW will, for example, ascertain if nursing homes have valid transfer agreements with a hospital, if the home has job descriptions but in no case will actually look at patients and assess the quality of patient care.

As for the study that is underway within HEW of nursing home problems, it is not known what the scope of this study is, but it is hoped that it encompasses alternatives to institutionalization, the question of who owns nursing homes, and what are the implications, and the question of how profitable is the nursing home industry.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

It is apparent that a new Federal program is needed to help nursing home upgrade and repair. A good start was provided by the addition of Senator Moss' bill S. 2923 to the Housing bill which passed the Senate on March 3. The bill provides FHA insured loans to nursing homes for the purchase of fire safety equipment. A wider approach is needed particularly with regard to nursing homes endeavoring to serve minority groups.

In its terms of recommendations, the Committee endorses a comprehensive attack on the complicated nursing home problems. Senator Moss has introduced such a package which is directed toward these basic problems. If enacted, it will go a long way toward making nursing homes "symbols of comfort and concern". No one claims that this approach will be inexpensive. It will undoubtedly cost much more than the $9.5 million spent by the Administration on its 8-point plan last year but the benefits to

individuals in this and future generations, who suffer the compound burdens of illness and advanced age, is well worth the expenditure. The Committee recommends that:

- A national policy must be established with regard to treatment of the infirm elderly. This policy should consider the total needs of the individual including medical, dental, residential, social, and psychological services. The policy should look first to treating the individual in his own home with appropriate housing, congregate living facilities, and home health services. Some consideration should also be given to senior citizens day-care centers and for plans to subsidize the family to help them care for the elderly ill in their own homes.
- The present system must be realigned so that greater financial rewards will be available to those nursing homes which provide exemplary care. An excellent rehabilitation program which gets individuals up and around should be rewarded. The Connecticut "points" system is one good positive example.
- Physicians must be involved with the care of patients in the nursing home. Geriatrics must be rapidly advanced as a specialty in the United States.
- Nursing home personnel must be trained and paid higher wages if they are expected to perform the difficult job they are given.
- States must enforce standards and the Federal Government must play an aggressive role to insure that they do.
- Nursing home patients must be treated like human beings with intrinsic worth and be provided with a sense of human dignity. Anything less will secure for nursing homes their present labels of "elephant's graveyards" and "warehouses for the dying."

V. HOUSING: NOT ONLY SHELTER BUT NEEDED SERVICE

Housing continues to be the number one expenditure for the elderly, accounting for about 33 percent of their limited budgets.

But despite this real and basic need, existing Federal policies remain muddled with very little clearcut direction:

—A popular and effective direct loan housing program (Section 202)[1] for the aged, is now being phased out in favor of a controversial interest subsidy (Section 236) program.[2]

—HUD spokesmen have resisted bipartisan Congressional efforts to establish an Assistant Secretary for Housing for the Elderly.

—Far too little attention has been devoted to the service component of the elderly's overall housing needs. What attention has been given has oftentimes been delayed, confused or contradictory.

—Interest subsidy programs, including Section 236, have been coming under increasing fire because of widespread reports about poor quality housing and scandals of huge proportions.[3]

And caught in the middle of this dilemma are older Americans, who have been among the primary victims of our Nation's ill-defined housing commitment.

Discontent with the existing housing situation was strongly expressed at the White House Conference on Aging, particularly in the Housing Section.

Nearly 23 years ago, the 1949 Housing Act declared that a "decent home and a suitable living environment" should be a national policy. Yet today, it is estimated that perhaps 6 million older Americans—about 30 percent of all persons 65 and over—live in dilapidated, deteriorating or substandard housing.

Even more fundamental, housing starts fall far short of the documented need for substantially more units.

Viewed against this backdrop, the Housing Section of the White House Conference was faced with a formidable challenge in developing a long overdue national housing policy for older Americans.

White House Conference Recommendations:

Formulation of a new national housing policy for aged and aging Americans was one of the urgent goals of the White House Conference.

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[1] Under Section 202, direct Government loans at 3 percent over a 50-year period are made to nonprofit sponsors to construct apartment units for moderate-income elderly and handicapped persons.

[2] Under the Section 236 interest subsidy program for multifamily housing construction, the owner or sponsor pays off a loan at 1 percent. The Federal Government pays the interest difference between the 1 percent and the interest level which is charged by the financial institution.

[3] The Department of Housing and Urban Development's own audit of the section 236 interest subsidy program concluded that much money was lost in excessive fees, unwarranted land mark-ups, and fraudulent practices. As a result, the cost per unit ran considerably higher in many instances than conventionally built apartments.

And the basic tenants of this overall strategy were stated forcefully and effectively in the preamble to the Housing Section report:

> A NATIONAL POLICY ON HOUSING FOR THE ELDERLY WORTHY OF THIS NATION MUST ENJOY A HIGH PRIORITY AND MUST EMBRACE NOT ONLY SHELTER BUT NEEDED SERVICES OF QUALITY THAT EXTEND THE SPAN OF INDEPENDENT LIVING IN COMFORT AND DIGNITY, IN AND OUTSIDE OF INSTITUTIONS, AS A RIGHT WHEREVER THEY LIVE OR CHOOSE TO LIVE.

To meet a whole host of housing needs of older Americans, the Housing Section proposed 25 comprehensive recommendations. Heading the list was a call for the production of at least 120,000 units per year.

Among the other major proposals of the Housing Section:

1. An Assistant Secretary of Housing for the Elderly should be established within the Department of HUD to provide overall direction for the implementation for a national housing policy for older Americans.
2. Funds now impounded for the highly successful 202 program should be released.
3. Production of congregate units for older Americans should be increased to help provide social services which are essential to their overall housing needs.
4. A variety of living arrangements should be developed to meet the many and varying needs of the aged including (a) long-term care facilities for the sick; (b) facilities with limited food, medical and homemaker services; (c) congregate housing with food and personal services; and (d) housing for independent living with recreational and activity programs.
5. Mechanisms should be developed at the Federal or State levels to authorize tax relief for overwhelmed elderly homeowners and renters.

Congressional Actions:

Approved by a vote of 80 to 1 in the Senate, the 1972 Housing Act (S. 3248) includes a number of provisions with important implications for the elderly.

Senator Harrison Williams in one of the amendments[4] won approval for the revitalization of the Section 202 direct loan program which has been so successful in the past. Unlike other housing subsidy programs, Section 202 has yet to have a default. It is the intention of the Williams amendment to breathe new life into the 202 program so that it may coexist with the other subsidy programs. This amendment responds directly to one of the specific recommendations of the White House Conference.

Three amendments put forward by Senator Alan Cranston were designed to give more visibility to the elderly in the omnibus bill. The first insured that from 15 to 25 percent of the housing units under Section 502 (the multifamily housing assistance section that would replace Section 236 of the 1968 Act) would be available for the elderly. The second extends to 60 percent the permissible limits of Section 502 units occupied by the elderly and eligible for rent supple-

4 For details, see Part Two, pp. 100–101 of this report.

ments. The third amendment authorizes supplemental assistance for additional space in congregate dining facilities to accommodate elderly persons who do not live in the project.

In another vital move, Senators Charles Percy, Harrison Williams, and Alan Cranston won approval of an amendment to create an Assistant Secretary for Housing for the Elderly in the Department of Housing and Urban Development.

An Assistant Secretaryship in HUD has been resisted by the Administration, but on March 27, 1972, HUD Secretary George Romney announced the appointment of Mercer L. Jackson, Jr., to the newly created position of Assistant to the Secretary for programs for the elderly and handicapped. His duties will require continuous assessment of all HUD programs to ensure full responsiveness in serving the needs of the elderly. He will report directly to the Secretary giving coordination to the programs of direct or indirect benefit to the elderly.

Presidential Message:

The housing section of the President's Message suggested that 66,000 units of subsidized housing for the elderly would be funded under HUD's housing assistance programs for the current fiscal year, followed by an additional 82,000 in fiscal year 1973.

The President also reported that new guidelines were now available for the Section 236 subsidized rental program for lower income elderly.

On other fronts, the President made mention of (1) initial guidelines for the new Section 106(a) program which will provide technical assistance to nonprofit sponsors of low- and moderate-income housing; (2) a joint effort of HUD and the Administration on Aging to develop training programs dealing with the management of housing for the elderly; (3) Law Enforcement Assistance Administration funds for research to determine factors which encourage or inhibit crime and to develop total security systems to reduce crime in housing projects; (4) instructions to HUD to encourage greater provision of community space for senior centers within subsidized housing projects for the elderly; and (5) a description of the housing programs under the Farmers Home Administration designed to meet the housing needs of elderly persons in the rural areas.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Presidential initiative in the field of housing for the elderly has not begun to match the challenging call of the White House Conference on Aging.

Although the Administration is increasing the number of units for production in this fiscal year and the next, the totals which they propose fall far short of the documented need. Even more disturbing, primary emphasis is being placed on controversial interest subsidy programs which have failed to produce quality housing for the elderly. The Committee recommends that a minimum annual production rate of 120,000 units be made an integral part of a comprehensive national policy for housing the elderly.

For this national policy to be effective, it must be directed by someone who is highly visible, has direct access to the Secretary of Housing and Urban Development, and has direct control of the Housing Programs of the Elderly. The recent appointment of an Assistant to the Secretary to coordinate elderly housing programs simply lacks the overall clout to get the job done. This position, at a minimum, should include management control over all 202 and 236 housing projects for the elderly, and should review and approve all public housing projects and other federally assisted housing which are predominantly for the elderly.

After detailed hearings on the merits of the Section 202 Direct Loan Housing Program for the Elderly, the Committee finds that this remarkably successful program should be restored with an increased level of funding.

A national policy on housing for the elderly will be less than complete if it focuses on production increases alone. Equal emphasis must be stressed in the areas of supportive services and alternative living arrangements. Among the many worthwhile proposals currently being considered, the Committee recommends that:

- Funds be provided for innovative options for housing the aged such as the "intermediate housing" program where elderly persons share a private house and the "campus for the elderly" concept. Programs must be developed to serve the many elderly who cannot live independently but also do not require institutional care.
- The congregate meals provisions of the 1970 Housing Act be amended to include funding for the cost of food.
- Federal funding be released to provide trained security personnel at public housing projects and to explore further mechanisms to increase the security at housing projects for the elderly.
- Permit up to 60 percent of subsidized housing units occupied by the elderly to be eligible for rent supplement.

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VI. GOVERNMENTAL ORGANIZATION AND RESPONSE

"Structure has little to do with the effectiveness of any Federal agency. What really matters is its level of funding and the priority given by the administration to the agency."

So goes an argument sometimes used to challenge proposals calling for major organizational changes in Federal structure related to older Americans.

Much the same argument is made by the administration in 1972 despite:

—White House Conference on Aging recommendations calling for striking changes in organization.

—An earlier call by the Senate Special Committee on Aging for almost identical action.

—A finding by the President's own Task Force on Aging in 1970 that "If the Nation is to achieve the goals set forth in the Older Americans Act . . . present efforts of the Federal Government should be organized more effectively."

To the Senate Committee on Aging, it remains clear that—while mere reorganization certainly will not result in improvement unless supported by commitment, concern, and adequate funds—*defects* in organization can produce negative results.

As long as those defects remain, higher funding of the present structure—even with minor adjustments proposed by the administration—can result in confusion, dead-ends for programs, and waste of taxpayers' money.

White House Conference Recommendations:

Major statements on Governmental structure were made by two conference sections.

To the 221 delegates at the Section on Government and Non-Government Organization, it was apparent that "the time has come to develop, support, and enhance an improved and strengthened moving organizational force which will lead to strong reforms and action whereby every older person in our land shall be privileged to live out his life in decency, dignity, and with a sense of personal worth." As one step toward that goal, the Section recommended:

> AT ALL LEVELS OF GOVERNMENT, A CENTRAL OFFICE ON AGING SHOULD BE ESTABLISHED IN THE OFFICE OF THE CHIEF EXECUTIVE, WITH RESPONSIBILITY FOR COORDINATING ALL PROGRAMS AND ACTIVITIES DEALING WITH THE AGING, FOSTERING COORDINATION BETWEEN GOVERNMENTAL AND NON-GOVERNMENTAL PROGRAMS DIRECTLY AND INDIRECTLY ENGAGED IN THE PROVISION OF SERVICES, AND FOR PLANNING, MONITORING, AND EVALUATING SERVICES AND PROGRAMS. EACH OPERATING DEPARTMENT SHOULD

ESTABLISH THE POST OF ASSISTANT SECRETARY FOR AGING WITH RESPONSIBILITY FOR MAXIMIZING THE DEPARTMENT'S IMPACT IN RELATION TO THE NEEDS OF THE OLDER PERSON. A COORDINATING COUNCIL SHOULD BE ESTABLISHED IN EACH CENTRAL OFFICE OF AGING TO BE CHAIRED BY THE DIRECTOR OF THE OFFICE AND SHOULD INCLUDE THE SEVERAL DEPARTMENT ASSISTANTS ON AGING.

AT THE FEDERAL LEVEL, THIS CENTRAL OFFICE SHOULD BE IMPLEMENTED WITH THE AUTHORITY AND FUNDING LEVELS AND FULL-TIME STAFF NEEDED TO FORMULATE AND ADMINISTER POLICY, AND SHOULD BE ASSISTED BY AN ADVISORY COUNCIL, AND SHOULD BE REQUIRED TO MAKE AN ACCURATE AND COMPREHENSIVE ANNUAL REPORT ON ITS PROGRESS IN RESOLVING PROBLEMS AND MEETING GOALS.

THIS WHITE HOUSE LEVEL OFFICE SHOULD HAVE ENOUGH PRESTIGE AND RESOURCES TO ASSURE THAT IT WILL ENCOURAGE THE DEVELOPMENT OF PARALLEL UNITS AT THE STATE AND COMMUNITY LEVELS.

A Conference Section on Planning—attended by 164 delegates—also saw a relationship between Federal and State structure on aging. It called for local parallels to the structure described in one of its major recommendations as follows:

A SEPARATE ENTITY SHOULD BE CREATED WITHIN THE EXECUTIVE OFFICE OF THE PRESIDENT THROUGH LEGISLATION AND CHARGED WITH THE RESPONSIBILITY FOR COMPREHENSIVE PLANNING AND ADVOCACY IN AGING.

THIS ENTITY SHOULD HAVE RESOURCES (e.g. AUTHORITY, FUNDS, STAFF) ADEQUATE TO MEET THIS RESPONSIBILITY. THE ADMINISTRATION ON AGING SHOULD BE RETAINED WITHIN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, BUT IT SHOULD BE RAISED TO THE STATUS OF AN INDEPENDENT AGENCY WITHIN THE DEPARTMENT, REPORTING DIRECTLY TO THE SECRETARY.

THERE SHOULD BE AN INTERDEPARTMENTAL COMMITTEE WITH REPRESENTATION AT THE SECRETARIAL LEVEL TO BE CHAIRED BY THE SENIOR FEDERAL OFFICIAL ON AGING.

Congressional Actions:

Concern about Federal structure on aging began early in 1971 when the President's budget request listed only $29.5 million for the Administration on Aging, a reduction of $2½ million from the amount actually appropriated for the previous fiscal year. Bipartisan criticism led to hearings in both Houses of Congress, a decision by the Department of Health, Education, and Welfare to seek $39.5 million instead of the earlier sum, and later congressional actions leading to an initial appropriation of $44.75 million and a final appropriation of $100 million, the highest AoA funding ever.[1]

[1] For additional discussion, see pp. 37–39, "A Pre-White House Conference on Aging Summary of Developments and Data," A Report of the U.S. Senate Special Committee on Aging, November 1971 (Senate Report No. 92–505).

Vital as the funding issue was, however, members of Congress were concerned about what they regarded as a general deterioration of the mission and status of the Administration on Aging. When established by the Older Americans Act of 1965, the agency was said to be a focal point for all Federal efforts on aging. But in 1967 it was made a subunit of the new Social and Rehabilitation Service within HEW over the protests of the Senate Committee on Aging and leaders of national organizations concerned about older Americans. A Report of the President's Task Force on Aging in April 1970 confirmed the validity of the earlier protests. The Task Force Report said: [2]

> The experience of the Administration on Aging during the last four years . . . makes it abundantly clear that interdepartmental coordination cannot be carried out by a unit of Government which is subordinate to the units it is attempting to coordinate. Nor does the experience of the President's Council on Aging suggest that coordination can be accomplished effectively through a committee.

Complaints about placement of AoA within SRS were intensified later in 1970 and early the following year when it became known that: (1) AoA research and training programs were to be transferred to 10 SRS regional offices (2) two AoA programs—the Retired Senior Volunteer Program and the Foster Grandparent Programs—were to be spun-off to a new agency for volunteer activity called ACTION.

Faced by such developments, Senator Frank Church established an Advisory Council to the Senate Committee on Aging to evaluate the situation and to report its recommendations well before the White House Conference on Aging. That Council, including members of both political parties and leaders of major national organizations on aging, made its report in October 1971. Among its major findings and conclusions: [3]

—AoA falls far short of being the Federal focal point in aging sought by Congress.
—Recent reorganizations have led to a further downgrading of "an already flawed and feebled agency."
—At the White House level, an independent agency on aging—to be directed by an Assistant on Aging to the President—should be established. An Advisory Council should work with him at that high level and should issue a yearly report evaluating progress made in resolving problems confronting older Americans.
—Within the Department of Health, Education, and Welfare, an Assistant Secretary on Aging should be named and he should administer the Administration on Aging directly.
—At other appropriate departments or agencies, the position of Assistant Secretary on Aging or its equivalent should be established.

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[2] Page 12, "Toward a Brighter Future for the Elderly," The Report of the President's Task Force on the Aging, April 1970.

[3] Summarized from "The Administration on Aging—Or a Successor?" A Report to the U.S. Senate Special Committee on Aging from a 20-member Advisory Council, October 1971. Dr. Harold Sheppard, Staff Social Scientist at W. E. Upjohn Institute for Employment Research, served as Council Chairman.

—Every effort should be made to encourage State governments to take similar actions.

Thus, the Advisory Council recommendations were similar in all important respects to the recommendations later made at the White House Conference.

On February 16, Senator Church introduced an Action on Aging Bill (S. 3181) [4] designed to carry out major themes of the President's Task Force, his own Advisory Council, and the White House Conference on Aging. His bill has already received favorable commentary in both House and Senate hearings. Two Republicans are among the co-sponsors of the bill.

Hearings in the House began on March 1 on legislation similar to the Church bill, but major emphasis was put on H.R. 12017, the Older Americans Act Amendments of 1972, introduced in early December by Representative John Brademas. Among its major provisions:

—The Older Americans Act would be extended for 3 years and the Commissioner on Aging would be made directly responsible to the Secretary of HEW.

—Special emphasis would be put on nutrition, transportation, pre-retirement counseling, expanded worker opportunities, and establishment of a network of multipurpose senior citizen community centers.

—A new National Information and Resource Center within AoA would compile and disseminate data on aging.

—A new Gerontological Center would be established with AoA to study biological processes related to aging.[5]

Chairman of committees in both Houses were hopeful that the early action taken on hearings would lead to prompt enactment of legislation extending the Older Americans Act.

Presidential Message:

Only two new proposals are made in the section of the President's Message dealing with "Organizing for Future Action:"

—The Secretary of Health, Education, and Welfare, is to "strengthen the Department's Advisory Committee on Older Americans and provide it with staff capability to support its increased responsibilities." The Commissioner of Aging, in his capacity as Chairman of the Advisory Committee, will report directly to the Secretary.

—A Technical Advisory Committee for Aging Research will be created in the office of the Secretary of HEW to develop a "comprehensive, coordinated research program" in disciplines ranging "from biomedical research to transportation systems analysis, from psychology and sociology to management science and economics."

Earlier, the President had announced that he would keep Dr. Arthur Flemming, Chairman of the White House Conference on Aging, as his Special Consultant and as a participant in a Committee on Aging of

[4] See p. 101 for additional details.
[5] For additional details, see p. 102.

the Domestic Council. HEW Secretary Elliot Richardson is Chairman of that Domestic Council Committee.

In testimony before House and Senate Subcommittees during March, Richardson described, in more detail, organizational changes of particular importance to the Administration on Aging.[6] He said that greater emphasis would be placed under the Older Americans Act upon strengthening State agencies on aging, that areawide projects under title III (community services) of the Older Americans Act would be emphasized, and that the Nutrition Program for the Elderly Act would be built into a service system [7] for the elderly.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

As described by the President's message and testimony in both Houses by HEW Secretary Richardson, the administration's "reorganization" plan fails to remove the Administration on Aging from within the Social and Rehabilitation Service, where its mission and activities are distorted by the SRS focus on welfare services, with heavy emphasis upon the "vulnerable" elderly.

As long as the AoA remains within SRS it will be especially susceptible to the criticism made by the President's task force in 1970: "That interdepartmental coordination cannot be carried out by a unit of Government which is subordinate to the units it is attempting to coordinate."

In place of a Special Office on Aging within the White House the administration is apparently relying primarily upon a Committee on Aging of the Domestic Council. That council is chaired by the Secretary of HEW, apparently on the assumption that HEW has the major interest in programs for the elderly. This assumption may reduce the interest of other Federal departments in the work of the committee: departments that deal with such key areas as transportation, housing, and food programs, for example, in spite of presidential assurances that such a committee can achieve interdepartmental coordination. The committee bears a strong resemblance to the President's Council on Aging which existed from 1962 to 1967 and which was severely criticized for non-accomplishment. That council eventually disbanded. The same may be expected of the Domestic Council Committee on Aging.

A full-time White House Office on Aging, however, with a small but competent staff, could provide the hour-by-hour attention needed for interdepartmental communication and ultimate coordination.

Administration proposals to remodel title III of the Older Americans Act and to change the ground rules considerably for such purposes raise far-reaching questions about the origins of such policy. State executives on aging in some areas, for example,

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[6] Text of Richardson statement on pp. 309–315.
[7] See p. 58 for additional discussion of "The New Focus on Services."

have raised serious issues about the appropriateness of the area-wide model. Projects on which such heavy emphasis is being placed. The "service network" concept has been expressed before, but it usually has deterred action rather than accelerated it. Will a welter of difficult pre-requirements cause delay and confusion on the delivery of services, including meal programs sought by Congress when it passed—over administration opposition—the Nutrition Program for the Elderly Act? Such questions are far from resolved, and yet the Congress has authorized additional fundings for AoA and is now asked to authorize still more. An administration bill submitted on March 21 does little to answer those questions.

Such questions, however, are far more likely to be answered in constructive ways if the Congress insists upon elevating the administration on aging within HEW while at the same time it requires establishment of an office on aging at the White House level to provide constant, rather than part-time attention, to older Americans during this especially significant post-conference period.

VII. OPTIONS FOR EMPLOYMENT AND SERVICE

Unemployment for aging Americans takes two forms: before retirement age and after.

Today the so-called older worker—45 years old and up—is facing long-term joblessness on a scale which is ominous in its implications for the future. Talk of business upturn may offer precious little comfort to a man or woman who was laid off or dismissed entirely during the slump which began over 2 years ago.

This problem is severe, and there are signs that present programs—including manpower training—are not giving help on a scale needed for this group.

In addition, the White House conferees and other persons concerned about aging are giving more and more attention to the need for options in or near retirement. They see a need for part-time, service-oriented, or other innovative work patterns for persons in their late 50's, 60's, and beyond.

But the "climate of free choice" to which the conferees referred simply does not exist at present.

And there is good reason to believe that new pressures for forced, early retirement—usually with a sharp drop in income—are worsening the situation.

1 Million Older Workers Unemployed

Unemployment for middle-aged and older workers—persons 45 and older—continued to remain at a high level throughout 1971 and in early 1972. Today more than 1 million persons in this age category are jobless, nearly 74 percent higher than 3 years ago. Approximately 466,000 have been looking unsuccessfully for work for 15 weeks or longer. And 222,000 or almost 4 times as many as in January 1969, have been unemployed for 27 weeks or longer.

Depressing as these figures are, they still reflect only a small part of a grim picture for many mature workers. They do not, for example, reveal the large amount of underemployment for older persons. Nor do they reflect the number of individuals who were forced to accept pay cuts or forgo salary increases only as an alternative to losing their position.

And these statistics can never express the mental and physical anguish experienced by mature workers after they have lost their jobs. However, newly announced findings by Dr. Sidney Cobb of the University of Michigan revealed that more than half of the men who were laid off at a Detroit plant developed significant psychological or physiological changes. A job loss, according to Dr. Cobb, frequently

brings a rise in the incidence of ulcers, arthritis, and high blood pressure. Also significant, the study showed that a lay-off can have a serious impact upon other family members. For example, several wives developed peptic ulcers, which is rare in women.

Pressures for Early Retirement

Pressures upon mature workers and their families continue to mount because of a growing trend toward earlier and earlier retirement. And the net impact is that many middle-aged and older persons are now denied fundamental choices for their present and future economic well-being: to work or retire; to work full time or part time; and many other basic decisions.

Even in the Federal Government, which is often presumed to be a "model employer," there is strong evidence to suggest that many older career civil servants are being pressured to "retire" early. A preliminary report [1] prepared for the Committee on Aging makes this startling revelation:

For fiscal 1971, the number of Federal "involuntary" retirements was 2½ times as great as in 1970 and 6 times the total for 1969. And figures for 1972 are very similar to the monthly averages for 1971.

In private industry large numbers of older workers are also finding themselves "eased out" of the job market.[2] Many are now accepting actuarially reduced Social Security benefits only as an alternative to sporadic work patterns or prolonged periods of unemployment. Yet, these individuals are frequently the ones who can least afford to "retire" early. Typically, they have worked in lower paying jobs; they oftentimes have little savings; and they frequently have no pension or other retirement benefits to supplement their Social Security payments.

Older Workers Underrepresented in Manpower Programs

Despite serious and growing unemployment problems, our Nation still lacks a well-defined and comprehensive manpower policy to provide new and gainful job opportunities for mature persons. *In fact, fiscal 1971 was one of the lowest years in terms of the proportion of middle-aged and older persons in manpower programs. Only 3.7 of all enrollees were 45 and older, compared with 4.4 percent for fiscal 1970. Even in Operation Mainstream—enacted primarily to serve older workers—participation fell sharply, from 51 percent in 1970 to 40 percent in 1971.*

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[1] "Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees." A report to the Senate Special Committee on Aging, by Elizabeth M. Heidbreder, Institute of Industrial Gerontology, The National Council on the Aging, May 1972.

[2] See "Social Security Bulletin," *Benefit Levels of Newly Retired Workers: Findings from the Survey of New Beneficiaries,* July 1971, p. 3. One striking finding in this article is that nearly 85 percent of all persons awarded payable benefits in the last half of 1969 received some reductions in their primary insurance amounts because they claimed benefits before age 65. Moreover, a study of major group pension plans in 1958 by the Society of Actuaries found that 21 percent of the people who retired did so early. A similar study in 1968 found that the percentage of people retiring early had increased to 33 percent of the total.

ENROLLEES IN MANPOWER PROGRAMS, BY AGE GROUP, FISCAL YEAR 1971 (1ST TIME ENROLLMENTS)

[Number in thousands]

Program	Total	21 and under		45 and over		55 and over	
		Percent	Number	Percent	Number	Percent	Number
Job opportunities in the business sector	92.6	45	41.7	5	4.6	(1)	(1)
On-the-job training	62.5	35	21.9	10	6.2	3	1.9
Public service careers	45.1	39	17.6	5	2.3	(1)	(1)
Institutional training	163.8	40	66.0	9	14.7	2	3.3
Job Corps	49.8	100	49.8				
In school	120.0	100	120.0				
Summer	464.0	100	464.0				
Operation Mainstream	21.9	5	1.1	40	8.8	25	5.5
Out of school	53.0	96	50.9				
Concentrated employment program	77.2	46	35.5	6	4.6	2	1.5
Work incentive program	95.7	27	25.8	5	4.8	1	1.0
Total	1,245.6	71.8	894.3	3.7	46.0	1.1	13.2

[1] Information not available.

Source: Department of Labor.

By whatever standard of measurement one would choose to use, older persons have been grossly underrepresented in present work and training programs. Individuals 45 and older now account for less than 4 percent of all enrollees. Yet, they represent about 21 percent of the total unemployment in the United States; 30 percent of the long-term joblessness (15 weeks or longer); 30 percent of the very long-term unemployment (27 weeks or longer); and 37 percent of the civilian labor force.

For persons 55 and older, the situation is equally serious. They constitute only 1 percent of all participants in present manpower programs. But, they account for 9 percent of the joblessness and 17 percent of all unemployment for 27 weeks or longer.

Violations Under Age Discrimination Act Increase

Complicating everything else, many older persons are finding that advancing age continues to be a formidable obstacle for new or more gainful employment, despite the passage of the Age Discrimination in Employment Act more than 4 years ago. And the 1971 report by the Secretary of Labor clearly shows that job bias because of age is still a serious problem.

More than 2,500 violations were found under the Act for fiscal 1971, for a 14 percent jump. In practically every category, the number of reported violations increased. And these figures probably represent only a portion of the infractions under the law, since many illegal practices go unreported.

Yet, only 80 suits have been filed under the Act, despite the prevalence of job bias because of age.

Service Options

Even with the high unemployment rate today, a growing need exists in most localities for expanded services. And the elderly provide a ready reservoir of talent to help governments meet the needs of their citizens.

For many older Americans, service in their communities can mean a new and rewarding experience helping others. It can also provide badly needed income to supplement inadequate retirement benefits.

Today large numbers of aged and aging Americans are discovering that inactivity is their greatest enemy. But for many, a job can mean a place for association or a means to engage in productive activity.

Equally important, service programs can be tailored for their special needs—such as to work for pay or as a volunteer, or to work part time or full time.

White House Conference Recommendations:

Urging employment options before and after retirement, the White House Conference declared:

> OUR LONG ESTABLISHED GOAL IN EMPLOYMENT AND RETIREMENT POLICY IS TO CREATE A CLIMATE OF FREE CHOICE BETWEEN CONTINUING IN EMPLOYMENT AS LONG AS ONE WISHES AND IS ABLE, OR RETIRING ON ADEQUATE INCOME WITH OPPORTUNITIES FOR MEANINGFUL ACTIVITIES.[3]

To implement a national employment policy for older persons, the conferees called for a comprehensive program built upon several important concepts:

—The need for a flexible retirement age to assure older Americans a broad and meaningful range of choices, depending upon their needs and desires.

—Earmarked funding to take into account the unique and growing unemployment problems of mature workers, since existing manpower programs fail to respond adequately to their needs.

—Expanded service opportunities for older Americans who are ready, willing and able to help others in their communities.

—More stringent enforcement of age bias laws.

—Elimination of the age-65 limitation and the age discrimination law and extension of the Act to cover all employees in both the private and public sectors.

Congressional Actions:

Strong bipartisan support now exists in Congress for many of the White House Conference proposals. On several key fronts the Congress has already initiated action to implement the goals of the delegates. Final action is nearing in the Senate Labor and Public Welfare Committee on proposals to establish (1) a national senior service corps (S. 555) and (2) a midcareer development services program in the Department of Labor (S. 1307).[4] Legislation (S. 3318) has also been introduced to extend the application of the Age Discrimination in Employment Act to the Federal Government as well as State and local governments. And an Older Americans Home Repair Assistance Act (S. 2888) has been sponsored by Senator Frank Church to build upon the solid achievements of such programs as Green Thumb.[5]

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[3] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions," S. Doc. No. 92–53, December 1971, p. 4.

[4] For a more detailed description of these legislative proposals, see "Summary of Legislative Actions Taken from January 1971 to April 1, 1972," p. 104.

[5] Green Thumb is sponsored by the National Farmers Union, and it is funded under Operation Mainstream. To participate in the program, individuals must (1) be at least 55 years old, (2) be below the poverty income level, and (3) have a farming or rural background. Green Thumbers engage in a wide range of community service activities, including planting trees and shrubbery; cleaning out lakes; restoring historical sites; and building picnic tables and campgrounds.

Two employment measures with important implications for older workers became law during the 92d Congress. First, the Emergency Employment Act [6] would provide nearly 150,000 public service jobs in a wide range of capacities. Particularly significant for older persons the legislation includes language designed to assure that persons 45 and older are adequately represented in the new public service employment program—reasonably consistent with their proportion of the total unemployment in the United States. Based upon the most recent data, this would mean that mature workers could conceivably be eligible for about 30,000 of the job opportunities funded under the Act.

Second, the Congress approved the Emergency Unemployment Compensation Act [7] which authorizes an additional 13 weeks of unemployment compensation for workers who have exhausted all regular and extended benefits. Under the triggering mechanism provided in the Act, emergency payments would be available when the rate of State unemployment, counting both insured unemployment and those who have exhausted unemployment insurance, is 6.5 percent or greater.

Additionally, the House passed legislation (H.R. 12350) to extend the poverty program for 2 years. Of special significance for older Americans, the measure will continue Operation Mainstream.

Presidential Message:

One of the basic thrusts of the Presidential Message on Aging was the need to expand opportunities for older Americans to be active members of society. To help encourage employment for mature workers, the president proposed: (1) broadening the Age Discrimination in Employment Act to include State and local governments; and (2) increasing the funding level for the Mainstream pilot programs from $13 million to $26 million, in order to raise the number of participants from about 5,000 to 10,000.

At the administrative level, he stated that he would:

—Send a directive to Federal agencies to reaffirm that age alone shall not be a bar to a job in the Executive Branch; and

—Request the Secretary of Labor to urge State and local governments to include persons 65 and older in jobs authorized under the Emergency Employment Act and to work with public employment offices to that they will be in a position to help open job opportunities for the over 65 age group.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Recent hearings [8] conducted by the committee provide compelling evidence that older workers and their families have been hard-pressed by the widespread unemployment during the past 2 years. Many have not only lost their jobs but their pension coverage as well. Others are finding themselves in a "no-man's land", being too old to hire but too young to retire. The net impact of

[6] Public Law 92–54, approved July 12, 1971.
[7] Public Law 92–224, approved Dec. 29, 1971.
[8] "Unemployment Among Older Workers," hearings, June–Aug. 1971, parts 1 through 4.

these alarming trends is that our Nation may be witnessing the emergence of a new class of elderly poor who are forced out of the labor force in their late 50's or early 60's. And recent poverty statistics provide a clear warning. From 1969 to 1970, poverty increased by 100,000 for persons 55 to 64, from 2 million to 2.1 million.

Denial of employment opportunities for older workers constitutes a tragedy not only for them, but our Nation as well. Much more can be gained, the committee firmly believes, through a national effort to raise our productive capacity and to control inflation.

The need for a national manpower policy to maximize job opportunities for persons 45 and older has long been needed. To help implement this goal, the committee recommends:

- Prompt and early enactment of the Older American Community Service Employment Act and the Middle-aged and Older Workers Employment Act.
- Increased funding for the Age Discrimination in Employment Act to provide additional personnel to enforce the act more forcefully.
- Extension of the Age Discrimination in Employment Act to cover all employees in the public and private sectors of our economy.
- Encouragement of job-redesign in Government and industry to provide greater freedom of choice for older persons who are not yet ready to retire.

VIII. NEW EMPHASIS ON NUTRITION

Nutrition took on new importance during 1971 in terms of governmental response to an especially acute problem affecting older Americans:

—Congress began the year by challenging an administration decision to suspend pilot meals and services projects when their 3-year trial period was drawing to a close. A determined bipartisan effort resulted in a 1-year extension of the 21 projects.

—Congress then provided arguments and legislative impetus—despite administration opposition—to legislation intended to establish a National Nutrition Program for the Elderly. That legislation became law on March 22, 1972.

—At the White House Conference, nutrition was the subject of deliberations by an entire section. This decision by the Conference planners, made in response to governmental and private individuals who saw it as a major issue, helped pave the way for the congressional action.

—President Nixon's Message on Aging assigned "priority action" to implementation of the new National Nutrition Program for the Elderly.

Despite the new administration attitude, however, questions have already arisen about the way in which the objectives of the law will be met.

White House Conference Recommendations:

One measure of Conference concern about nutrition was the section declaration that approximately one-half to one-third of the health problems of the elderly are believed to be related to nutrition. The section also stated:

> FOOD IS MORE THAN A SOURCE OF ESSENTIAL NUTRIENTS—IT CAN BE AN ENJOYABLE INTERLUDE IN AN OTHERWISE DRAB EXISTENCE. THUS, PROVISION SHOULD BE MADE TO MEET THE SOCIAL AS WELL AS THE NUTRITIONAL NEEDS OF OLDER PEOPLE. A FACTOR THAT ADDS DIGNITY AND SIGNIFICANCE TO THE LIFE OF THE AGED IS THE FEELING THAT THEY TOO ARE USEFUL AND IMPORTANT. ASSISTANCE SHOULD BE PROVIDED TO MAKE POSSIBLE PREPARATION OF MEALS FOR THEMSELVES AND OTHERS. COMMUNITY MEALS, HOWEVER, SHOULD BE AN ALTERNATIVE. VOLUNTEER GROUPS CAN BE INVOLVED IN SUCH SERVICES AS TRANSPORTATION, SHOPPING, AND DISTRIBUTION OF HOT MEALS. YOUNG PEOPLE SHOULD BE ENCOURAGED TO PARTICIPATE IN THESE SERVICES AND TO JOIN THE ELDERLY IN MEALS.
>
> ALL NUTRITION PROGRAMS SHOULD BE SUPPLEMENTED BY APPROPRIATE EDUCATIONAL MEASURES. OLDER PEOPLE

SHOULD BE PROTECTED FROM FOOD QUACKERY AND UNFOUNDED NUTRITIONAL CLAIMS. LACK OF RESEARCH, EVALUATION AND COMMUNICATION LEAD TO FAILURE OF OTHERWISE GOOD PROGRAMS AND TO THE PERPETUATION OF POOR PROGRAMS. THE SEARCH FOR MORE EFFICIENT AND BETTER MEANS OF PROVIDING FOR GOOD NUTRITION, HEALTH AND HAPPINESS OF OLDER PEOPLE SHOULD BE A CONTINUOUS PROCESS.

Among the section recommendations:

—Action programs should provide funds for rehabilitation of the malnourished aged and to prevent malnutrition among those approaching old age; but adequate funds should be provided for research evaluation of program results and techniques.
—High standards for food and nutrition services should be required in all federally-assisted institutional care; and all health programs, including Medicare and Medicaid, should have nutrition service and nutrition counseling components.
—Needs of the poor should have priority attention, but a significant portion of funds should be designated for nutrition education of all consumers.
—All meal delivery systems should stress the favorable psychological values and "economics inherent in group feeding."
—Improvements should be made in the Food Stamp and Food Commodities programs.

Congressional Actions:

Only a determined bipartisan effort in both Houses of Congress early in 1971 prevented suspension of eminently successful pilot nutrition programs for older Americans in 21 projects throughout the Nation.[1]

Despite the uncertain outlook at the beginning of the year, the Nutrition Program for the Elderly Act became law on March 22 of this year. As Public Law 92–258, it amends the Older Americans Act to provide grants to States for the establishment, maintenance, operation, and expansion of low-cost meal projects, and nutrition training and education projects.

Sponsors of the legislation, and advocates who have sought its passage for years, see these potential dividends:

—Older people who cannot shop and who often have inadequate income or no motivation to prepare meals for themselves alone will now have an opportunity to obtain low-cost meals in a group setting. Social contacts and social services will thus be made available to them.
—As in the early AoA pilot projects, great emphasis can be placed upon linkages of meal programs with other social services. Thus, a so-called "categorical program" can help create a climate and help provide the personnel and funding needed to help develop other components of an overall delivery system.

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[1] For example, Senator Charles L. Percy (R., Ill.), challenged Health, Education, and Welfare Secretary Elliot Richardson on April 27, 1971, at a Committee on Aging—Subcommittee on Aging hearing, after the Secretary announced plans to permit the pilot programs to lapse. Senator Percy said: . . . that possible termination would be "nothing less than disastrous." Later, in Senate Floor discussion of a bill to broaden the nutrition effort, Senator Percy said: "The case for continuing this (nutrition) program is overwhelming. There is every indication that it is a highly successful program."

Questions About Administration Policy

On this very point, however, questions about executive branch intent have already arisen.

The administration has made it clear that it will seek the full amount authorized for the first year under this law. But, it has *not* made clear the manner in which it intends to spend the amount authorized, or how much will actually be used for meals.

Health, Education, and Welfare Secretary Elliot Richardson was challenged on such matters at a recent hearing after he said:

> . . . we would prefer to see as an original matter the legislative authority for the support of nutrition programs incorporated into the legislative authority for the support of other services . . . [2]

The Secretary also said:

> We hope that the committee will consider favorably the idea, even though it means amendments of the bill as enacted, tying together the extension of title III [see section on Government Organization for discussion of title III] and nutrition legislation.

And:

> When we talk about a hundred million dollars for nutritional services what is possible, really is the development of the means whereby nutritional services can be provided and perhaps some funds to help pay for food for elderly people.

He added:

> We would also run into the philosophical question of whether it is desirable to add to the benefits that are contemplated in H.R. 1 . . .

Senator Edward Kennedy, sponsor of S. 1163, stated:

> We considered those arguments in terms of this committee, and there were those that said . . . we ought to wait and not develop this kind of program, but I think that reasoning was rejected by the committee, and although this is not certainly the kind of a nationwide program that one might hope for, I think it is an important start.
>
> I think there is a considerable difference between providing people with the resources and providing a balanced meal. You might be able to give them sufficient resources but they are unable to get out or buy the right kinds of food.
>
> This legislation which we included here is a much more expansive program in terms of what it is attempting to do . . .

[2] In testimony on S. 3181 and related legislation before the Subcommittee on Aging, Senate Committee on Labor and Public Welfare, March 23, 1972.

Presidential Message:

In addition to requesting full funding during the next fiscal year for the nutrition program, the President said he is also directing that:

—An outreach campaign called Project FIND be launched this year to find "those who should be participating in nutrition programs but who are not yet involved."

—His proposed amendments to the Older Americans Act are intended to strengthen the nutrition program for the elderly by insuring that the Food Stamp Program is planned as part of a more comprehensive service effort.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

If the new and highly significant Nutrition for the Elderly Program is to meet its full potential, it should be implemented by an agency with far more power and prestige than is now true of the Administration on Aging. For reasons given in the Government Organization section of this report, the Committee again urges that the Administration on Aging be put under the direction of an Assistant Secretary on Aging within HEW, and that a special Office on Aging be established at the White House level to assure effective coordination of all programs related to nutrition and others of direct importance to older Americans.

The Committee also requests additional details from the Secretary on plans to implement the nutrition program. Further, the Committee urges the fullest consultation possible before regulations are issued.

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IX. THE ADMINISTRATION FOCUS ON SERVICES

Virtually every conference on aging declares that neither the Nation nor its communities have developed a full range of service alternatives to meet the varied and changing needs of older Americans.

The 1971 White House Conference was no exception: delegates called for the forging of a "national social policy on protection of the older person's rights and choices that will be reflected in provision of a wide range of facilities, programs, and services, whether preventive, protective, rehabilitative, supportive, or developmental in their focus."

As has been seen in the preceding section, Congressional initiatives to strengthen the Federal agency on aging spring largely from discontent with what is seen as the lack of status and potency of the Administration on Aging, together with its failure to serve as coordinating agency for programs and services on aging.

And yet, the Executive Branch—through the President's Message and through more detailed testimony provided by Health, Education, and Welfare Secretary Elliot L. Richardson (see appendix 3, p. 309—propose to establish a broader service network for the elderly through the very agency in question: the Administration on Aging.

White House Conference Recommendations:

Participants in the Facilities, Programs, and Services Section of the White House Conference produced recommendations that would have the effect of producing a "social utilities" network that would meet the following description:

> Exactly as we now regard a municipal water supply or a municipal transportation system as a public utility, so should we regard services for the elderly as a public function, available to low-income and more fortunate persons alike.[1]

Among the basic social services "that would enhance the ability of the elderly to retain independence,"—as expressed by the White House conferees—were the following:

—*Supportive services* including homemaker-housekeeper services, organized home health care, chore service, home meal services, and escort services.

—*Preventive services* to prevent the breakdown of the capacity of the older person to function physiologically, psychologically, or socially through detection and through social intervention prior to old age or prior to a crisis in old age.

—*Protective services* to "protect the civil rights and personal welfare" of older persons "with limited mental functioning due to mental deterioration, emotional disturbance, or extreme infirmity."

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[1] Excerpt from *Social Utilities How Far Away?*, Chapter 7, p. 69, of "A Pre-White House Conference Summary of Developments and Data," Report of the U.S. Senate Special Committee on Aging, November 1971.

Conference participants called for a mix of public and private resources to provide such services; for involvement of all age groups in determination of policies and standards for facilities and services; minimum quality standards and guidelines to provide uniform services and care in all federally administered programs and grant-in-aid programs to the States; special emphasis on "government funded legal services . . . to older persons in all communities;" a portion of Federal funds earmarked for prevention of crime affecting the elderly, with special attention to minority groups; and a multi-purpose Senior Center to provide services in every community and neighborhood, as appropriate.

To plan, coordinate, and fund, health, welfare, and other services for older people, the section called for immediate establishment of "a Federal Department of Elder Affairs." [2] A 2-year period would be allowed for planning transfer of appropriate operating functions from other Federal agencies.

Congressional Actions:

Major Congressional actions related to services were discussed in the Government Organization section, dealing with government reorganization. Improvement of Federal structure on aging would, it would seem, also result in improvement of social service delivery systems.

In discussing H.R. 12017, (to extend and strengthen the Older Americans Act) for example, former Administration on Aging Commissioner William Bechill said that the bill was significant because one of its foremost objectives is the provision of a comprehensive range of basic services for older people.

"To my knowledge," he said, "this is the first time that the goal of comprehensive services for older people has been this clearly articulated." [3]

Mr. Bechill also saw possibilities for coordination of the Title III [4] service programs under the Older Americans Act with service programs authorized for Old Age Assistance recipients and other eligible elderly persons under Titles I and XVI of the Social Security Act.[5]

This prospect, however, is faced by "immense challenges," according to Mr. Bechill, "in coordinating and orchestrating the channeling of these funds into such an approach, but it is only by utilizing these resources that a truly comprehensive system can be built."

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[2] Proposals for a Department on Aging were made during the debate which eventually led to enactment of the Older Americans Act in 1965. Arguments usually used against this proposal: programs serving the elderly cut across too many department and agencies to be gathered together in one department; artificial divisions of programs could occur: for example, the Old Age, Survivors, Health Insurance, and Disability system serves younger persons as well as older Social Security beneficiaries; and operating departments would be far more likely to resist the establishment of a new department than they would a White House Office or an Independent Commission which could perform coordinating functions without removing entire programs from departments.

An interesting exception to this line of argument has, however, occurred in Massachusetts where a Commonwealth department on elder affairs has been established.

[3] In testimony before the House Select Subcommittee on Education, March 8, 1972. See Part II for discussion of H.R. 12017.

[4] Title III projects are intended "to strengthen and develop new community services for the elderly and to stimulate community interest to meet identified needs of elderly." See Appendix 1, Item 2, p. 154, for Administration on Aging report indicating that during 1971, 800,313 older persons were served by 1,721 projects under Title III.

[5] Titles I and XVI authorize the provision of supportive services for persons now receiving Old Age Assistance. Under regulations which were to take effect by April 1971, the range of services were broadened and were extended not only to present OAA recipients but to former and prospective recipients. It is still too early to determine how extensively the new regulations are being applied.

Another dimension of the challenge was described in the Senate hearing on S. 3181, Action on Aging Act, (see Part II for details) by Harold Sheppard, Chairman of the Senate Committee on Aging Advisory Council on the Administration on Aging or a Successor. Dr. Sheppard discussed examples of under-representation of older workers in training and employment service programs. He added:

> Given the fact that the present Commissioner on Aging and his little agency is buried within SRS [which in turn is only a part of HEW], how does a person in such an organizational role effect changes in our training programs, in the Employment Service, in our programs to combat job discrimination because of age? How does he make his influence felt in the quality and the quantity of our private pension plans? At best, he can only "advocate"—assuming that anyone bothers to inform him that such facts and practices exist, partly attributable to the policies and practices of another department, the Department of Labor. But advocacy is only rhetoric under the present circumstances.

Presidential Message:

Given an increase in appropriations from the $29.5 million requested at the beginning of 1971 to the $100 million appropriated by the Congress by the end of that year, President Nixon said he is asking for an additional $100 million for nutritional and related purposes.

"With this substantial increase in funds," said his Message, "we would be able to step up significantly our efforts to develop and coordinate a wide range of social and nutritional services for older Americans."

> *Our central aim in all of these activities will be to prevent unnecessary institutionalization—and to lessen the isolation of the elderly wherever possible.*[6] (emphasis added)

The President asked for strengthening and planning of delivery of services at State, local and Federal levels. To encourage "mobilization and construction of a wide range of resources—public and private— to meet such goals," the President proposed:

> The Administration on Aging would be authorized to fund up to 90 percent of the cost of social and nutritional services provided under plans developed by the area planning agencies. In fiscal year 1973, $160 million would be allocated in formula grants for nutritional and social services. An additional $40 million would be allocated in special project assistance to develop new and innovative approaches and to strengthen particularly promising area plans.

To assure better coordination at the Federal level, the President said he was "directing those agencies whose programs have a major impact on the lives of older persons to provide the Cabinet-level Committee on Aging, within 7-days, with the amounts they identify as serving the needs of the elderly."

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[6] Discussing services which help prevent needless institutionalization, Senators Frank Church and Edward Kennedy (in a preface to a U.S. Senate Committee on Aging Report, "Making Services Work",—November 1971), noted: "The issue, however, is not always self-sufficiency versus institutionalization. Quite often, services simply make life more livable, a goal that should not be minimized."

The Message also said the President is directing that each agency "identify, within the sum that will be available to the States and localities for purposes related to the Older Americans Act. The Administration on Aging will then provide this information to the States so that it can be utilized in the State and local planning processes."

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

For reasons expressed in the section dealing with Government Organization, the Committee again recommends that a special office on aging be established in the White House and that the post of Assistant Secretary on Aging be established in the Department of Health, Education, and Welfare. These actions are especially vital if there is to be any hope at all for the development of coordinated service delivery to older Americans. The fallacy of expecting the Administration on Aging to provide super-agency effectiveness while serving as a unit within the Social and Rehabilitation Service has been demonstrated time and time again. Increased funding levels for AoA may serve merely to increase efforts to divert such funds to purposes not specified by Congress.

Plans to increase the effectiveness of the State agencies on aging are welcome, but only if they are based on adequate discussion with the directors of such agencies and with State governors. But, even though Administration legislation for such purposes has already been introduced, there is reason to believe that it was not preceded by adequate consultation.

The President's call for departments to report priority needs to his Domestic Council Committee on Aging was issued on March 12. The Domestic Council Committee on aging was first announced on October 13, 1971; and plans for establishing such a Committee had been underway for some weeks before. In other words, a period of almost six months passed before operating departments were asked for essential information that should have been used to guide Council Committee on Aging deliberations, thus casting some doubt on the value of the Committee and the responsiveness of operating departments. (See Government Organization section for additional discussion.)

Once again, the Senate Committee on Aging questions the effectiveness of a Cabinet-level Committee as a coordinating force for action on aging. Difficulties in such an approach are particularly apparent in efforts to provide services for older Americans.

X. TRANSPORTATION: ANY SIMPLE ANSWERS?

Transportation problems of older Americans, pervasive and complex, were compellingly summarized by participants in the White House Conference Section on that subject:

> For many of the elderly, the lack of transportation itself is the problem; for many others, it is the lack of money for bus fares; the lack of available services to places they want and need to reach; the design and service features of our transportation systems.
>
> These problems interact with one another and in doing so further augment the transportation difficulties of the elderly.
>
> For example, their low incomes often force them to live in poor transit service areas and prevent them from owning private automobiles. Rising fares and reduced services of financially declining transit companies restrict their travel. Even when transit is available, design features and the lack of directional information may preclude access to available part-time work which might improve their incomes.
>
> The elderly, like everyone in society, must depend upon the ability to travel for acquiring the basic necessities of food, clothing, and shelter as well as employment and medical care. The ability to travel is also necessary for their participation in spiritual, cultural, recreational, and other social activities.
>
> *To the extent that the aged are denied transportation services they are denied full participation in meaningful community life.* (emphasis added)

The fact that transportation was the subject of deliberation by an entire Conference Section was, in itself, significant. In early Conference planning, transportation was thought of as a "sleeper issue,"[1] one that had emerged during the community forums of 1970.

But, although concern is great, comprehensive action on transportation needs of the elderly had not taken place in Congress; nor did the President's Message offer a definitive plan of attack. Despite the announced concern of the Department of Transportation, jurisdiction on transportation matters offers many voids in which issues, problems, and proposed solutions may fall.

White House Conference Recommendations:

Conferees, calling for "immediate action", offered proposals calling for help to individuals and also for entire transportation systems.

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[1] It was so described in a White House Conference on Aging Bulletin of December 1970 in a report dealing with 6,000 community forums held earlier in the year. During the same month the U.S. Senate Special Committee on Aging issued a report called: "Older Americans and Transportation: A Crisis in Mobility" (Senate Report 91-1520).

—*Subsidies and funding.*—"Both system subsidies and payments to elderly individuals may be needed, the choice depending on the availability and usability of private transportation," said the report. In addition, the report recommended that subsidies should be made for development of flexible and innovative systems, especially where no such facilities now exist. Reduced fare or no fare transit at all for the elderly was described as a "program purpose" of such subsidies;[2] and similar action should be taken "on all modes of public transportation". To develop and improve transportation services and to foster coordination, Congress was urged to adopt legislation permitting use of earmarked Highway Trust Funds for such purposes.

—*To promote coordination.*—Transportation needs should be considered in the design of all service programs for the elderly; public policy related to transportation project shall require coordination with programs for the elderly; government passenger vehicles shall be made available to serve the disadvantaged elderly; an area clearinghouse should be established to assure efficient use of all transportation resources. Individualized flexible transportation, to meet specialized needs in differing locales, should be developed with Federal support and leadership by local and State Governments, private enterprise and voluntary community action.

—*Design and safety.*—Federal cooperation with State and local governments was sought for development of minimum comforts of safety, comfort and convenience of vehicles and facilities; similar teamwork was requested for provision of guidelines "to assist in the development of improved ancillary services such as: terminal design, shelters, centralized transit information, traffic control, and crosswalk markings."

An architecturally barrier-free transportation system was recommended "in order to provide accessibility for all people".[3]

—*Insurance and licensing.*—The report requested: a nationwide set of driver's licensing standards prohibiting discrimination on the basis of age; a national policy of guaranteed liability insurance to cover volunteer programs (and other incentives to encourage such volunteers); prohibition of cancellation of automobile insurance policies (or raising of premiums) on the basis of age alone and exploration of no-fault insurance concepts."

Special concern was also voiced about the needs of the rural elderly, Reservation Indians, and tenants in senior housing projects. In addition, Section members asked for a follow-up workshop discussion.

Congressional Actions:

Since October 1970, the United States has been committed by law to a national policy declaring that "the elderly and the handicapped per-

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[2] Approximately 70 reduced-fare plans are now in effect. Full information is available from the American Transit Association, 465 L'Enfant Plaza, SW., Washington, D.C. 20024.

[3] Barriers to the use of buildings and services are also discussed in Section XI of this report. Three days of hearings on "A Barrier-Free Environment for the Elderly and the Handicapped" were conducted by the Senate Special Committee on Aging on Oct. 18, 19, and 20, 1971, Senator Frank Church, presiding. A summary appears on pp. 52–54. "A Pre-White House Conference on Aging Summary of Developments and Data" (Senate Report 92–505).

sons have the same right as other persons to utilize mass transportation facilities and services; that special efforts shall be made in planning and design of mass transportation facilities and services so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured; and that all Federal programs offering assistance in the field of mass transportation . . . should contain provisions implementing this policy."

This language is taken from the Mass Transportation Assistance Act of that year. It was added to the legislation in an amendment sponsored by Representative Mario Biaggi; and it earmarked up to $46.5 million for loans and grants to modify mass transit systems to meet the special needs of the elderly and handicapped. The Department of Transportation has discretionary authority, however, to make use of this amount.

Congressional intent, therefore, seems clear in this area. One concrete result thus far is DoT announcement of plans to have an operational bus without any barriers on the streets within the next year.[4] In addition, DoT has hired a specialist to supervise inclusion of appropriate design features in all new transit projects.

In addition, individual members of Congress have sought greater overall funding for transportation development and for operating subsidies.[5] Senator Harrison A. Williams, author of much of the commuter assistance legislation for more than a decade, is also sponsor of the Older Americans Transportation Services Development Act (S. 1124) calling for a special research and demonstration program.[6] Senator Frank Moss. in S. 1808, calls for reduced fares on airlines for older Americans.[7] Senator Charles Percy, in S. 1591, asks for extension of the Architectural Barriers Act to cover mass transit Facilities.[8]

Presidential Message:

As he did in his address to the White House Conference, the President said that he would, by administrative action, "require that Federal grants which provide services for older persons also ensure that transportation to take advantage of these services is available."

Within the DoT, said the President, a program to develop new ways to meet public transportation needs of older persons is underway with special emphasis upon "demand-responsive" techniques to transport the elderly to needed services. Referring to the need to make such new techniques generally available, the President said:

> One proposal which could help significantly in this effort is the recommendation recently submitted to Congress by the Secretary of Transportation under which some of the funds now in the Highway Trust Fund could be used by States and localities to augment resources in the mass transportation area.[9]

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[4] For additional details, see report from DOT in Appendix 1, item 7, p. 201.

[5] Senator Williams introduced an amendment to S. 3248, calling for operating subsidies for hard-pressed transit systems. This measure passed the Senate March 2, and is now before the House Banking and Currency Committee.

[6] See Part 2 "Summary of Legislative Actions Taken From January 1971, to April 1, 1972," pps. 105–106.

[7] See footnote 6.

[8] See footnote 6.

[9] Questions about the use of Highway Trust Fund for funding urban mass transportation systems were, however, raised by Senator Williams, long an advocate of such a move. In a press release dated March 30, he said: "While I endorse the basic objectives of this proposal . . . I do have serious reservations as to the advisability of placing urban mass transportation under the highway administration. I am also concerned with the level of funding for urban mass transportation given the Department's preoccupation over the years with the highway program."

. . . The Department of Transportation is ready to give priority attention to community requests for helping older Americans through capital grants from the urban Mass Transportation Funds and it is willing to commit significant resources to this end.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Despite clear Congressional direction that transportation systems make adequate provision for the needs of the elderly, compliance seems to be at preliminary stages. Every effort should be made by the Administration on Aging, the Department of Transportation, and by other appropriate Federal agencies to implement policies expressed in legislation and now in the President's Message.

The use of the Highway Trust Fund for Urban Mass Transit Systems should be authorized in the near future, but under terms indicating that progress made under commuter assistance legislation during the last 12 years shall not be dissipated. Specifically, proposals to place urban mass transportation under the Highway Administration should be resisted. In addition, new language requiring responsiveness to the needs of the elderly and the handicapped should be incorporated into final authorizing statutes.

Actions to improve accessibility and attractiveness of transportation vehicles and facilities should be taken.

The Administration on Aging, given more clearcut authority and status and working relationships with a White House Office on Aging (as discussed in earlier sections of this report) should once again sponsor[10] with the Department of Transportation, a workshop to explore areas for joint action and cooperation. The President's request that service programs for the elderly include a transportation component is welcome, but it raises questions about jurisdiction and responsibility. A thorough inquiry into this question alone is badly needed.

The Administration on Aging should extend its studies of reduced fare arrangements on public transportation to include other modes of transportation as well.

Action should be taken at an early date on White House Conference recommendations related to encouragement of volunteer drivers and discriminatory suspension of automobile insurance because of age.

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[10] An Interdisciplinary Workshop on Transportation and the Aging under sponsorship of AoA and DoT was conducted in May 1970.

XI. CONSUMER ISSUES: INCREASED VULNERABILITY

For most Americans, basic necessities—such as housing, food, transportation, and health care—take a big chunk out of their budgets. And for older Americans, these items consume the vast proportion of their limited incomes.

According to the latest Bureau of Labor Statistics Budget for urban retired couples, approximately 80 percent of their income is spent on housing, food, transportation, and medical care.

Housing alone accounts for 35 percent of their budgets, compared with 23 percent for all Americans.

And with a markedly reduced income in retirement, the aged find themselves particularly vulnerable to inflation and other pressures upon their fixed incomes.

These pressures were intensified in 1971 with a 4.3 percent rise in the Consumer Price Index.

But even more significant, many items which affect the aged to a much greater degree have risen at a more accelerated rate. Property taxes, for example, jumped precipitously by more than 9 percent. Hospital daily service charges continued to remain unchecked with almost a 9 percent rise. And home maintenance and repair costs increased by more than 7 percent.

As of February 1972, the cost-of-living had registered increases for 61 consecutive months—the longest unbroken string in the history of the Consumer Price Index.

And Phase II has yet to yield concrete results in slowing the never-ending spiral of two major costs for the elderly: food and rental costs.

With these developments gaining greater momentum at the time of the White House Conference, the Elderly Consumer Special Concerns Session had a vital role in protecting the purchasing power of older Americans in the marketplace.

White House Conference Recommendations:

The Special Concerns Session on the Elderly Consumer reaffirmed four basic consumer rights for all citizens: the right to safety; the right to be informed; the right to be heard; the right to choose. Delegates to the Conference listed a comprehensive set of recommendations to insure these basic rights to elderly consumers. Among the major recommendations:

1. The establishment of Consumer education programs, including consumer information centers with special emphasis on person to person contacts.
2. Research programs to study the behavior of older consumers to document their needs, and the type of education and protections most suitable to these needs.

3. New vehicles for advocacy and representation to provide the consumer with a greater voice in the events in the marketplace. Examples include:

a. The establishment of an independent consumer agency within the Federal Government structure which would have the authority to serve as a consumer advocate in proceedings before Federal agencies and courts.

b. Establishment of the right of consumers to join together and sue as a class (class action suits) in proceedings before Federal and State courts and agencies.

c. The assignment of Staff within the President's Office of Consumer Affairs to deal specifically with the consumer problems of older people.

4. Consumer protection legislation, including:

a. A Consumer Product Safety Act which will provide undiluted responsibility for preventing consumers from being exposed to unsafe goods, drugs, cosmetics, and other consumer products.

b. No fault automobile insurance.

c. The development of model laws regarding the dispensing of hearing aids, physical therapeutic devices and appliances.

d. Unit pricing of goods to facilitate easy price comparisons and open-dating to indicate when packaged goods should be removed from the store shelf.

e. Labeling and identification of all active ingredients in over-the-counter drugs.

f. The repeal of legislation prohibiting the advertising of prescription drug prices.

g. More effective implementation of the Flammable Fabrics Act.

h. Amendments to the Interstate Land Sales Full Disclosure Act to provide better property report disclosures, and a 72-hour "cooling-off" period in interstate land sales (buyers would have 72 hours to cancel the contract without penalty).

Congressional Actions:

A particularly encouraging sign from the standpoint of the Special Concerns Session on the Elderly Consumer is that many of their far-reaching recommendations have been translated into legislative proposals during the 92d Congress. And on a number of key fronts, the Congress has acted on these measures. Among the major proposals affecting consumers during the 92d Congress: [1]

—Truth in Advertising (S. 1461) to require documentation to support the advertised claim about the safety, performance and other characteristics of a product or service.

—Truth in Food Labeling (S. 3083) to provide open dating, unit pricing, ingredient labeling and nutrition labeling. Additionally this proposal establishes uniform standards and grades to enable consumers to rely on a particular representation (such as grade A) as a standard of quality.

[1] For more detailed information about these proposals, see "Summary of Legislative Actions Taken from January 1971 to April 1, 1972", pp.107–109.

—Establishment of a Consumer Protection Agency (S. 1177) to serve as a high-level and effective advocate for all consumers in Federal judicial and administrative proceedings.
—No fault automobile insurance (S. 945).
—Fair Credit Billing (S. 652) to enable consumers to have an itemized explanation of their bill. Moreover, this legislation would prohibit business establishments from turning accounts over to collection agencies prior to following this procedure.

Senate action has already been completed or initiated on two important consumer measures. S. 986, which passed the Senate in November, would provide more effective warranties on purchased goods, as well as more thorough information about these warranties. And the Commerce Committee has reported out a consumer product safety measure, S. 3419, to provide for improved testing to protect buyers from being exposed to unsafe drugs, goods, cosmetics, or other dangerous products.

Flammable Fabrics

Further congressional attention was devoted to the special consumer problems of the elderly when the Committee on Aging initiated hearings in 1971 on "Flammable Fabrics and Other Fire Hazards to Older Americans". In his opening statement, Senator Frank Church provided important background information for the Committee's overall study.

—Latest information indicates that, for overall fire involvement, the elderly constitute just under 10 percent of the population, but account for about 30 percent of the deaths by fire.
—Elderly persons suffer a disproportionate share of the 5,000 deaths and 250,000 burn cases attributed annually to clothing and apparel fires. In a 1969 survey of 23 States, conducted by the Food and Drug Administration, it was discovered that 59 percent of fires related to clothing ignition involved those 65 and over.
—71 percent of fires occur in the home; for the elderly, it is an even 80 percent.
—Those who live alone are the highest risks, including—of course—many elderly widowed and others who have single occupancy quarters.
—Elderly persons quite often are ill or medicated when fire breaks out.[2]

These facts provide compelling evidence for the need to move quickly to protect elderly consumers, not just from the hazards of death and injury by fire, but in all areas of the marketplace.

Architectural Barriers: Toward a Barrier-Free Environment

On October 18, Senator Frank Church opened 3 days of hearings on the impact of barriers—architectural and otherwise—upon older and handicapped Americans.

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[2] See opening statement by Senator Church, hearing, "Flammable Fabrics and Other Fire Hazards to Older Americans," pp. 1–3, October 12, 1971.

At the hearing the Chairman noted the Committee's concern not only with buildings which in one way or other have limited usefulness to people with varying degrees of disability. He stated:

> Most vividly, the image of a person in a wheelchair comes to mind. If he encounters one step in his dwelling or in a public building, he will need help in moving about. But, remove the barrier and he has the same access as do those without handicaps.
>
> Less obviously, other persons face handicaps. An elderly person may give up all hope of using public transportation because of high bus steps or fear of escalators. A man with a respiratory or heart condition may be denied full freedom of worship because designers of his church built barriers into its structure. Remember, disability may be temporary, and it may occur fairly early in life. Thanks to modern means of rehabilitation, the return to full activity is occurring more and more for many persons—including combat veterans—who might have permanently been disabled.
>
> But for the period in which they had a handicap, should they have been denied a reasonable amount of mobility? [3]

Estimates of the number of persons adversely affected by barriers vary, but, one witness at the hearing indicated the importance of the problem by citing Department of Transportation statistics. He said:

> Twenty million of our citizens are 65 years of age or older. Further it is estimated that approximately 6 million Americans of all ages suffer physical handicaps which limit their mobility. To deprive these people of transportation is to deprive them of their right to live normal and fulfilling lives. Equally important, it is to deprive this Nation of the contribution that their maturity and experience can make.[4]

Perhaps even more significant, the hearing underscored another fundamental point: As consumers the elderly are among the chief victims of a system which is oftentimes "off limits" for the infirm, frail or handicapped.

Presidential Message:

Older Americans are estimated to spend about $60 billion a year for goods and services. As a means to protect their purchasing power, the President called for action on three main fronts. Specifically, the President recommended enactment of the proposals in his Consumer Message,[5] which called for a Fair Warranty Disclosure Act, a Consumer Fraud Prevention Act, and other measures.

Additionally, the President stated that his Special Assistant for Consumer Affairs and the Secretary of Housing and Urban Development would develop a program to foster greater awareness for older

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[3] "A Barrier-Free Environment for the Elderly and the Handicapped", part 1, p. 1, October 18, 1971.
[4] "A Barrier-Free Environment for the Elderly and the Handicapped", part 3, p. 173, October 20, 1971.
[5] "Buyer's Bill of Rights" House Doc. No. 92–52, Feb. 25, 1971.

Americans of their rights under the Interstate Land Sales Full Disclosure Act.

And he noted that his Special Assistant for Consumer Affairs and the Secretary of Health, Education, and Welfare would develop a program of technical assistance to help States establish consumer education programs specifically designed for the elderly.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Elderly consumers are confronted with unique problems as a consequence of their reduced retirement incomes, decreased mobility and increased problems related to health. Because of these problems they are at a competitive disadvantage in the marketplace. Older Americans pay proportionately more of their income for the necessities of life, including food and housing. And they have been the hardest hit by escalating real estate taxes and rents. Unfortunately, current economic policies have permitted sharp increases in these very items.

Accordingly, there is a dramatic need for a comprehensive attack on these consumer problems. The attack should include education, enforcement as well as new legislation. It is recommended that:

- **Present economic controls be strengthened to limit the sharp and adverse increases, particularly with regard to prices of food, medical care, and rent.**
- **Consumer education programs should be established to be specifically tailored for the elderly.**
- **Existing consumer protection legislation, such as the Interstate Land Sales Full Disclosure Act, should be more stringently enforced.**
- **The fair credit bill should be enacted to provide all citizens with a full accounting of items in a billing and prevent the turning over of accounts to collection until this procedure is completed.**
- **The Truth in Advertising bill should be enacted to prohibit the false or inflated claims about products.**
- **The Truth in Food Labeling bill should receive the favorable attention of the Congress to provide open dating, unit pricing, nutritional, and ingredient labeling.**
- **The Product Safety bill should be enacted to require testing for safety and efficacy and keep unsafe products off the market.**
- **The Consumer Protection Agency should be established as the advocate of consumers before Federal courts and agencies.**
- **The No-Fault Insurance bill should be adopted to help lower insurance rates for the elderly who drive.**

XII. RESEARCH AND TRAINING

Upwards of 45 to 50 million Americans will reach their 65th birthdays before the end of this century, just 28 years from now.

Vast sociological and economic changes can be expected as years spent in retirement increase. Many persons, in fact, will spend one-third or more of their lives retired from full-time employment. Medical care patterns will—or should—change as more people live into their 70's, 80's, and 90's, causing a demand for services meagerly provided by today's institution-oriented system. Many new skills will be needed to design or manage housing, to devise and channel new services, and to make the later years of life more satisfying for more people who enter the "retirement revolution."

Clear as the gerontological future may be, national allocations for research and training related to aging have been shamefully short of need. American industry typically allocates from 2 to 10 percent of annual budgets to research and development. In the field of aging, the investment is only about two-tenths of 1 percent.[1]

But gerontological research has clearly demonstrated that it can have "multiplier" effects. Like research in other areas, research in aging can refine and improve existing programs. And, it can discover new avenues for solving basic everyday problems. Yet, improving programs for the elderly without an active research program is like "going to the moon without the ability to make course corrections." [2]

Closely connected with the need for additional research is the growing demand to train more personnel to serve the elderly in coming years. We already face a shortage of trained personnel as well as an ever-growing need for more.

> Today only one out of every five persons serving the elderly has had any formal preparation for his work. And it is projected that the requirements for trained personnel in 1980 will be at a level two and three times above the present amount.[3]

The number of facilities and programs serving the elderly continues to grow at an accelerated pace, but the necessary qualified personnel are just not being trained to provide the services. "The gap between the need for trained personnel and the capacities of present training programs is so great that there is no danger in overtraining for several decades".[4] Although there are a few institutions with high

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[1] "A Pre-White House Conference on Aging Summary of Developments and Data," U.S. Senate Special Committee on Aging, November 1971, p. 75.

[2] Statement by Jerome Kaplan, Joint Hearings on "Evaluation of Administration on Aging and Conduct of White House Conference on Aging," U.S. Senate Special Committee on Aging and the Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, p. 86, Mar. 25, 1971.

[3] P. 75 of report cited in footnote 1.

[4] "Research and Training in Gerontology" a report prepared by the Gerontological Society for the U.S. Senate Special Committee on Aging, p. 33, November 1971.

quality programs, the majority of the States "do not have appreciable training of any type." [5]

A funding increase for research and training is truly a long-term investment. But it is also a sound investment because as the number of elderly citizens increases each day, the more valuable the dividends from that initial outlay will become.

White House Conference Recommendations:

In addressing themselves to the dual problems of research and training, the delegates to the White House Conference on Aging recognized the past neglect and the urgent current needs and concluded:

> THE TIME HAS COME TO ACCELERATE RESEARCH EFFORTS AIMED AT UNDERSTANDING THE BASIC PROCESSES OF AGING AND ALLEVIATING THE SUFFERING OF THOSE WHO ENCOUNTER DIFFICULTY IN ADAPTING TO THIS PHASE OF LIFE.

On the issue of training, they declared:

> AS NEW SERVICE DELIVERY SYSTEMS ARE DEVELOPED NEW MODES OF TRAINING AND NEW TYPES OF PERSONNEL WILL BE REQUIRED. THE DECADE OF THE 1970'S IS THE DECADE IN WHICH MAJOR PLANS FOR TRAINING MUST BE PUT INTO EFFECT.

Among the specific recommendations put forward were the following:

1. Establish a National Institute of Gerontology to support and conduct research and training in the biomedical and social-behavioral aspects of aging.
2. Create a position within the Executive Branch with sufficient support and authority to develop and coordinate, at all levels of the Government, programs for the aged, including research and demonstration programs.
3. Appropriate a major increase in Federal funds for research, research training, and demonstration—such amount to be, on the average, no less than 3.5 percent of the total expenditure of funds for programs in the interest of older persons.
4. Initiate a fully developed national policy on training that will focus on both the immediate and the future needs of the aged population.
5. Create a new Federal agency for aging, adequately financed, and with the power to coordinate all Federally supported training programs in aging.
6. Establish regional, multidisciplinary research and training centers of excellence in gerontology with a close relationship to service-delivery systems.
7. Establish a national data bank and retrieval system to make available all research knowledge and curriculum materials on aging.

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[5] P. 33 of report cited in footnote 4.

Congressional Actions:

Prior to the White House Conference, two bills were introduced in the Senate to provide greater visibility and a more coordinated approach for research in the field of aging. S. 887, sponsored by Senator Thomas Eagleton, would establish a National Institute of Gerontology for the conduct and support of biomedical, social, and behavioral research and training relating to the aging process and the diseases and other health problems of the aged. The other legislative proposal (S. 1925), introduced by Senator Harrison Williams, would establish a seven-member Aging Research Commission to be appointed by the President. The Commission would be responsible for preparing a long-range gerontological research plan designed to promote intensive coordinated research into the biological, medical, psychological, social, and economic aspects of aging. Hearings were held on these proposals last June by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee. And the Subcommittee began to consider these measures in Executive Session on April 5.[6]

In July of 1971, Senators Frank Church and Winston Prouty, in testimony before the Labor-HEW Appropriations Subcommittee urged an increase from $7.2 million to $12 million for aging research and training at the National Institute of Child Health and Human Development (NICHHD).

This $4.8 million increase in funding was later approved by the Appropriations Committee and the Senate. Later in conference committee this measure was deleted. In its place the House and Senate Conferees raised the total appropriation for NICHHD by $7.1 million and indicated their strong intent that within this additional $7.1 million, priority should be given to research on aging.

Presidential Message:

President Nixon described two specific areas of training that were to be developed, and spoke of his intention to establish a Technical Advisory Committee on Aging Research within HEW.

Specific training programs were discussed in the fields of nursing home personnel and housing management. The nursing home program is entitled "Short-term Training for Professional and Paraprofessional Nursing Home Personnel" and is currently funded at the $2.4 million level to train 20,000 persons. The fiscal year 1973 budget contains $3 million to train an additional 21,000. Secondly, the President has directed the Secretary of Housing and Urban Development to work with the Administration on Aging in developing training programs dealing with the management of housing for the elderly.

Finally, to coordinate a research program covering a wide multi-disciplinary range, the President mentioned that a new Technical Advisory Committee for Aging Research will be established in the office of Health, Education, and Welfare. The scope of this committee is left very much in doubt, however, and there is no indication that it will have much power outside its role as a coordinator.

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[6] Several similar measures are being considered in the House of Representatives. The Subcommittee on Public Health and Environment initiated hearings on Mar. 14, 1972, on H.R. 4979 to establish a National Institute of Gerontology and H.R. 3335, the Research on Aging Act.

FINGINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

A critical shortage of funding for research and training continues to be one of the most pressing problems in the field of gerontology. Moreover, the absence of a coordinated Federal commitment has led to fragmented and haphazard efforts. To correct these longstanding problems, the committee recommends that:

- **Appropriations for research and training should be increased substantially. Specifically, the committee urges full funding for research and training under the Older Americans Act and at least $12 million for aging research and training at the National Institute of Child Health and Human Development.**
- **A central unit should be created—whether it be a national institute of gerontology, an aging research commission, or some other body—to provide a high level focal point to coordinate research and training efforts in the field of aging.**
- **Immediate action should also be initiated to upgrade the Administration on Aging's research and training activities.**
- **Efforts should be made to encourage the establishment of gerontological centers or institutes at universities. At a very minimum each major region of the Nation should be served by several interdisciplinary centers.**

XIII. THE CLEAR, PRESSING PROBLEMS OF MINORITY GROUPS

Older Americans—individuals all—nevertheless share many common problems and concerns: limited incomes, rising health costs, soaring property taxes, transportation difficulties, and many others. For the nearly 2 million elderly persons who are members of minority groups, these pressures are greatly intensified. Nowhere is this more evident than in their shockingly high incidence of poverty.

Table 1—Elderly minority groups (age 65 and older)

Negro	1,600,000
Spanish Origin	300,000
Mexican-American	(147,000)
Puerto Rican	(31,000)
Cuban	(23,000)
Central or South American	(17,000)
Other	(86,000)
Indians	30,000
Asians	(1)

[1] Data not available.

Source: "Facts and Figures on Older Americans: An Overview 1971," No. 5; U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Administration on Aging; Prepared by Herman B. Brotman, Assistant to the Commissioner for Statistics and Analysis.

Nearly one out of every two elderly persons in minority groups falls below the poverty line. They are more than twice as likely to be poor as the Anglo aged and nearly four times as great as for the total population. And recent Census data suggest that they may suffer deeper extremes of impoverishment. Median incomes for blacks living alone or with nonrelatives is only $1,443 a year, more than $400 below the poverty threshold.

TABLE 2.—POVERTY AMONG AGED BY RACE IN THE UNITED STATES IN 1970

Race	Number 65 plus	Total aged poor	Percent of aged poor by race
White	17,684,000	3,984,000	22.5
Negro	1,422,000	683,000	48.0
Other Races, not including white and Negro	148,000	42,000	28.4
Total	19,254,000	4,709,000	24.5
Negro and other races	1,570,000	725,000	46.2

Source: Bureau of Census.

Perhaps one of the most economically disadvantaged persons in our entire Nation is the aged Negro woman who lives alone. More than 88 percent—or nearly nine out of every ten—are considered poor or near poor.

White House Conference Recommendations:

In response to complaints that appropriate attention was not being paid to the special needs of minorities, Conference officials agreed in September to hold special concerns sessions on the problems of Aging and Aged Blacks, the Elderly Indian, the Asian-American Elderly, and the Spanish-speaking Elderly. The special concerns sessions on the aged minority, as well as several other subjects, were held on December 1 from 8 a.m. to noon.

Despite the many cultural and other differences among elderly minority groups, several common themes emerged from their special concerns sessions. One of the most prevalent was the problem of "multiple jeopardy" because of age, race, nationality, language barriers, and false stereotypes.

Another recurring message is that too little attention is being paid to their special problems. Perhaps even more important, was an unmistakable call for new and far-reaching action—in many cases far beyond what any administration to date has been willing to seek—to insure genuine economic security for all older Americans.

A priority proposal in practically every instance was the need for a guaranteed annual income, ranging in amounts from $6,000 for an individual and $9,000 for a couple at the Black Special Concerns Session to the Spanish-speaking proposal of $3,375 for an aged individual and $4,500 for married persons.

Another common concern was the appalling lack of concrete statistical information about aged minority groups. What data is available is usually sketchy, incomplete or inadequate. Yet, without this data, it will be difficult, if not impossible, to implement a national policy on aging for *all* older Americans. To help close this deepening "information gap", the Spanish-speaking called upon: (1) The Bureau of Census to conduct an indepth study to evaluate the accuracy of the number of Spanish-speaking elderly, (2) the Bureau of Labor Statistics to make an ethnic breakdown of unemployment figures, and (3) the Social Security Administration to compile a census on the number of Spanish-speaking persons who receive benefits. And the aged blacks proposed that the Federal Government should provide a detailed report on elderly Negroes at least every five years.

The need for earmarked funding or special emphasis programs was also emphasized time and time again. The Indian Special Concerns Session, for example, urged that a special desk be created in the Administration on Aging to act as a built-in advocate for their needs. A Cabinet Committee for Asian-American Affairs—paralleling the Cabinet Committee on Opportunities for Spanish-speaking People—was proposed by the Asian elderly.

Additionally, the Special Concerns Sessions focused on several unique problems confronting each minority group. For example, the elderly Indians recommended that the Older Americans Act be amended to permit direct funding for Indian tribes. The Asian-Americans urged that Federal food assistance programs should be re-examined with a view to take into account their cultural preferences. Federal housing programs, the Spanish-speaking stressed, should be sufficiently flexible to accommodate their special cultural considerations with regard to design, location, and size. Finally, an earlier age

requirement for Social Security benefits was proposed for black males and aged Mexican-Americans because of their shorter life expectancy.[1]

Moreover, other sections at the White House Conference made a number of proposals directed at the special needs of the elderly. One such example was urged by the Employment and Retirement Section when it recommended that a universal and national portable pension plan, to be administered by the Social Security Administration, should be established to provide protection for minority groups who normally would not be covered by other pension plans.

Congressional Actions:

One of the major effects of the Special Concerns Sessions was to dramatize the immediate need for far-reaching action to come to grips with the serious problems confronting the minority aged—especially in the areas of income, employment, health care, nutrition, and housing. In response to this challenging call, the Congress has initiated action on several proposals to implement key policy recommendations of the White House Conference. Among the principal measures:

—The Labor and Public Welfare Committee is nearing completion on legislation [2] to establish a national Senior Community Service Program, which can provide many new employment opportunities for thousands of the minority aged.

—Legislation establishing a new national hot meals program for persons 60 and over was signed into law in March.[3] Of special significance, the Senate Committee report emphasizes that the nutrition programs are to give priority attention to the special needs of minorities and low-income persons.[4]

—The House of Representatives has approved legislation (H.R. 12350) to extend the Economic Opportunity Act for 2 years, including the Senior Opportunities and Services Program.

—Despite the need for further major improvements, H.R. 1 includes a number of provisions of vital importance to the minority aged, such as extension of Medicare coverage for disabled Social Security beneficiaries; a new special minimum benefit; full Social Security benefits for widows; and a new guaranteed annual income for the elderly, even though it is far below the level sought by delegates at the Special Concerns Sessions.

Additionally, a proposal [5] was signed into law in August to extend the Cabinet Committee on Opportunities for Spanish-Speaking People.

Moreover, in December Congressman Anderson of California introduced a bill (H.R. 12208) to establish a Cabinet Committee for Asian-American Affairs. The Committee would have authority to advise and direct Federal agencies with regard to appropriate action for assuring that present programs are providing the assistance needed by Asian-Americans. The bill also provides for the investigation of possible dis-

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[1] For the text of these recommendations, see pp. 12–13.

[2] S. 555, the Older American Community Service Employment Act. For more detailed discussion, see "Summary of Legislative Actions Taken from January 1971 to April 1, 1972." p. 104.

[3] The Nutrition Program for the Elderly Act, Public Law 92–258, approved Mar. 22, 1972. For more detailed discussion of the provision in this act, see "Summary" mentioned in footnote 2.

[4] Sen. Report 92–515, Nov. 29, 1971, p. 2.

[5] Public Law 92–122, approved Aug. 16, 1971.

criminatory practices against Asian-Americans in the areas of employment, housing, education, and other public services.

And several working papers and reports prepared for the Committee on Aging have helped to unearth new and helpful information about elderly minority groups.[6]

Presidential Message:

Only brief reference was made to minorities in the Message on Aging. In the one sentence in which the President specifically mentions minority groups, he noted that their "difficulties are intensified."

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

By any standard of measurement, the minority aged—whether they be Spanish-speaking, Indian, Asian-American, or Black—have a less satisfying quality of life than the Anglo aged or the total U.S. population. They run a substantially greater risk of living in poverty. And they are more likely to have poorer health, live in run-down housing, suffer from malnutrition, and experience other forms of deprivation.

The needs of minority groups have received scant attention for far too long. What is needed now is a comprehensive plan for action on several fronts to deal effectively with their deep-rooted problems and to lay a firm foundation for implementing the long-range goals of the Special Concerns Sessions.

As an immediate step to move toward the long-term recommendations of the Special Concerns Sessions, the committee urges that all older Americans must be assured of an income that will eliminate poverty once and for all for the elderly.

Additionally, the Committee recommends prompt adoption of the following measures:

- **Assurances in legislation enacted by Congress to benefit older Americans that minority groups will be appropriately represented and that their special needs will be effectively met.**
- **Substantial increases in minimum monthly Social Security benefits for persons with low lifetime earnings.**
- **Major increase in Social Security benefits to lift large numbers of older persons out of poverty without the necessity of resorting to welfare.**
- **Extension of Medicare benefits to coincide with the age requirements for becoming eligible for Social Security benefits.**
- **Coverage of out-of-hospital prescription drugs under Medicare.**

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[6] For a listing of these publications, see "Reports and Committee Prints Issued by U.S. Senate Committee on Aging from December 1970 to April1, 1972," pp. 115–119.

- **Elimination of the premium charge for supplementary medical insurance.**
- **Home repair services for older Americans who would otherwise have difficulty in paying for these costs.**
- **Reduced price fares for public transportation for lower-income elderly persons.**

Moreover, the Committee recommends that the Social Security Administration, Bureau of Census, Bureau of Labor Statistics, and Bureau of Indian Affairs undertake appropriate studies to provide vitally needed information for important policy recommendations affecting aged and aging minority groups.

XIV. TOWARD A MORE SATISFYING RETIREMENT

The basic needs of the elderly—income, health, housing, and the like—usually receive the lion's share of attention. And this focus is appropriate.

But compelling facts now dictate that similar concern be directed toward other aspects of the "retirement years."

What are the new realities that demand this new emphasis?

Retirement now affects more people, and for more years in their lifetime, than ever before. And a continuation of present trends would mean that over a third of our lifetimes would be spent as retirees.

Despite these trends most people are simply not ready for retirement when it comes. "Retirement shock," rather than the "golden years," may more accurately describe what awaits many new retirees.

And a profile of the retiree in the year 2000 shows that the dimensions of the retirement problem will grow even more complex and challenging in the years ahead.[1]

Indispensable as an effective income strategy is for older Americans, it alone cannot assure that the later years will be a time of fulfillment and satisfaction. A proper mix of other ingredients—such as recreation, continuing opportunities to earn and learn, a more meaningful role in retirement, and a full range of opportunities for citizen participation—is essential for a full life. To the vast majority of the delegates at the White House Conference, this fundamental fact was all too apparent. And it was for these compelling reasons that other basic needs of the elderly were also considered in detail at the Conference: Education, Employment and Retirement, Retirement Roles and Activities, the Older Family, the Religious Community and the Aged, Volunteer Roles for the Aged, and others.

White House Conference Recommendations:

The recommendations of the White House Conference on Aging speak to the current and future challenges of the retirement years. Essential improvements are called for in basic needs like income, health, and housing. But a broader range of retirement concerns was explored and it is some of the key recommendations on these fronts that will be looked at here.

These include:

—*Pre-retirement Education.*—Pre-retirement education was stressed in many Conference recommendations. The Section on Retirement Roles and Activities, declaring that "Society should adopt a policy for preparation for retirement," stated that "every

[1] For such a profile see "A Pre-White House Conference on Aging Summary of Developments and Data," U.S. Senate Special Committee on Aging, Nov., 1971, pp. 102–103.

employer has a major responsibility for providing preparation-for-retirement programs during the working hours." [2]

—*Flexible Retirement Age.*—The Section on Employment and Retirement charged that, "Our society presently equates employability with chronological age rather than with ability to perform the job." The Section recommendations called for "a flexible policy" for retirement, based on the worker's desires, needs, and capacities. Job opportunities after age 65 were urged, as well as opportunities for retirement prior to age 65.

—*Education.*—Education was seen by the conferees as a prime instrument for achieving a more satisfying retirement. The Education Section declared that "The expansion of adult educational programs having a demonstrated record of success should receive a higher priority." And the Education Section participants urged that "Available facilities, manpower, and funds" be used for "educational programs designed and offered on the basis of the assessed needs and interests of older persons." The Education Section also called for a unit in the Office of Education that would serve and promote the educational needs of the aging.

—*Spiritual Well-Being.*—The Section on Spiritual Well-Being recommended government cooperation "with religious organizations and concerned social and educational agencies to provide research and professional training in matters of spiritual well-being to those who deliver services to the aging." In addition, the Section participants recommended that "the government provide financial assistance for the training of clergy, professional workers, and volunteers to develop special understanding and competency in satisfying the spiritual needs of the aging."

—*Youth and Age.*—The Special Concerns Session on Youth and Age declared that "One of the major aims of the White House Conference on Aging should be to harness the activity and energy of youth and link it to the solution of the problems confronting the aging." The conferees listed "three areas of youth volunteer activity" "for immediate action." These included providing "information to senior citizens regarding existing social services and financial resources"; rendering "direct service to senior citizens"; and acting "as advocates in behalf of the elderly."

Congressional Actions:

The broad concerns of the White House conferees about providing a more satisfying retirement for the elderly were reflected in Congressional actions on several fronts in 1971 and early 1972.

A summary of major Congressional actions in these areas is outlined below.

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[2] See footnote 3, p. 8.

The Federal Employees Pre-retirement Assistance Act

Sponsored by Senator Walter Mondale, S. 1392 (the Federal Employees Pre-retirement Assistance Act) requires all Federal agencies to provide their employees who are eligible for or approaching retirement with an appropriate program of pre-retirement assistance.

S. 1392 also requires the Civil Service Commission to establish standards for such programs; provide training for agency pre-retirement advisers; and study and publish guidelines about related work-life programs, such as phased retirement, trial retirement, new kinds of part-time work and sabbaticals.

In introducing this measure, Senator Mondale declared that "The transition from a daily work routine to retirement is surely one of the most difficult adjustments that modern man is called upon to make." And yet, he pointed out, "with adequate advance preparation, retirement from a job need not mean retirement from life itself. Techniques of self-renewal that will enable personal growth in every situation must be fostered." [3]

The Adult Education Opportunity Act

Another important proposal to provide greater freedom of choice for aging Americans is the Adult Education Opportunity Act (S. 1037), which was introduced by Senator Harrison Williams. The Williams bill would:

1. Establish a Bureau of Adult Education within the Office of Education to operate, coordinate, and develop long-range planning, as well as administer any adult education programs assigned to it by the Congress or by the Commissioner of the Office of Education. It would also promote coordination and dissemination of information among such programs.
2. Establish a National Center for Adult Education which would employ an initial Federal grant for development of combined public-private funding of information and referral services throughout the Nation and for pilot projects and applied research to solve problems in the field of adult education.
3. Create an Advisory Council on Adult Education to assist the Bureau of Adult Education and to serve as the policy body for the National Center.

Senator Williams has pointed out that S. 1037 is "the first legislation recognizing adult education as a vital part of national policy." [4]

Drawing on his experience and insight as former Chairman of the Special Committee on Aging, Senator Williams said that the legislation "would have special value to older Americans, especially those near or in retirement."

The Senator added:

> Time and time again, the committee has been told that retirees wish to have educational opportunities designed spe-

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[3] These remarks were made when Senator Mondale introduced S. 1392. See the *Congressional Record*, March 29, 1971, p. S3973.

[4] All quoted statements by Senator Williams concerning S. 1037 are taken from his remarks when the bill was introduced. See the *Congressional Record*, March 1, 1971, pp. S2144–2145.

cifically for them. Well-informed witnesses have told us that well-being—and even health—of the elderly improves when those individuals are living active and stimulating lives. Education certainly would make a significant contribution toward such a goal.

The Community School Center Development Act

A second measure to expand the range of educational opportunities for older Americans is the Community School Center Development Act (S. 2689), which was sponsored by Senators Frank Church and Harrison Williams. Senator Church said that the community school concept "aims at transforming the traditional role of the neighborhood school into that of a total community center for people of all ages and backgrounds, operating extended hours throughout the year." [5]

S. 2689 would assist the development of community schools in three ways:

1. Federal grants would be available to strengthen and sustain existing community education centers, located at colleges and universities throughout the Nation, which would train community school leaders and, in general, promote and assist the community school movement. Federal grants would also be available to institutions of higher learning to develop and establish new community education centers.
2. Federal grants in each of the 50 States would be available for the establishment of new community school programs and the expansion of existing ones.
3. The Commissioner of Education of the U.S. Office of Education would administer this Act and would also be charged with the added responsibility of promoting community schools through specific national programs of advocacy and education.

Senator Church, when introducing S. 2689, said the Act would "benefit all segments of our population" but emphasized "the advantages that will accrue to our elderly through enactment of this bill:"

> Programs of education, health, recreation, nutrition, and transportation—possibly with school buses—could be established through community schools. The variety of possible programs of assistance and interest to the senior citizen is almost unlimited; senior citizens will join with their neighbors in serving on the community school councils that will help devise programs to serve the special needs of each community.

Presidential Message:

The President's aging message contained the following comments and recommendations related to promoting a more satisfying retirement for the elderly: [6]

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[5] All quoted statements by Senator Church concerning S. 2689 are taken from his remarks when the bill was introduced. See the *Congressional Record,* October 12, 1971, p. 16161.

[6] All references to the President's message on aging are taken from "Message from the President of the United States Transmitting Recommendations for Action on behalf of Older Americans," March 23, 1972, reprinted as House of Representatives Document No. 92–268, 92d Cong., 2d Sess.

—The President pledged that the Administration would "develop a program designed to help each State create consumer education programs for older citizens."
—The Administration would also, said the President, encourage "the provisions of more space for senior centers within housing projects for the elderly."
—A "national program" was promised "to expand employment opportunities for persons over 65."
—A "Technical Advisory Committee on Aging Research in the Office of the Secretary of Health, Education, and Welfare" would be created "to develop a comprehensive plan for economic, social, psychological, health, and education research on aging."

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

The Senate Committee on Aging, mindful that less than 30 years remain for adjusting to major projected changes for retirees in the year 2000, recommends that well-reasoned and reliable projections be developed to prepare for the future requirements of the aged.

The Committee further recommends that the Federal Employees Pre-Retirement Assistance Act (S. 1392) be enacted promptly. For Federal employees, this could help ease the way toward making the adjustments needed for a more satisfying retirement. And, hopefully, other employers would follow the example set by the Federal Government in developing pre-retirement assistance programs.

Educational opportunities have too long been denied the elderly. The Senate Committee on Aging recommends early passage of The Adult Education Opportunity Act (S. 1037) and The Community School Center Development Act (S. 2689), both of which would greatly expand the range of educational opportunities open to older Americans. And both would signify a continuing commitment to the importance of education for Americans in their later years.

Retirement years are often years of isolation for many. The Committee on Aging sees The Community School Center Development Act as providing a means of helping to end this isolation through the elderly's participation in, and planning of, activities and programs shared with others of all ages in their communities. To the Committee, this is a further important reason for prompt enactment of S. 2689.

XV. RURAL OLDER PEOPLE

One out of every four older Americans, approximately 5.4 million in all, live on farms or in communities of less than 2,500 population.[1]

Their needs and problems are similar in many respects to those of other elderly persons; but problems of transportation, shortages of essential services, a declining economic base in many areas, and limited earnings in preretirement years complicate their later years and too often fill them with hardship.

And yet, despite the need for intensive and informed scrutiny of this large group of elderly Americans, planning for a "special concerns" session on rural issues at the White House Conference on Aging did not begin until early autumn of 1971, less than 3 months before the White House Conference.

Addition of this Special Concerns Session was a welcome—and essential—action. Participants at the Special Concerns Session made this clear when they issued a report making these major declarations:

—Rural transportation problems must be solved before there can be effective solutions to rural health, income, employment, or housing problems.

—Nationally, one out of every ten of our citizens is old. In rural areas that ratio is often one in five.[2]

—As the younger people are forced to leave to find jobs, they leave a shrinking tax base and a growing scarcity of services.

—Rising property and sales taxes in rural areas are "becoming increasingly oppressive to older rural people."

—Opportunities for Social Security coverage in earlier years were limited, causing much lower benefits than in more urban areas.

—Rural areas have one-third of the poverty in this country, yet they get only 16 percent of the Federal manpower funds. Special Sessions participants agreed, however, that employment programs—including the Green Thumb and home repair programs—have special appeal in rural areas.

—Unless government programs are presented in tactful and understanding ways, they will be regarded with hostility or distrust.

Within the Congress during 1971 and early 1972 considerable attention was given to proposals for economic development of rural areas. It is clear, however, that such proposals will fall short of their goals unless they take into account the large population of

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[1] For additional statistical information about rural elderly, see pp. 78–80, "A Pre-White House Conference on Aging Summary of Developments and Data," a report of the Senate Special Committee on Aging, Nov. 1971, S. Rept. 92–505.

[2] See testimony by Woodrow M. Morris, Director of Iowa Institute of Gerontology, on effects of out-migration of younger residents and other factors upon the "Senescity Index" of selected Iowa counties, pp. 69–87, hearings on "Older Americans in Rural Areas," U.S. Senate Special Committee on Aging, Sept. 8, 1969.

older persons in such areas, and their special need for new forms of practical—and often part-time—employment.[3]

White House Conference Recommendations:

Transportation was at the top of the list offered by the Special Concerns Session on Rural Older People.

Participants called for "people-delivery systems," and they asked for legislation "enabling and requiring public, social, health, and employment services in rural areas to help provide transportation and outreach."

In addition, they asked for removal of such legal barriers as school bus insurance restrictions.

Other recommendations:

—Legal and protective services especially on issues which involve possible encroachment on their rights and property.

—Community service employment programs should be "expanded into every rural county." Public job assistance training, and placement programs should be as accessible to the older worker as to the young.

—Social Security minimum benefits should be increased; automatic cost-of-living adjustments made; and "present legislative and regulatory impediments" to income supplementation through employment should be removed.

—A major home repair program for older people should be implemented, making full use of all existing programs. In addition, "a major new rural housing program must be developed to meet the needs of the rural elderly."

—Unique characteristics of rural areas "must be considered" in the design of a national health service delivery system. Health education programs should be greatly expanded, with special attention to nutrition practices.

Congressional Actions:

The Committee on Aging, in a study [4] initiated more than 2 years ago provided important spade work for calling special attention to the mounting problems of older Americans in rural areas. And these hearings have helped to provide a solid foundation for important Congressional legislative initiatives to respond to their more intense problems.

Especially noteworthy is the twin-pronged attack to provide badly needed services while offering new and gainful job opportunities for the rural aged. One such example is the Older Workers Conservation Corps Act (S. 3208)[5] which would build upon the successful achievements of Operation Mainstream, and which includes the outstanding Green Thumb Program. However, this measure would focus primarily on utilizing persons 55 and older to engage in conservation of natural resources and environmental improvement activities. With a first year funding authorization of $150 million, an estimated 50,000 to 60,000

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[3] See, for example, testimony by Idaho State Senator John Evans, pp. 198–201, at hearing on "Unemployment for Older Workers," U.S. Senate Special Committee on Aging, Pocatello, Idaho, Aug. 27, 1971, for suggestions to provide work for farmers between the ages of 45 and 65 "who have found it's necessary to seek additional employment or special help in meeting their financial requirements for subsistence."

[4] "Older Americans in Rural Areas," parts 1 through 12.

[5] For a more detailed description of S. 3208, see p. 113 in the "Summary of Legislative Actions Taken from January 1, 1971 to April 1, 1972."

older Americans could beautify the American countryside while helping to improve themselves economically.

Additionally, the Senate Subcommittee on Aging has completed hearings on two measures to maximize employment opportunities for mature workers: the Older American Community Service Employment Act and the Middle-Aged and Older Workers Employment Act.[6] Of special significance, both measures include specific language to assure an equitable distribution of funds between rural and urban areas. Equally important, the Older American Community Service Employment Act would provide a basis for establishing a national senior corps throughout the United States. Under new funding levels now being considered by its sponsors, approximately 60,000 persons could participate in this new national program—nearly 12 times the level of Operation Mainstream.

One of the key findings of the Committee's hearings is that perhaps 60 percent of all substandard housing units are located in nonmetropolitan areas. In response to this challenge, Senator Frank Church introduced legislation [7] in November to establish a national home repair program for older Americans who otherwise would have difficulty in paying for these costs. Strong support for this concept was expressed in the Rural Older People Special Concerns Session.

Another clearcut finding in the Committee's overall study is that many rural communities now face critical shortages of health manpower and facilities. And the elderly have been among the chief victims of this intensifying deficiency.

Approximately 30 percent of the Nation's total population live in rural areas. But only about 12 percent of all physicians are located in these localities.

This crucial problem received the close attention of Senator Edward Kennedy when he introduced his comprehensive Health Maintenance Organization bill, S. 3327,[8] on March 13. In his floor remarks, Senator Kennedy pointed out:

> . . . It has become apparent that the problems of the provision of health services to rural areas are far different from those which exist in urban areas. The problems most important in rural areas seem to be those of attracting adequate numbers of health practitioners and problems associated with transportation and communication once health professionals have located in the area.[9]

To deal with these growing concerns, S. 3327 includes special provisions to encourage the improvement of the organization and distribution of health services to nonmetropolitan areas.

On other key fronts, the Congress has adopted legislative proposals with potentially far reaching implications for the rural elderly. H.R. 1, for example, includes a number of provisions which will be particularly beneficial for older Americans living in rural areas, such as:

—A new special minimum Social Security benefit for persons with long periods of covered employment;

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[6] For a more detailed description of these proposals, see p. 104 of the Summary cited in footnote 5.
[7] S. 2888, the Older Americans Home Repair Assistance Act. For a more detailed discussion of this proposal, see p. 112 of Summary cited in footnote 5.
[8] For a more detailed discussion of S. 3327, see p. 98 of the Summary cited in footnote 5.
[9] March 13, 1972, Cong. Rec., p. 3781.

—Liberalization of the earnings limitation; and
—Coverage of the disabled under Medicare.[10]

Presidential Message:

President Nixon did not direct specific attention to the special problems of the rural elderly.

However, one of the President's proposals had immediate relevance to the more than 5 million persons 65 and over who now live on farms or in rural communities. And this was his recommendation to increase funding by $13 million for the Mainstream pilot programs. The effect of this measure is to boost the number of elderly participants from approximately 5,000 to 10,000. The largest project funded under Mainstream is Green Thumb which enables nearly 2,600 elderly participants with rural or farm backgrounds to beautify our countryside by cleaning out lakes, planting trees and shrubbery, restoring historical sites, and building campgrounds.

FINDINGS AND RECOMMENDATIONS: U.S. SENATE COMMITTEE ON AGING

Older Americans have been, to a very significant degree, "left behind" by the mass exodus of millions of rural inhabitants to the crowded cities during the past two decades. And they continue to be among the chief victims of the enormous problems confronting rural communities; depressed economic conditions, a critical shortage of health personnel and facilities, limited opportunities for jobs, dilapidated housing, inadequate or nonexistent public transportation, and an eroding tax base. Their needs cry out for immediate and special attention on several fronts. To help implement these goals, the Committee recommends:

- **A 20 percent increase in Social Security benefits along with appropriate reforms to take into account the special problems of the rural elderly (for a more detailed discussion of the Committee's Social Security recommendations, see page 16);**
- **Enactment of any health care delivery or service system should consider the special needs of the rural elderly;**
- **Early adoption of legislation to establish a national home repair program for older Americans;**
- **Enactment of the Older Workers Conservation Corps Act and the Older American Community Service Employment Act to provide vitally needed services and gainful work for the rural elderly;**
- **Increased Federal funding should be made available for mobile health screening units to provide disease detection and other health maintenance services for persons living in rural areas;**
- **Legislation should be approved to help defray any additional costs of rural school districts which attempt to make more effective use of their school buses during off-duty hours to help meet the severe transportation problems of the aged.**

[10] For a more detailed discussion of the provisions in H.R. 1, see pp. 89 and 93 of Summary cited in footnote 5.

PART TWO

SUMMARY OF LEGISLATIVE ACTIONS TAKEN FROM JANUARY 1971 TO APRIL 1, 1972

INTRODUCTION: A QUICKENING OF RESPONSE

Congressional and executive branch actions related to aging quickened during 1971 as the White House Conference approached. In the months since the delegates went home, attention has turned to implementation of Conference recommendations. The President's Message, already discussed in Part One, is not analyzed here. But additional details are provided on legislative actions or proposals made during and after the Conference.

I. PROPOSALS RELATED TO RETIREMENT INCOME

H.R. 1

A. LEGISLATIVE HISTORY

Sponsored by Representatives Wilbur Mills and John Byrnes, H.R. 1 makes major changes in the Social Security, Medicare, Medicaid, and Welfare programs. The bill was reported out by the Ways and Means Committee on May 26, 1971. And it passed the House of Representatives by a vote of 282 to 132 on June 22.

B. MAJOR PROVISIONS

Social Security*

1. BENEFIT INCREASE.—5 percent, effective June 1972.

2. SPECIAL MINIMUM.—A new special minimum would be provided for people who worked 15 or more years under Social Security (equal to $5 multiplied by the number of years of covered employment). The highest minimum benefit under the new provision would be $150 per month for a single person.

The Finance Committee proposed a new special minimum, ranging from $80 to $200 a month for persons with long periods of covered employment. Specifically, the new provision provides a special minimum of $10 per year for each year in covered employment after 10 years. Because the present minimum monthly benefit is now $70.40, the new special minimum would come into operation after 18 years of covered employment.

3. AUTOMATIC ADJUSTMENTS.—Benefits would be adjusted annually according to rises in the cost-of-living provided: (1) The

*At this writing, H.R. 1 was still under executive consideration by the Senate Finance Committee. All changes made by the Committee are indicated in italics, and are to be regarded only as *tentative* Committee action.

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Consumer Price Index increased by at least 3 percent, and (2) legislation increasing Social Security benefits had neither been enacted nor become effective during the previous year. To finance the automatic benefit raises, the wage base would be automatically adjusted according to the rise in average wages covered under the Social Security program.

The Finance Committee adopted the House Provision for automatic adjustments but it changed the method of financing. Under the Committee bill, the amount of additional benefits would be financed by: (1) One-half from an increase in the tax rate, and (2) one-half from an increase in the wage base.

4. FULL BENEFITS FOR WIDOWS.—Widows aged 65 and older would be entitled to benefits equal to 100 percent of their spouses' primary insurance amount.

5. INCREASED BENEFITS FOR PERSONS DELAYING RETIREMENT.—Benefits would be increased by 1 percent for each year a worker does not receive benefits because he is working after age 65.

The Finance Committee approved the House provision but applied it to persons already retired, instead of only those coming on to the Social Security rolls after the bill's enactment.

6. AGE-62 COMPUTATION POINT FOR MEN.—Special advantages for women would be eliminated by applying the same rules to men as now apply to women (phased in over a 3-year period).

7. ADDITIONAL DROPOUT YEARS.—One additional year of low earnings—in addition to the 5 years provided under present law—for each 15 years of covered work would be dropped in computing benefits. Effective date January 1972, and applied prospectively.

8. WORKING WIVES.—A working couple would be able to combine their wages for purposes of computing benefits if this would result in higher payments, provided they each had at least 20 years of covered earnings after their marriage.

9. LIBERALIZATION OF THE RETIREMENT TEST.—Major changes include: (1) The annual earnings limitation would be raised from $1,680 to $2,000. (2) For earnings in excess of $2,000, $1 in benefits would be withheld for each $2 of earnings. (Under present law the $1 for $2 feature applies only to the $1,200 band above $1,680; thereafter, benefits are reduced for each dollar of earnings above $2,880.) (3) The earnings limitation would be adjusted automatically by the same percentage by which the wage base is automatically adjusted.

10. WAITING PERIOD FOR DISABILITY BENEFITS.—The existing 6-month waiting period to qualify for disability benefits would be reduced to 5 months.

The Finance Committee reduced the waiting period to 4 months.

Welfare Reform

PROVISIONS

1. OLD AGE ASSISTANCE.—The existing Federal-State adult categorical assistance programs (Aid to the Aged, Blind, and Dis-

abled) would be replaced by a new Federal program (effective July 1972), administered by the Social Security Administration. Under the new program, the Social Security Administration would make payments sufficient to bring an individual's monthly income up to $130 ($195 for a couple). For an aged person, the first $60 of monthly earnings would be excluded in determining his monthly income. States would also be permitted to make supplemental payments in addition to the Federal income standard.

The Finance Committee adopted the House income standards—$130 for a single person and $195 for an aged couple. However, the Committee provides that the first $50 of Social Security benefits would not cause any reduction in payments to bring an elderly person's monthly income up to $130 ($195 for a couple). In addition, the Committee would permit aged, blind or disabled recipients to disregard $50 of earned income plus one-half of any earnings above $50.

Taxation

1. Updating the Retirement Income Credit.—The retirement income credit would be modernized by raising the maximum amount for computing the 15 percent credit for a single person from $1,524 to $2,500 (for an elderly couple the maximum amount would be raised from $2,286 to $3,750). Additionally, the exempt earnings limitation under the law would be liberalized to correspond to the new retirement test under Social Security—a flat $2,000 exemption with a $1 reduction in benefits for each $2 of earnings.

C. Status of April 1, 1972

H.R. 1 is now before the Senate Finance Committee and is in the final stages of "mark-up." The Committee is expected to report out the bill in the very near future.

10 Percent Increase in Social Security Benefits

Signed into law in March 1971, Public Law 92–5 provides for a 10 percent increase in Social Security benefits retroactive to January 1, 1971. Under this measure 27 million Social Security beneficiaries received a $3.6 billion added boost in their annual benefits. On an individual basis, the Act had the following effects:

—Increasing monthly benefits for the typical retired couple from $199 to $219;
—Raising monthly payments for the average retired worker from $118 to $131; and
—Boosting widow's benefits from $102 to $113.

10 Percent Increase in Railroad Retirement Annuities

A 10 percent increase for Railroad Retirement annuitants was also approved on July 2, 1971. Like the Social Security boost, Public Law 92–46 makes the Railroad Retirement increase retroactive to January 1, 1971.

Increase in Veterans' Pensions

Approximately 1.6 million veterans and widows received, on the average, a 6.5 percent increase in their pension benefits on January 1, 1972. The higher benefits are large enough to prevent persons who receive VA pensions from losing any part of their payments because of the 10 percent increase in Social Security benefits, which was signed into law in March 1971. Under the new law (Public Law 92–198), the top income limitation was raised by $300—from $2,300 to $2,600 for single veterans or widows and from $3,500 to $3,800 for a veteran or widow with dependents.

Veterans' Dependency and Indemnity Compensation Payments

Public Law 92–197 provides a 10 percent increase in dependency and indemnity compensation payments for approximately 176,000 widows. Additionally, the new law, which became effective on January 1, 1972, provides an average increase of 6.5 percent in the DIC rates payable for 68,500 dependent parents.

II. PROPOSALS RELATED TO PROPERTY TAX

Housing for the Elderly Act (S. 1935)

A. Legislative History

S. 1935 was introduced by Senator Harrison Williams on May 24, 1971.

B. Provisions

The bill provides for the establishment of an Intergovernmental Task Force to report at the earliest possible date on the feasibility and desirability of: (1) Providing Federal tax relief to elderly homeowners or renters, or (2) making Federal assistance available to States granting relief to aged property owners or tenants. Relief would be limited to aged persons whose: (1) Annual incomes do not exceed $7,500, and (2) property taxes exceed 5 percent of their incomes. (For tenants, relief would be available if their rent exceeds 20 percent of their income.)

C. Status as of April 1, 1972

This measure is pending before the Senate Banking, Housing and Urban Affairs Committee.

Tax Credit For Property Taxes (S. 1960)

A. Legislative History

Sponsored by Senator Thomas Eagleton, S. 1960 was approved as an amendment to the Revenue Act (H.R. 10947) on November 20, 1971 by a vote of 65 to 19. However, this measure was later removed in Conference Committee.

B. Provisions

S. 1960 would authorize a Federal income tax credit up to $300 for homeowners who are at least 65 years of age with adjusted gross in-

comes not in excess of $6,500. For tenants, 25 percent of their rent would be considered property taxes which would be eligible for the credit provided that they met the age and income requirements.

C. STATUS AS OF APRIL 1, 1972

This proposal has been reintroduced as an amendment to H.R. 1.

PROPERTY TAX EXEMPTION (S. 3088)

A. LEGISLATIVE HISTORY

Another property tax relief measure (S. 3088) was introduced by Senator Frank Moss on January 28, 1972. This proposal has been referred to the Senate Finance Committee.

B. MAJOR PROVISIONS

S. 3088 would provide Federal incentives to States which enact senior citizen exemptions for the first $5,000 of actual value of real property. Federal reimbursement for loss of revenue to the States would be based on a formula according to the property tax rate for each $100 of actual value. However, the Federal reimbursement would be limited to an amount not in excess of $200 for each property taxpayer who is 65 or older.

C. STATUS AS OF APRIL 1

S. 3088 is pending in the Senate Finance Committee.

III. PROPOSALS RELATED TO HEALTH CARE

H.R. 1

Medicare*

1. EXTENDING MEDICARE TO DISABLED.—Medicare would be broadened to include disabled beneficiaries under age 65, provided they have been receiving disability benefits for at least 2 years.

The Finance Committee approved this measure.

2. PART B DEDUCTIBLE.—The deductible for supplementary medical insurance would be increased from $50 to $60.

The Finance Committee deleted this provision from the bill.

3. COINSURANCE UNDER HOSPITAL INSURANCE.—Beginning with the 31st day and continuing through the 60th, the patient would be subject to a charge of $7.50 per day for hospitalization. Under present law, the patient is subject to a $68 deductible. After satisfying this requirement, the patient pays nothing for his hospital bill through the first 60 days.

The Finance Committee removed this provision from the bill.

4. INCREASING LIFETIME RESERVE.—The lifetime reserve (under which the patient pays $34 per day) would be increased from 30 to 60 days.

*At this writing, H.R. 1 was still under executive consideration by the Senate Finance Committee. All changes made by the Committee are indicated in italics, and are to be regarded as *tentative* action. For discussion of legislative history and a current status account of H.R. 1, see p. 33 and p. 89.

This measure was deleted by the Finance Committee.

5. HOSPITAL INSURANCE FOR UNINSURED.—Persons reaching age 65 who are ineligible for Part A (Hospital Insurance) of Medicare could enroll under the program for $31 per month. Additionally, States and other organizations could enter into agreement with the Secretary of HEW to purchase such protection on a group basis for their retired or active employees 65 and older.

The Finance Committee adopted this measure with one modification. Under the Committee amendment, enrollment in Part B (Supplementary Medical Insurace) would be required to buy into the Hospital Insurance program.

6. PART B PREMIUMS.—Premiums for the elderly for supplementary medical insurance—now $5.60 per month but scheduled to rise to $5.80 in July—will be increased only if Social Security benefits have been raised. In no event would the premium rise be greater than the percentage increase for Social Security benefits.

This measure was adopted by the Finance Committee.

7. HEALTH MAINTENANCE ORGANIZATIONS.—Medicare patients would be able to elect to have their covered care provided by a prepaid group or other capitation plan.

The Finance Committee adopted this measure with a number of modifications. One of the key changes would limit recognition of an HMO to those organizations which demonstrate capability over a reasonable period of time to provide appropriate care and treatment to substantial numbers of enrollees. To qualify for incentive reimbursement under Medicare, an HMO, as a general rule, would be required to have at least 25,000 members (not more than half of whom may be Medicare eligibles) and to have been in substantial operation for at least 2 years. Exceptions would exist for HMO's in rural areas where the minimum size requirement would be 5,000 members and where the organization had been in operation for at least 3 years.

8. PROTECTION AGAINST RETROACTIVE DENIAL OF PAYMENTS.—Under present law, the determination of whether a patient qualifies for posthospital extended care is usually made after the services are rendered. As a consequence, coverage is frequently denied retroactively—causing hardship for the patient, the nursing home, and the physician. To help provide a solution for this problem, the Secretary of HEW would be authorized to establish minimum periods of time after hospitalization during which a patient would be presumed to require extended care.

9. SOCIAL SERVICES REQUIREMENT.—The existing requirement for social services in extended care facilities would be removed.

This measure has been deleted by the Finance Committee.

10. ELIMINATION OF 3-YEAR REQUIREMENT TO ENROLL IN PART B.—Aged persons would now be permitted to enroll in the Medicare supplementary medical insurance program during any prescribed enrollment period (under present law, individuals must enroll within 3 years after first becoming eligible).

The Committee adopted this provision. The effect of this measure is to provide for automatic enrollment of the elderly and disabled as they become eligible for protection under Hospital Insurance (Part A). Persons eligible for automatic enrollment would be informed of their right to decline coverage under the Part B program.

11. CHIROPRACTIC CARE.—A study, utilizing the experiments and experience under the Medicaid program, would be undertaken to determine the desirability of extending Medicare coverage to include chiropractic services.

The Finance Committee substituted a provision to extend Medicare coverage to services provided by a licensed chiropractor who meets certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services applicable to Medicare would also pertain to States providing such care under Medicaid.

Medicaid

PROVISIONS

1. REPEAL OF COMPREHENSIVE MEDICAID REQUIREMENT.—The bill would repeal the existing provision requiring States to have comprehensive Medicaid programs by 1977.

2. REDUCTIONS IN MEDICAID CARE AND SERVICES.—States would be permitted to eliminate or reduce the scope and extent of health care services which are optional under the Medicaid law such as dental care, eyeglasses, and out-patient prescription drugs.

However, the House-passed bill would contain the maintenance of effort provision for the six mandatory health care services now required for Medicaid programs. The Finance Committee substitute repeals the section of existing law which includes the maintenance of effort requirement.

3. DISINCENTIVES FOR LONG STAYS IN INSTITUTIONS.—Federal matching funds for Medicaid would be cut back by one-third after: (1) 60 days of care in general or tuberculosis hospitals, (2) 60 days of care in a skilled nursing home, unless the State establishes an effective utilization review program, or (3) 90 days of care in a mental hospital.

The Finance Committee modified this provision. In addition to the requirement for utilization controls, States must also undertake independent professional audits of patients to assure that they are receiving Medicaid services for the proper setting.

4. INCENTIVES FOR COMPREHENSIVE CARE.—Federal matching funds for Medicaid programs would be increased by 25 percent when a State is under contract with a health maintenance organization or other comprehensive health care organization.

The Committee deleted this provision.

5. PATIENT COSTS UNDER MEDICAID.—Medically indigent patients under Medicaid could be subject to a premium charge based on income. Moreover, States would be authorized to make the medically indigent subject to copayment provisions which would not be

based on income. In addition, States would be permitted to establish cost-sharing arrangements for categorically needy recipients—the aged, blind, and disabled—but only for services not required to be provided under the State program.

The Finance Committee agreed to the provision in H.R. 1 which would require States that cover the medically indigent to apply monthly premium charges graduated according to the person's income and resources. The Committee modified the provision in H.R. 1 which would permit States to impose copayments and deductibles on the medically indigent by limiting any such copayment to patient-initiated services only. Additionally, the Committee deleted the measure to allow the States to impose copayments and deductibles on indigent persons in connection with any optional services provided them under a Medicaid program.

Commission of Mental Health and Illness of the Elderly Act (S. 2922)

A. Legislative History

Senator Edmund Muskie introduced this bill on December 1.

B. Major Provisions

S. 2922 establishes a Commission on Mental Health and Illness of the Elderly to:

1. Develop a national policy for the proper maintenance of mental health, as well as the care and treatment of mental illness among older Americans.
2. Study the future needs for mental health facilities, manpower, research, and training to meet the mental health needs of the elderly.
3. Evaluate present mental health programs to determine if they are responsive to the needs of aged persons.
4. Develop priorities among research programs that will increase our knowledge about various aspects of mental illness among the aged.

Support for this concept was expressed in the Physical and Mental Health Section of the White House Conference.

C. Status as of April 1, 1972

S. 2922 is pending before the Subcommittee on Aging of the Labor and Public Welfare Committee.

Health Security Act (S. 3)

A. Legislative History

On January 25, 1971, Senator Edward M. Kennedy introduced the Health Security Act (S. 3). A companion measure, H.R. 22, was introduced on January 22, 1971 by Representative Martha W. Griffiths.

B. Major Provisions

Under the provisions of S. 3:

1. Medicare would be replaced by a health insurance program and Medicaid would become a supplementary program. Begin-

ning in mid-1973, there would be provision for comprehensive health insurance coverage, including preventive and disease detection services; care and treatment of illness; and medical rehabilitation.

2. There would be no cutoff points; no coinsurance (requiring out-of-pocket payments as under Medicare); no deductibles (calling for additional payments by patients as Medicare does); and no waiting period. Coverage under the program would be automatic. And there would be no "means test" (as under Medicaid).

3. Virtually all health services would be covered in full except there would be certain limitations for nursing home care; dental care; psychiatric care; and prescription drugs.

C. Status as of April 1, 1972

As of April 1, 1972, hearings on H.R. 22 and other national health plans had been completed by the House Ways and Means Committee, which was expected to meet in executive session soon to draft its own bill for a national health plan. Chairman Wilbur D. Mills of Arkansas reportedly expects these meetings to last 6 or 7 weeks.

S. 3 had been referred to the Senate Committee on Finance, which is scheduled to hold hearings on it and other national health plans after the Committee completes work on H.R. 1, the House-passed bill amending the Social Security Act.

National Health Insurance Partnership Act of 1971 (S. 1623)

A. Legislative History

H.R. 7741, the National Health Insurance Partnership Act of 1971, was introduced by Representative John W. Byrnes on April 27, 1971. A similar bill, S. 1623, was introduced by Senator Wallace F. Bennett, on behalf of the administration.

B. Major Provisions

Under the administration's plan:

1. Employers would be required to furnish a basic health care plan for all employees, purchased through insurance companies or directly from Health Maintenance Organizations (HMO's). Employers and employees would contribute to costs.

2. Family Health Insurance would be provided for the poor, with a sliding scale of expected contributions from low income families. Individuals and families could elect HMO or insurance carrier coverage. Medicaid would be discontinued for families but continued for the aged, blind, and disabled.

3. Coverage under Parts A and B of Medicare would be combined. The monthly premium for Part B would be eliminated, but coinsurance for inhospital care would be increased.

C. Status as of April 1, 1972

The comments on "Status as of April 1, 1972" in the discussion of the Health Security Act apply equally to H.R. 7741 and S. 1623.

Health Maintenance Organization and Resource Development Act of 1972 (S. 3327)

A. Legislative History

On March 13, 1972, Senator Edward M. Kennedy introduced the Health Maintenance Organization and Resources Development Act of 1972 (S. 3327).

B. Major Provisions

S. 3327 provides support for health maintenance organizations, health service organizations, and area health education and service centers. In addition, it provides for the establishment of an independent Commission on Quality Health Care and extends the authority of several sections of the Public Health Service Act important to the development and support of national health care resources.

Under the bill:

1. Health Maintenance Organizations (HMO's), intended primarily for metropolitan areas, would provide a wide range of medical services to a defined, enrolled population for a predetermined, prepaid, periodic premium. The premium would be unrelated to the actual number of services utilized by a particular enrollee in a particular time period.
2. Health Service Organizations (HSO's), intended primarily for nonmetropolitan and rural areas, would be similar to HMO's but with more flexible requirements regarding the range of services to be provided and the relationship of the providers to the central organization.
3. Area health education and service centers would be intended to bring the latest medical knowledge into medically underserved nonmetropolitan areas.
4. The Commission on Quality Health Care would create and monitor standards relating to the quality of health services delivered in the United States.

C. Status as of April 1, 1972

As of April 1, 1972, S. 3327 had been referred to the Senate Committee on Labor and Public Welfare. No date had been set for hearings on the bill, but they were expected to be scheduled for later in the spring of 1972.

Comprehensive Home Health and Preventive Medicine Act (S. 3364)

A. Legislative History

The Comprehensive Home Health and Preventive Medicine Act was introduced by Senator Hubert Humphrey on March 15, 1972.

B. Major Provisions

S. 3364 amends the Older Americans Act to promote and maintain the health of elderly persons by authorizing a comprehensive program of home health services. For fiscal 1973 the bill would authorize $150 million for the development of home health agencies. Covered services under this legislation would include out-of-hospital preventive care and diagnosis, all necessary prescription drugs, hearing aids, optional

supplies, speech pathology, audiology services, nutrition counseling, and physical therapy.

C. Status as of April 1, 1972

S. 3364 will be considered by the Senate Subcommittee on Aging during its hearings on legislation to amend, strengthen or replace the Older Americans Act.

IV. PROPOSALS RELATING TO LONG-TERM CARE

A. Legislative History

On December 1, Senator Frank E. Moss introduced 13 of his 20-bill package to improve America's system of long-term care. These bills are a result of 19 hearings which have been held by the Subcommittee on Long-Term Care over the past 3 years. On March 2, the Senator introduced the last five bills all of which fall into the category of alternatives to institutionalization.

B. Major Provisions

The following are the Moss bills by category:

Alternatives to Institutionalization

—S. 3267. Authorizing day care under Medicare.
—S. 3268. Providing supplementary nursing services under Part B of Medicare.
—S. 3269. Providing expanded homemaker services to older Americans to maintain them in their homes.
—S. 3270. To provide home health and visiting nurse services to all eligible individuals over 65.
—S. 2935. To provide for "campuses for the elderly," which would center in one location the broad spectrum of housing for the elderly, from acute hospital services on one end of the spectrum to housing for the ambulatory elderly on the other.

The Absence of the Physician From the Nursing Home Setting

—S. 2934. Establishing a National Institute of Geriatrics.
—S. 2933. Authorizing grants to colleges and universities to assist them in the establishment and operation of programs for the training of physician's assistants.
—S. 2932. To provide for the training of veterans with appropriate paramedical experience to serve as medical assistants on long-term care institutions.
—S. 2931. Authorizing grants of up to $500,000 to each of six medical schools to establish departments of geriatrics.

The Reliance of Untrained and Inadequate Personnel

The Moss bill authorizing HEW to establish inservice training programs for aides and orderlies and to work out with colleges and professional organizations, such as the American Nurses Association, a career ladder whereby aides could with experience and education move on to higher paying and more prestigious employment plateaus, is being drafted.

LAW ENFORCEMENT BY THE STATES AND THE FEDERAL GOVERNMENT

—S. 2924. Would apply the Life Safety Code of the National Fire Protection Association to Intermediate Care Facilities.
—S. 2925. Would require all nursing homes receiving Federal funds to certify their costs annually.
—S. 2926. Would require those with a 10 percent or greater interest in intermediate care facilities to disclose such interest to the State.
—S. 2927. Would close a loophole in the existing law by requiring that any interest whatsoever in a nursing home—whether by mortgage, deed of trust, note, or other secured obligation—be disclosed.
—S. 2928. Would require the Secretary of HEW to communicate directly with the Governor of a State whenever he finds a failure to comply with Federal standards.
—S. 2929. Would make public State inspection files for Medicare and Medicaid.

THE EXISTENCE OF BUILT-IN FINANCIAL INCENTIVES IN FAVOR OF POOR CARE

No legislation has been introduced but Senator Moss has encouraged States to adopt incentive reimbursement systems such as the Connecticut "points system" where a nursing home, in effect, is graded and placed into classes A, B, C, etc. The better the nursing home in the State's estimation, the higher the rate of reimbursement. A Class A home, for example, might receive $18 a day, a Class B home, $17 a day, etc.

OTHER LEGISLATION INTRODUCED BY SENATOR MOSS

—S. 2923. To provide FHA insured loans for the purchase of fire safety equipment for nursing homes. (Incorporated in the 1972 Housing bill, S. 3248, which passed the Senate on March 2.)
—S. 2930. To provide for the making of direct loans at 5 percent interest or the Government's borrowing rate, whichever is lower, for the construction of nursing homes owned and operated by churches.

C. STATUS AS OF APRIL 1, 1972

With the exception of S. 2923 none of these bills has been reported out of Committee or passed by the Senate. With the exception of S. 2930 (direct loans for the construction of nursing homes owned by churches), and S. 2935 (Campuses for the Elderly) which are before the Senate Committee on Banking, Housing, and Urban Affairs, and the bills listed under the category "The Absence of the Physician" which are before the Labor Committee, the other bills in this legislative package are pending before the Committee on Finance.

V. PROPOSALS RELATING TO HOUSING

HOUSING AND URBAN DEVELOPMENT ACT OF 1972 (S. 3248)

A. LEGISLATIVE HISTORY

The Housing and Urban Development Act of 1972 (S. 3248), which includes a number of important provisions for older Americans, passed the Senate on March 2, by a vote of 80 to 1.

B. Major Provisions

Major provisions of S. 3248 affecting the elderly include the following:

1. The authorization level of the Section 202 housing program for the elderly would be increased to $750 million, an increase of $100 million.

2. A new position of Assistant Secretary for Housing for the Elderly would be established at the Department of Housing and Urban Development to administer all of the HUD programs providing assistance to the elderly.

3. In the Multifamily Housing Assistance section (502), not less than 15 percent nor more than 25 percent of the total funds appropriated would be available for use only with respect to projects planned in whole or in part for the elderly.

4. The Secretary of Housing and Urban Development would be authorized to make additional assistance payments or rent supplement payments for up to 60 percent of the units in any multifamily housing project (section 502) in which all or substantially all of the units are occupied by elderly families.

C. Status as of April 1, 1972

S. 3248 is being considered in Executive Session by the Housing Subcommittee of the House Committee on Banking and Currency.

VI. PROPOSALS RELATING TO GOVERNMENT ORGANIZATION

Action on Aging Act (S. 3181)

A. Legislative History

In October 1971 the Committee's Advisory Council on the "Administration on Aging or a Successor" issued a comprehensive report calling for far reaching changes to streamline government organization in the field of aging. These proposals were later adopted by the Government and Non-Government Organization Section of the White House Conference on Aging. And on February 16, 1972 Senator Frank Church introduced the Action on Aging Act (S. 3181) to implement the recommendations of the Committee's Advisory Council and the White House Conference.

B. Major Provisions

S. 3181 proposes four major changes to strengthen and improve the Federal commitment in the field of aging:

1. Establishment of an independent Office on Aging at the White House level—to be headed by a presidentially appointed Assistant on Aging—to formulate policy and to coordinate programs serving older Americans.

2. Creation of an advisory council to assist the independent Office on Aging in a wide variety of capacities.

3. Upgrade the Administration on Aging by placing it under the direction of an Assistant Secretary on Aging, instead of a Commissioner as is the case now.

4. Extend the programs under the Older Americans Act for 2 years through June 30, 1974.

C. Status as of April 1, 1972

Hearings by the Select Education Subcommittee of the House Education and Labor Committee were initiated on March 1, 1972 on proposals to amend, strengthen or replace the Older Americans Act. Nine days of hearings were held by the subcommittee during the month of March. The Subcommittee on Aging of the Senate Labor and Public Welfare Committee also began hearings on similar proposals on March 3. Additionally, the subcommittee held two more days of hearings on March 22 and 23.

Further hearings are planned during April by the Subcommittee on Aging. After the conclusion of these hearings, the subcommittee will mark up the legislative proposals possibly during the latter part of April or the first part of May. The House Select Education Subcommittee is tentatively scheduled to consider similar measures in executive session in April.

Older Americans Act Amendments of 1972 (H.R. 12017)

A. Legislative History

On December 2, 1971 Congressman John Brademas proposed comprehensive changes to the Older Americans Act when he introduced H.R. 12017. This bill was referred to the Select Education Subcommittee of the House Education and Labor Committee.

B. Major Provisions

H.R. 12017 provides for a 3-year extension of the Older Americans Act and a strengthened role for the Administration on Aging, by making the Commissioner on Aging directly responsible to the Secretary of Health, Education, and Welfare. Other key provisions in the bill include:

—Establishment of multipurpose senior citizen community centers;
—A new National Information and Resource Center on the Aging to make available data on programs affecting the elderly;
—A new Gerontological Center to study the biological aspects of the aging process; and
—Provision for comprehensive services, including nutrition, transportation, preretirement counseling, health, and adult education.

C. Status as of April 1, 1972

(Discussed under the Action on Aging Act)

Older Americans Amendments of 1972 (S. 3391—Administration Bill)

A. Legislative History

S. 3391, the Older Americans Amendments of 1972, was introduced by Senator Glenn Beall on March 21.

B. Major Provisions

S. 3391 proposes to strengthen and improve State and sub-State planning capability in the following ways:

—Permit up to 8 percent of a State's total allotment to be available to enable State agencies to administer a broadened title III program;

—Allow up to 8 percent of a State's total allotment to be available to support administrative costs of new sub-State units on aging; and

—Require the new sub-State agencies to develop comprehensive plans on aging.

Additionally, the bill would require State and local agencies to develop coordinated programs which will seek to promote independent living in their homes for older Americans who are capable of self-care.

C. Status as of April 1. 1972

(Discussed under Action on Aging Act.)

Mini-White House Conferences on Aging (S.J. Res. 212)

A. Legislative History

One of the key recommendations of the Government and Non-Government Organization Section of the White House Conference was the need for a continuing mechanism to assure proper follow-up for implementation of the Conference recommendations. On March 3 Senator Frank Church introduced legislation (S.J. Res. 212) to carry out this purpose.

B. Major Provisions

S.J. Res. 212 would authorize periodic Conferences on Aging to be held every 2 years to provide a means for more indepth inquiry and follow-up on individual subjects (such as income) than was possible at the White House Conference. Additionally, these periodic conferences would provide a basis for assessing the effectiveness of the Nation's efforts in implementing the proposals advanced at the 1971 White House Conference.

C. Status as of April 1, 1972

This joint resolution has been referred to the Senate Labor and Public Welfare Committee.

VII. PROPOSALS RELATING TO EMPLOYMENT AND SERVICE OPPORTUNITIES

Emergency Employment Act (Public Law 92–54)

Signed into law in July 1971, the Emergency Employment Act authorizes $1 billion to provide public service jobs for unemployed persons, ranging from jobless professionals to welfare recipients. Of special significance to older workers is language in the report and law to assure that persons 45 and older will be adequately represented in the new public service employment programs—reasonably consistent with their proportion of the total unemployment in the United States.

Emergency Employment Compensation Act of 1971 (Public Law 92–224)

Public Law 92–224 extends unemployment insurance to workers who have exhausted all rights to both regular and extended unemploy-

ment compensation. Extended benefits were authorized under the Employment Security Amendments of 1970 which put an overall 39-week limitation on regular and extended benefits. Under the new law, an additional 13 weeks would be allowed when the rate of unemployment in an individual State equals or exceeds 6.5 percent for a 13-week period.

Older American Community Service Employment Act (S. 555)

A. Legislative History

S. 555 was introduced with strong bipartisan support by Senator Edward Kennedy on February 2, 1971. Hearings were held in July 1971 on this proposal by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee.

B. Major Provisions

S. 555 would authorize new opportunities for community service employment in a wide range of activities for low-income persons 55 and older. Additionally, this measure would provide a basis for converting the successful pilot projects under Operation Mainstream—such as Green Thumb, Senior Aides, and the Senior Community Service programs—into permanent, ongoing national programs.

C. Status as of April 1, 1972

The Subcommittee on Aging is scheduled to consider this measure in executive session in April.

Middle-Aged and Older Workers Employment Act (S. 1307)

A. Legislative History

The Middle-Aged and Older Workers Employment Act was adopted as an amendment in 1970 to S. 3867, the Employment and Training Act. However, the bill was later vetoed by the President because of his opposition to the public service employment provisions in the bill. A similar measure (S. 1307) was introduced by Senator Jennings Randolph on March 19, 1971. Hearings were held on this proposal in July 1971 by the Subcommittee on Aging.

B. Provisions

S. 1307 would establish a midcareer development services program in the Department of Labor to authorize training, counseling, and special supportive services for unemployed or underemployed persons 45 and older. Additionally, the bill would make placement and recruitment services available in communities where there is large scale unemployment because of a plant shutdown or other permanent reduction in the work force.

C. Status as of April 1, 1972

Executive sessions are scheduled to be held on the bill by the Subcommittee on Aging during the month of April.

VIII. PROPOSALS RELATING TO NUTRITION

Nutrition Program for the Elderly Act (Public Law 92–258)

One of the priority recommendations of the Nutrition Section at the White House Conference was that the equivalent of a national school lunch program should be established for senior citizens. And Public Law 92–258, which was approved on March 22, 1972, is designed to implement this goal.

Public Law 92–258 would establish a national hot meals program for persons 60 and over in conveniently located centers, such as senior citizen centers, schools and other nonprofit settings. To carry out this objective, $250 million—$100 million for fiscal 1973 and $150 million for fiscal 1974—would be authorized. Additionally, the bill would provide a basis for continuing the 21 nutrition demonstration projects which are now funded under title IV of the Older Americans Act.

IX. PROPOSALS RELATING TO SERVICES

Other legislative proposals relating to services—such as the Action on Aging Act, the Older Americans Act Amendments of 1972, the Older Americans Amendments of 1972—are discussed in section VI (Government Organization).

Legal Services for the Elderly (S. 2957)

A. Legislative History

Senator Vance Hartke introduced S. 2957 on December 6, 1971.

B. Major Provisions

S. 2957 would authorize a special emphasis program to meet the legal problems of older Americans. Specifically, the bill would authorize the training of paraprofessionals to identify and help resolve the legal issues of the aged. Additionally, the Director of the Office of Economic Opportunity would be authorized to offer assistance and advice to all agencies providing legal services and assistance to the elderly.

C. Status as of April 1, 1972

This measure is pending before the Subcommittee on Employment, Manpower, and Poverty of the Senate Labor and Public Welfare Committee.

X. PROPOSALS RELATING TO TRANSPORTATION

Older Americans Transportation Services Development Act (S. 1124)

A. Legislative History

S. 1124 was introduced by Senator Harrison Williams on March 4. A similar proposal was also incorporated in the Older Americans Act Amendments of 1972 (H.R. 12017).

B. Major Provisions

S. 1124 would authorize a special emphasis transportation research and demonstration program concentrating on:

—Economic and service aspects of transportation in urban and rural areas;
—Special services in target areas where there are high concentrations of aged persons;
—Portal-to-portal transportation services;
—Reduced price fares and their impact on the elderly's ridership; and
—Providing better coordinated services rendered by social service agencies.

C. Status as of April 1, 1972

Hearings have been initiated on this legislation as a part of the Senate Subcommittee on Aging's and the House Select Education Subcommittee's inquiry concerning whether the Older Americans Act should be continued, modified, or replaced.

Reduced Air Fares for Senior Citizens (S. 1808)

A. Legislative History

Senator Frank Moss introduced S. 1808 on May 10, 1971.

B. Major Provisions

S. 1808 would authorize reduced air fares for persons 65 and older.

C. Status as of April 1, 1972

S. 1808 is pending before the Senate Commerce Committee.

Senior Citizens' Transportation Services Act (S. 1591)

A. Legislative History

S. 1591 was introduced by Senator Percy on April 20, 1971 and was referred to the Committee on Banking, Housing, and Urban Affairs, and the Committee on Commerce.

B. Major Provisions

S. 1591 permits reduced fares for persons 65 or over on airlines and provides for reduced rates for persons over 65 on common carriers in interstate commerce. Additionally, this measure calls for prescription of accessibility standards for facilities constructed with assistance under the Urban Mass Transportation Act of 1964. It further authorizes grants for the study of transportation services for the elderly and makes it unlawful to refuse to sell automobile insurance to an individual because of age.

Status as of April 1, 1972

This measure is pending in the Senate Commerce and Banking, Housing, and Urban Affairs Committees.

XI. PROPOSALS RELATING TO CONSUMERS

Consumer Product Warranties and Federal Trade Commission Improvements Act (S. 986)

A. Legislative History

S. 986 was introduced by Senator Magnuson on February 25, 1971. It was reported out of the Commerce Committee on July 16. And it passed the Senate by a vote of 76 to 2 on November 8.

B. Major Provisions

S. 986 provides minimum disclosure standards for written consumer product guarantees and defines minimum Federal content standards for warranties. Additionally, the bill strengthens the powers of the Federal Trade Commission by authorizing the FTC to seek preliminary injunctions.

C. Status as of April 1, 1972

This measure is now pending before the Commerce and Finance Subcommittee of the House Interstate and Foreign Commerce Committee. The House Subcommittee completed hearings on similar proposals in October 1971.

Consumer Safety Act of 1972

A. Legislative History

S. 3419 is the Commerce Committee version of an earlier bill (S. 983), which was introduced by Senator Magnuson. The bill was reported out of full Committee on March 24, 1972.

B. Major Provisions

S. 3419 would establish an independent Consumer Safety Agency to protect the public from injury because of harmful or unsafe foods, drugs, or other consumer products. The bill also provides for the creation of a Consumer Safety Information Center to respond to written inquiries from consumers. Additionally, the Office of Consumer Information would conduct education programs to inform the public about certain safety hazards.

C. Status as of April 1, 1972

This measure is awaiting consideration by the Senate.

Fair Credit Billing Act

A. Legislative History

S. 652 was introduced by Senator Proxmire on February 8, 1971, and referred to the Committee on Banking, Housing, and Urban Affairs. Hearings were held in October 1971. The bill has been ordered reported out of Committee.

B. Major Provisions

S. 652 regulates communications between a creditor and a credit reporting agency whenever a billing dispute is involved. Additionally, this measure prohibits creditors from using so-called previous balance system on revolving charge accounts, prohibits creditors from imposing a minimum charge on their revolving charge accounts, and enables consumers to have an itemized explanation of their bill.

C. Status as of April 1, 1972

This measure was ordered reported on March 15, 1972.

Uniform Motor Vehicle Insurance Act

A. Legislative History

S. 945 was introduced by Senator Hart on February 24, 1971, and was referred to the Committee on Commerce. Three weeks of hearings were held in the Summer of 1971.

B. Major Provisions

This measure provides for a system of "no-fault" automobile insurance wherein the insurer shall pay net economic loss (with limitations) to persons harmed in a motor vehicle accident. Additionally, the insurer may not cancel, reject, or refuse renewal except for loss of license or failure to pay the premium.

C. Status as of April 1, 1972

This measure is now pending before the Commerce Committee.

The Truth in Advertising Act (S. 1461)

A. Legislative History

On April 1, 1971, Senator George McGovern introduced the Truth in Advertising Act (S. 1461).

B. Major Provisions

The purpose of the Truth in Advertising Act is to protect consumers by ensuring that no advertisement can be disseminated if substantiating documentation is not available to the public and by ensuring that individuals will be able to exercise their right to know and to act to promote fairness in advertising.

C. Status as of April 1, 1972

Hearings were completed on S. 1461 on October 4, 1972.

Truth in Food Labeling Act (S. 3083)

A. Legislative History

On January 27, 1972, Senator Vance Hartke introduced the Truth in Food Labeling Act (S. 3083).

B. Major Provisions

Under the provisions of S. 3083:

1. All food products would be labeled to show quality grade designations; all their ingredients; and nutritional value.
2. Additional labeling requirements would be required for perishable and semiperishable foods.

C. Status as of April 1, 1972

As of April 1, 1972, S. 3083 was pending the Senate Committee on Commerce.

Consumer Protection Organization Act (S. 1177)

A. Legislative History

On March 10, 1971, Senator Abraham Ribicoff introduced the Consumer Protection Organization Act (S. 1177).

B. Major Provisions

Under the provisions of S. 1177:

1. A Council of Consumer Advisers would be established in the Executive Office of the President, to assist the President in developing Federal consumer policy.
2. An independent Consumer Protection Agency would be established, with a wide range of responsibilities, including representing the interests of consumers in proceedings before Federal executive agencies and Federal courts.
3. A program of consumer protection grants would be established, to assist States, localities, and nonprofit private organizations to establish or strengthen consumer protection programs.

C. Status as of April 1, 1972

As of April 1, 1972, S. 1177 had been referred to the Subcommittee on Executive Reorganization and Government Research of the Senate Committee on Government Operations. Hearings on the bill were completed in November 1971, and it was being amended on a staff level.

XII. PROPOSALS RELATING TO RESEARCH AND TRAINING

National Institute of Gerontology (S. 887)

A. Legislative History

S. 887 was introduced on February 19, 1971 by Senator Thomas Eagleton. Hearings were held on this bill in June 1971 by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee. The Public Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee initiated hearings on companion proposals in March 1972.

B. Major Provisions

S. 887 would provide for the establishment of a National Institute of Gerontology as a part of the National Institutes of Health. The purpose of the Institute is to conduct and support biomedical, social, and behavorial research and training related to the aging process and the special health problems of the elderly.

C. Status as of April 1, 1972

The Senate Subcommittee on Aging plans to consider this measure, along with other aging research proposals (e.g. S. 1925), in executive session in April. The House Subcommittee on Public Health and Environment is scheduled to consider aging research proposals in April.

Research on Aging Act (S. 1925)

A. Legislative History

To promote the advancement of research in aging through a comprehensive and intensive program, Senator Harrison Williams introduced S. 1925, the Research on Aging Act. Hearings were held on this proposal by the Subcommittee on Aging in June 1971.

B. Major Provisions

S. 1925 would establish a seven-member Aging Research Commission to develop a comprehensive plan for coordinated research into the biological, social, and economic aspects of aging. Additionally, the commission would be charged with the responsibility of developing priorities for programs to increase existing knowledge about various aspects of aging.

C. Status as of April 1, 1972

(See discussion under National Institute of Gerontology.)

XIII. PROPOSALS RELATING TO MINORITY GROUPS

Cabinet Committee on Opportunities for Spanish-Speaking People

A. Legislative History

Signed into law in August 1971, Public Law 92–122 continues for 2 years the Cabinet Committee on Opportunities for Spanish-Speaking People. A major purpose of the Cabinet Committee is to assure that Federal programs are responsive to the needs of Mexican-Americans, Cubans, Puerto Ricans, and other persons of Spanish origin.

Specific functions of the Cabinet Committee include advising Federal departments and agencies concerning: (1) Appropriate action to be taken to help assure that Federal programs are providing the assistance needed by persons of Spanish origin, and (2) the development and implementation of comprehensive and coordinated policies and programs focusing on their special needs.

Asian-American Affairs Act (H.R. 12208)

A. Legislative History

H.R. 12208 was introduced by Congressman Glenn Anderson on December 13, 1971.

B. Major Provisions

H.R. 12208 would establish a Cabinet Committee for Asian-American Affairs, patterned in many respects after the Cabinet Committee on Opportunities for Spanish-Speaking People. This new Cabinet Committee would have authority to advise and direct Federal agencies for assuring that Federal programs are providing appropriate assistance for Asian-Americans. Additionally, the bill provides for the investigation of possible discriminatory practices against Asian-Americans in the areas of employment, housing, education, and other public services.

C. Status as of April 1, 1972

This bill has been referred to the Legislative and Military Operation Subcommittee of the Government Operations Committee, where it is pending.

XIV. PROPOSALS RELATING TO A MORE SATISFYING RETIREMENT

Federal Employees Preretirement Assistance Act (S. 1392)

A. Legislative History

S. 1392 was introduced by Senator Walter Mondale on March 29, 1971.

B. Major Provisions

S. 1392 would provide for a comprehensive program of preretirement counseling and assistance for Federal employees who are eligible for or approaching retirement. Additionally, the bill would require the Civil Service Commission to establish standards for this program; provide training for agency retirement advisers; and issue guidelines about related work-lifetime programs, such as phased retirement, trial retirement, new kinds of part-time work, and sabbaticals.

C. Status as of April 1, 1972

This measure has been referred to the Senate Post Office and Civil Service Committee, where it is pending.

Adult Education Opportunity Act (S. 1037)

A. Legislative History

On March 1, 1971, Senator Harrison A. Williams, introduced The Adult Education Opportunity Act (S. 1037). A similar bill, H.R. 5292, was introduced the same day by Representative Roman Pucinski.

B. Major Provisions

Major provisions of S. 1037 would:

1. Establish a Bureau of Adult Education within the Office of Education to operate, coordinate, and develop long-range planning, as well as administer any adult education programs assigned to it by the Congress or by the Commissioner of the Office of Education. It would also promote coordination and dissemination of information among such programs.
2. Establish a National Center for Adult Education which would employ an initial Federal grant for development of combined public-private funding of information and referral services throughout the Nation and for pilot projects and applied research to solve problems in the field of adult education.
3. Create an Advisory Council on Adult Education to assist the Bureau of Adult Education and to serve as the policy body for the National Center.

C. Status as of April 1, 1972

As of April 1, 1972, S. 1037 had been referred to the Senate Committee on Labor and Public Welfare and H.R. 5292 has been referred to the House Committee on Education and Labor. No date had been set for hearings on either bill.

Community School Center Development Act (S. 2689)

A. Legislative History

The Community School Center Development Act (S. 2689) was introduced on October 12, 1971, by Senators Frank Church and Harrison A. Williams, Jr. A companion bill, H.R. 11709, was introduced on November 10, 1971, by Representative Donald W. Riegle.

B. Major Provisions

Major provisions of S. 2689 include the following:

1. Federal grants would be available to strengthen and sustain existing community education centers, located at colleges and universities throughout the Nation, which would train community school leaders and, in general, promote and assist the community school movement. Federal grants would also be available to institutions of higher learning to develop and establish new community education centers.
2. Federal grants in each of the 50 States would be available for the establishment of new community school programs and the expansion of existing ones. These grants would help pay for the training and salaries of community school directors as well as other program expenses.
3. The Commissioner of Education, who would administer the Act, would also be charged with the added responsibility of promoting community schools through specific national programs of advocacy and education.

C. Status as of April 1, 1972

As of April 1, 1972, S. 2689 had been referred to the Senate Committee on Labor and Public Welfare and H.R. 11709 had been referred to the House Committee on Education and Labor. No date had been set for hearings on either bill.

XV. PROPOSALS RELATING TO RURAL OLDER PEOPLE

Older Americans Home Repair Assistance Act (S. 2888)

A. Legislative History

On November 19, 1971 Senator Frank Church introduced S. 2888, the Older Americans Home Repair Assistance Act. Support for this concept was strongly voiced at the Older Rural People Special Concerns Session at the White House Conference.

B. Major Provisions

S. 2888 would make home repair services available for elderly homeowners who otherwise would have difficulty in paying for these costs.

Under this proposal, the Secretary of Labor would be authorized to enter into contracts with public agencies and private nonprofit organizations sponsoring home repairs projects which would provide new and gainful employment opportunities for individuals 55 and older.

C. Status as of April 1, 1972

This measure is now pending before the Subcommittee on Aging of the Labor and Public Welfare Committee.

Older Workers Conservation Corps Act (S. 3208)

A. Legislative History

S. 3208 was introduced by Senator Hubert Humphrey on February 22, 1972.

B. Major Provisions

S. 3208 would promote useful part-time work opportunities in conservation and environmental improvement activities for unemployed persons who are 55 years and older. To carry out this purpose, the bill would authorize $150 million for conservation, beautification, environmental improvement, and community development projects.

C. Status as of April 1, 1972

This bill is pending before the Subcommittee on Aging of the Labor and Public Welfare Committee.

PART THREE

REPORTS AND COMMITTEE PRINTS ISSUED BY THE SENATE SPECIAL COMMITTEE ON AGING, DECEMBER 1970–APRIL 1972

U.S. Senate Special Committee on Aging publications during the past 17 months have included an unusually large number of special-purpose reports, prepared primarily to provide useful summaries on selected issues for those concerned about the White House Conference on Aging and the implementation of Conference recommendations.

The following digest of these documents is offered to provide a convenient reference to the reader who may wish more information on matters discussed in each. Individual copies may be obtained by writing to the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

REPORTS

Developments in Aging—1970

Report No. 92–46, March 1971 ..... $1.50

Serving as the annual report of the Committee, this publication also summarized recommendations made at the 1961 White House Conference and steps taken by Congress and the Executive Branch since that time. Committee recommendations for action on major issues were offered.

Income Tax Overpayments by the Elderly

Report No. 91–1464, December 1970 ..... .20

Based upon hearings earlier in the year, the report expressed criticisms of income tax forms, procedures, and policies of special concern to older Americans. Complicated retirement credit issues received special attention. One part deals with "Deductions Frequently Overlooked by Taxpayers."

Older Americans and Transportation: A Crisis in Mobility

Report No. 91–1520, December 1970 ..... .50

"Transportation—or mobility—difficulties now encountered by many elderly citizens of this Nation have reached the crisis stage," declares the introduction to this report, which provides examples of difficulties in urban and rural areas. Descriptions of reduced-fare programs, specialized transportation services, and changes in design of transit systems are offered. The report concludes that better transportation for the elderly is "a matter of self-interest" for all age

groups. An appendix summarizes proceedings of an Interdisciplinary Workshop on Transportation and the Aging conducted earlier in the year in Washington, D.C.

Economics of Aging: Toward a Full Share in Abundance

Report No. 91–1548, December 1970 ..... $1.00

Over a 2-year period, the Senate Committee on Aging conducted hearings and issued publications dealing with aspects of "The Economics of Aging." This report culminates that effort and provides new information upon the extent of poverty among older Americans, rising drains on income caused by higher health costs and property tax, the relationship of unemployment of older workers and lowered retirement income, and deficiencies in private pension coverage. Excerpts from testimony of experts and from elderly witnesses are provided.

Mental Health Care and the Elderly: Shortcomings in Public Policy

Report No. 92–433, November 1971 ..... .75

Concern over recent trends in the treatment of elderly patients in need of mental health care led to the publication of this report. Reports of "dumping" of patients from State institutions into unsuitable quarters are examined, and shortcomings in the community health center approach are also discussed. Part II offers examples of positive action taken to improve care in institutions or to assure truly effective "return to the community." Part III comprises essays by prominent authorities. Position statements by national organizations appear in the appendix.

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States

Report No. 92–450, November 1971 ..... .35

Statistical and descriptive material—prepared by Dr. Inabel Lindsay [1] in cooperation with the Research Department of the National Urban League—establish that Blacks over age 65, in the words of the author: "are less well educated, have less adequate income, suffer more illnesses and earlier death, have poorer quality housing and less choice as to where they live and where they work, and in general, have a less satisfying quality of life." An appendix item describes establishment and purposes of the National Caucus on the Black Aged.

A Pre-White House Conference on Aging: Summary of Developments and Data

Report No. 92–505, November 1971 ..... .70

This report was prepared for use immediately before and during the White House Conference on Aging. It provided the latest avail-

[1] Former Dean, School of Social Work at Howard University, member of the Planning Board of the White House Conference on Aging, and Trustee, National Urban League.

able statistical information, together with new Committee recommendations and findings. A report by the "Economics of Aging" Task Force appears as an appendix item.

COMMITTEE PRINTS

The Nation's Stake in the Employment of Middle-Aged and Older Persons

Working Paper, July 1971 ..... .35

Prepared by the staff of the Senior AIDES program of the National Council of Senior Citizens, this report describes long-term unemployment now encountered by approximately 1 million workers of age 45 and over; the limited efforts to provide service programs for older people; and lessons from the Senior AIDES program that should be heeded in a much-needed national senior service program. Appendix items include a summary of major legislation regarding employment of the elderly: 1960–70.

The Administration on Aging—or a Successor?

Committee Print Report, October 1971 ..... .30

A plan for strengthening the Federal Government organization as it relates to older Americans is offered in this report by an Advisory Council [2] to the U.S. Senate Special Committee on Aging. As requested by Committee Chairman Frank Church, the Council dealt with criticisms of the Administration on Aging since passage of the Older Americans Act in 1965. These criticisms take on additional urgency because present authority for the Act expires on June 30, 1972. An appendix to the report, prepared by the staff of the Senate Committee on Aging, provides historical background and offers pro and con arguments for varying approaches for strengthening the Administration on Aging or providing an alternative.

Alternatives to Nursing Home Care: A Proposal

A 2-Part Paper, October 1971 ..... .20

Part I of this report, prepared by Dr. Robert Morris [3] deals with the impact of long-term disability upon Medicare and Medicaid. He estimates that 250,000 to 500,000 persons annually are assigned to costly institutions for reasons other than medical needs, and he proposes development of a more efficient and less expensive system of "Personal Care Organizations."

Part II, prepared by staff specialists at the Levinson Gerontological Policy Institute (Waltham, Mass.) offers a model for mobilizing community resources to provide alternatives for nursing home care.

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[2] The 20-member Advisory Council, which included representatives of national organizations as well as individuals long associated with aging, elected Dr. Harold Sheppard, Staff Social Scientist for the W. E. Upjohn Institute for Employment Research, as its Chairman.

[3] Dr. Robert Morris, D.S.W., is Director of the Levinson Gerontological Policy Institute and Professor of Social Planning, the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University.

Advisory Council on the Elderly American Indian

Working Paper, November 1971 ..... .25

An Advisory Council [4] to the Senate Special Committee on Aging prepared this report, issued just before the White House Conference on Aging, primarily to focus attention on issues of major concern to elderly Indians. Comments are made on gaps in research, rights to old-age benefits, housing, nursing homes, nutrition, transportation, employment, health services, income, education and the need for an Indian Desk at the Administration on Aging. Part II summarizes available statistical and other research material.

Elderly Cubans in Exile

Working Paper, November 1971 ..... .20

Approximately 626,000 Cubans are now in the United States, and approximately 6.3 percent are 65 or older. In this report, Dr. Manolo J. Reyes [5] describes unique problems related to the life style of the Cuban family in the United States, workings of the Cuban Refugee Program, and issues related to housing, Social Security, and employment opportunities. He refers to a "language barrier" which makes it difficult if not impossible for Spanish-speaking persons "to understand the provisions and nuances of existing programs."

Making Services for the Elderly Work

Committee Print, November 1971 ..... .15

A seminar conducted at the University of Cambridge, England, last September provided the basis for this paper, prepared by Dr. Ethel Shanas. [6] Dealing with provision and coordination of services for the elderly, the seminar centered largely upon the implementation of the Social Services Act in Britain and Wales in April 1971. Efforts are now underway to link social and health services. The British have also arrived at a working definition of need, a step which is regarded by the author as essential in the United States, as well.

Research and Training in Gerontology

Working Paper, November 1971 ..... .30

Individual members of the Gerontological Society prepared this summary of research and training needs and declared that:

1. Public policy in aging is based upon inadequate information.
2. Where ongoing programs exist, they are often directed by persons with limited experience, or even sympathy, with gerontology.

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[4] Nineteen members of this Council elected Mr. Ronald Moore, then Assistant Director of Arizona Affiliated Tribes, Inc., Indian Community Action Project, as Chairman; and Mr. Roger Sandoval, Project Director of the Local Community Development Program Office of Navaho Economic Opportunity, as Vice Chairman.

[5] Dr. Reyes is now Latin News Director for WTVJ in Miami, Fla. In Cuba he was an attorney and executive for a radio-television station. He fled Cuba on August 23, 1960.

[6] Dr. Shanas is Professor of Sociology, University of Illinois; and Secretary of the American Executive Committee, International Association of Gerontology.

In "Bio-Medical Research on Aging," Dr. F. Marott Sinex [7] calls for a much more vigorous Federal research effort, recommending that a new Institute on Aging be established within the National Institutes of Health. In "Medical Education in Geriatrics," Dr. Joseph Freeman [8] reports grave deficiencies (and some progress) in medical school curricula related to geriatrics. In "Medical Research in the Care of the Aged," Dr. Manuel Rodstein [9] reports that a number of urgent medical problems that particularly affect the elderly are in urgent need of indepth research. In "Education and Research Training," Dr. James E. Birren [10] and Miss Kathy Gribbin [11] estimate that the need for trained personnel, specializing in services in aging, may increase by 10 to 15 times within the next two decades.

Home Health Services in the United States

A report to the Committee, April 1972_____ .60

Among the major points made in this report: Despite lipservice to the need for home health services, Medicare and Medicaid have fashioned serious roadblocks to the development of such services; the number of home health services is actually declining; less than 1 percent of Medicare expenditures now go to home health care, and even that small portion seems to be declining. Author Brahna Trager [12] gives her recommendations for improvement. Statements by 11 national organizations concerned with home health services appear in the appendix.

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[7] Dr. Sinex is Chairman of the Department of Biochemistry at Boston University School of Medicine.
[8] Dr. Joseph Freeman is an internist in Philadelphia and immediate past Chairman of the Commission on Geriatrics, Philadelphia Medical Society.
[9] Dr. Rodstein is Chief of Medical Services, the Jewish Home and Hospital for Aged, New York City.
[10] Dr. Birren is Director of the University of Southern California Gerontology Center.
[11] Miss Gibbin is enrolled at the USC Gerontology Center Ph. D. program.
[12] Miss Trager is a consultant and technical writer serving governmental and private agencies.

MINORITY VIEWS

MINORITY VIEWS OF MESSRS, FONG, MILLER, HANSEN, FANNIN, GURNEY, SAXBE, BROOKE, AND PERCY

Introduction

The Committee's November, 1971 Report entitled, "A Pre-White House Conference on Aging Summary of Developments and Data" was designed to summarize recent hearings and reports by the Senate Special Committee on Aging. It contained a rather comprehensive statement of our views.

Despite the brief interval which has intervened, fulfillment of our responsibilities to older Americans, to citizens of all ages, and to the Senate in accordance with its instructions, makes it appropriate to comment now on: (1) Progress made on behalf of older Americans, particularly during the past three year; (2) Major Federal legislation now before the Congress of special concern to persons past 65; (3) New proposals on behalf of older persons which deserve prompt consideration by the Congress; and (4) Further action, reasonably capable of fullfillment in the near future, to improve living conditions for older citizens.

Intelligent consideration of specifics in such an agenda for action, however, requires an examination of what we hope ultimately to accomplish for older persons—a careful look at our long-range goals as well as at immediate needs and probabilities.

The multiplicity of needs facing our growing older population—now numbering over 20 million persons past 65—and the complexity of problems in meeting those needs underscores the importance of a long view.

A long view in aging must begin with recognition that older Americans as a whole are too often denied opportunity for lives of dignity, independence and honor. It is essential to America that older persons be accorded a status within community and nation commensurate with their wants, capabilities, and aspirations.

Basic national policy must recognize the dynamics in aging. Great changes in the potential of older persons is inevitable through future social and scientific progress. We have already seen many such advances which change the character of age in America.

Fast action on behalf of those who are now old is essential. Such action may be self-defeating, however, if we ignore implications of progress during the last quarter of the 20th century.

Goals for Older Americans

We believe that national policy on aging must be committed to the concept of unlimited opportunity for all older Americans.

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Inherent in such a policy are basic rights to which all older Americans are entitled as citizens and human beings. Among these rights are:

1. *The right to recognition* of contributions in the past and of individual potential for the present and future,
2. *The right to life* in safety, decency, comfort and dignity,
3. *The right to choices* as to roles they may play in society and ways in which they shall live,
4. *The right to involvement* in family, community and national life as fully as personal capacity and desire permit—through social participation, communication, productivity, and exercise of responsibility.
5. *The right to growth* with recognition that—while subject to changing circumstances which may require personal adaptation—an individual's need to function and to expand personal horizons remain as long as life.

Decisions made now, or in the future, should be judged on the way in which they move this nation toward strengthening these rights.

Decisions to meet challenges in the new era of aging will be necessary by leaders in all walks of American life and at all levels of authority and responsibility. All elements of society—economic, educational, scientific, social, and religious—must be involved.

Government alone cannot and should not try to meet all needs of older Americans. Its leadership responsibilities, however, are evident.

The Federal Government in particular should give high priority to action which will:

1. Assure every elderly person of an income sufficient to provide for the basic necessities of life.

Most older Americans have been able, through their own efforts, to achieve economic independence which permits at least minimum levels of living comfort. There are many, however, who through no fault of their own are denied even the barest necessities of life. The good conscience of this Nation demands correction of these deficiencies.

2. Make fully available transportation services, recreational facilities, decent housing, adequate medical care, and other essential services or facilities at prices which all can afford.

While the primary need of older persons is for adequate income, their special needs call for special efforts to be sure that what they require in services and facilities are available to them where they live.

3. Eliminate age-related barriers to full participation in the nation's economic life.

Inevitably this necessitates a new look at retirement practices, employment policies and related attitudes manifest by government and society as a whole.

4. Expand opportunities for participation in the social life of community and nation so that their experience, skills and wisdom may be fully used to serve older Americans themselves, and the nation.

Meaningful roles in society are important to every human being regardless of age. Too often they are denied older persons to their own

disservice and the Nation's loss. Every one should have full opportunity for living with purpose, especially those who have done so much to build America.

5. Promote research of all types to insure that scientific and social advances in aging keep pace with progress in other fields and with growing needs of older persons.

Concurrent with expanding research related to aging must be improved avenues for making available to individual citizens the practical products of new knowledge so developed.

Major Impediments to Action

In looking at developments since the 1961 Eisenhower White House Conference on Aging, creation of this Special Committee on Aging later during that year, hopes generated by the 1971 Nixon White House Conference, and progress during the past 3 years, recognition should be given to 2 major and conflicting factors:

1. The need for action to solve the problems of individual older persons is urgent.

Regrettable as it is inevitable, persons who are now old simply do not have unlimited time to wait. To the extent that they have problems, early solutions are important.

2. So great is the task involved in meeting needs of older Americans, it is unrealistic to expect their immediate complete satisfaction.

Costs alone are a major impediment to early enactment and implementation of many important governmental programs on behalf of older Americans. In competition for tax dollars, the huge amounts of money required for adequate income support, medical care, housing and other necessities for the elderly are serious barriers to enactment of legislation the purposes of which we all endorse. No matter how great the need, such barriers cannot be overcome simply through wishing or through unrealistic promises.

Despite some progress, attitudes toward aging within society as a whole create equally serious obstacles to achievement of proper living conditions for older persons. They impede adequate governmental action. Thy also produce inadequate non-governmental responses to needs of older persons which sometimes may be just as important. Without new public attitudes, it will be difficult if not impossible to accord older Americans the independence, dignity, and freedom of choice which they deserve.

Nonetheless it must be acknowledged that real progress has been made since the 1961 White House Conference, the first in our nation's history, called by President Eisenhower.

Recent Progress

Some of the most important advances in our national response to problems of older persons have been made during the past 3 years. Reference is made to this progress elsewhere in this report, so we shall not try to give a comprehensive review here, but some of the highlights are worthy of special comment.

Early enactment of major legislation now before the Congress, including comprehensive proposals by President Nixon, will further improve the record.

It is not unreasonable to observe that the four years from 1969 through 1972 may, in retrospect, become recognized as a period of greatest advances in governmental support of older persons' income since enactment of the original Social Security Act.

Social Security benefit increases have already amounted to more than 26 percent. Not since 1954, during the Eisenhower Administration, has occurred such major growth in benefit levels. Further benefit increases, which we support, are almost inevitable within the next several weeks.

Control of Inflation Essential

Concurrently there has been a determined and vigorous effort by President Nixon to bring inflation under control—a goal which he recognizes as essential to maintaining the integrity of older Americans' incomes regardless of source.

It is obvious that the battle against spiralling costs of living is far from won. The roots of inflation, including Federal extravagances of the past and extraordinary expenditures of tax dollars for the Viet Nam war, have gone so deeply into our national economy that progress has been slower than any of us had hoped.

There have been momentary set backs, some of which have been most painful. Possibly there will be more in the future. It is essential, however, that the problem of rising costs of living be met.

Since the President insists that inflation is the nation's number one domestic problem—a view with which we agree—it is reasonable to assume that he will diligently apply every practical means to its further control during the months ahead.

No matter how vigorously the President wages his war on inflation, it is clear that he must have continued support in such efforts from the Congress and the people. If he receives such support, we are confident that his efforts will be attended with success.

Income levels for older Americans in general have risen during the past 3 years, even after discounts for cost of living increases. Such growth has fallen short of our hopes, and serious gaps remain, some of which we expect will be corrected momentarily, but recognition should be given to the fact that we have not stood still. The 26.5 percent increase in Social Security benefits, of course, has been most important.

Growth in Private Pensions

In any evaluation of progress, credit must be given for that within the private sector as well as government. Continuing growth of the American phenomenon of extensive private pensions has played an important role along with other private savings efforts in improving the economic position of older Americans.

Latest data shows that approximately 4.7 million retirees and their spouses were participants as beneficiaries of private pension programs at the end of 1970. With a total of over 30 million workers covered by private pension programs at the end of 1970, the private sector's involvement in retirement income becomes apparent.

Several major proposals have been presented to the Congress for legislation to strengthen the private pension system. Noteworthy among them are those by President Nixon and Senator Jacob K. Javits. They deserve serious consideration.

Concurrent with consideration of legislation regarding private pensions are the continuing efforts of the insurance industry and other financial institutions to achieve improvements and expansion of such private programs.

Gains Related to Quality of Life

There is no question but that progress in expanding income for older Americans and efforts to maintain the integrity of the dollars at their disposal are of highest importance. Concurrent with such improvements, however, there have been advances in other ways to improve services to older persons.

An enumeration of some of these positive steps to better serve the elderly of America or to strengthen their ability to provide for themselves, discussed more fully elsewhere in this report, include:

1. Increased funding for a variety of programs aimed at improving quality of life for older persons: The Administration on Aging, with a 1973 budget increased to $100 million; $100 million for an expanded program of hot meals for the elderly; tripling of funding for the Retired Senior Volunteers Program to $15 million; doubling of special job projects such as Green Thumb and Senior Aides under sponsorship of the Department of Labor; and doubling of the Foster Grandparents program funding.

2. Increases in money and emphasis for housing for older Americans subsidized by the Department of Housing and Urban Development, which will produce a record-breaking 66,000 units during fiscal year 1972, and 82,000 units in fiscal 1973. Expectations under HUD's Nursing Home and Intermediate Care Facility Programs for these 2 years are 14,000 and 18,000 units, respectively.

3. Implementation of the President's 8-point plan to upgrade the quality of care in nursing homes which has, since he enunciated it in August, 1971, resulted in training of over 400 State nursing home inspectors for Federally-sponsored programs; funding of a short-term training during fiscal year 1972 of 20,000 persons to work in nursing homes, and training of 21,000 in fiscal year 1973; employment of 142 additional persons to enforce Medicaid standards and regulations, designation of Social Security district officers as agencies to receive and investigate complaints about nursing home care, and creation of an Office of Nursing Home Affairs, under direction of Assistant Secretary of Health, Education, and Welfare Merlin K. DuVal, M.D., to provide continuing review and improvement of the Nation's nursing homes.

No one regards the 8 point program as an end of action to improve nursing homes, but it is a laudable beginning in a problem area too long neglected.

4. Announcement by the President that the Department of Transportation is to give priority to community requests for cap-

ital grants that help the elderly under the Urban Mass Transportation program.

5. A Presidential instruction to the Domestic Council Committee on Aging to determine how other government offices, such as the General Services Administration's information centers and Agriculture Extension Service offices, can be used—along with previously designated Social Security offices—as information centers serving older Americans.

6. A Presidential directive to the Secretary of Labor to take immediate steps to expand employment opportunities in both the public and private sectors for older persons.

It has been apparent for a long time that expansion of employment opportunities as envisioned in the President's directive is given high priority by older people, themselves. We believe that, because of the importance of this need for work by older persons on economic, social and psychological grounds, the President may ultimately find it desirable to involve himself personally in this matter.

He may decide that the full weight of his office should be brought to bear on expansion of part-time employment opportunities for older persons. Such approach might be far more effective than any legislative action. We request him to give serious study to this line of action.

The Expanded Nutrition Program

Expansion of the nutrition program to make available one hot meal a day at least five days a week to increasing numbers of older persons is gratifying. Increased funding for this program, which was the object of bi-partisian support, will include $100 million for the fiscal year beginning July 1 and $150 million in the year following.

The Administration on Aging has indicated it expects most of the meals to be served at senior centers, churches, restaurants after hours, and other facilities within walking distance of older people in the neighborhood.

This provision of meals at minimal or no cost to the older person has importance nutritionally; but its value extends far beyond physical satisfaction. As often stated by Senator Charles H. Percy, a primary sponsor of the nutrition program's expansion, "It is not just the hot food they get, although for many of the people it is the only hot meal they get during the day. It is also the fact that these people have someplace to go, an occasion for which to dress up; they have other people to meet and visit with."

White House Conference on Aging

Momentum for continued progress on behalf of older Americans has been generated through activities related to the White House Conference on Aging, held November 28 through December 2 under a call by President Nixon.

Under the leadership of John B. Martin, Commissioner on Aging and Special Assistant on Aging to the President, conference activities began with a nationwide series of community forums at which the elderly were asked to give their own assessment of needs and problems. Over 6,000 of these forums, attended by more than 500,000 persons were held during 1970.

State conferences on aging were then held in each of the Federal jurisdictions during the first half of 1971. Their recommendations, along with the results of deliberations by many technical committees and by national organizations of older persons, provided a base for deliberations by the conference at year's end in Washington.

Since extensive references to the recommendations by the various sections of the White House Conference are made in some detail in Part One of this report, and deserve careful consideration, we shall not labor them here. We strongly urge that every member of the Senate carefully review these recommendations in their entirety, as printed by this committee in the form of an interim report from conference chairman, Arthur S. Flemming. Every member of the Senate received a copy of this interim report from the Special Committee on Aging early in this session of Congress.

The speed with which the White House Conference section recommendations were transmitted to the Congress is a credit to Dr. Flemming as conference chairman, and to Senator Frank Church, chairman of the Special Committee on Aging.

The President's personal interest in a successful White House Conference on Aging was manifest in numerous ways including his personal appearance in a major address delivered to the delegates. No less important was his decision, early in 1971, to ask Dr. Flemming to work full time on the conference as its chairman.

Dr. Flemming, as an educational leader and former Secretary of Health, Education, and Welfare during the Eisenhower Administration, brought unique talents, experience and personal dynamism to the conference which will have a lasting beneficial effect for older Americans. The confidence reposed in Dr. Flemming by members of both political parties and by individuals with widely divergent points of view and interests was a major factor in a successful conference.

Dr. Flemming has pledged, on behalf of President Nixon, that he will vigorously continue in his role as an advocate for older persons in the future. This augurs well for ultimate achievement of conference objectives. That it is no empty gesture by either Dr. Flemming or the President, is emphasized by the latter's action in giving Dr. Flemming staff to support his efforts toward post-conference follow up on its recommendations, and naming him as Presidential Consultant on Aging on a continuing basis.

Among other steps promised by Dr. Flemming, is his announced intention, already in progress, to get information out promptly to the states on actions at the White House Conference, to hold regional and State meetings to promote their implementation, and his personal advocacy at all levels of government on behalf of older people.

It is reasonable to assume, therefore, that there will be vigorous follow up on the White House Conference within the executive branch of the Federal government, and, if Dr. Flemming's plans receive appropriate support, at the State and local levels of government as well. We sincerely hope that equally serious consideration of the conference recommendations will be forthcoming from the Congress.

Sharpened Federal Focus on Aging

President Nixon's initiatives to sharpen the Federal focus on needs of older persons and action to solve their problems, however, go far beyond his appointment of Dr. Flemming, his earlier appointment of John B. Martin as Special Assistant on Aging to the President, or his call of and involvement in the White House Conference. He has acted decisively in other ways to assure that older Americans be given full visibility at the highest levels of the Executive Branch of government and that their needs be given attention of high priority.

Creation of a Committee on Aging within the President's Domestic Council represents a major new emphasis on aging within the Federal government.

Secretary of Health, Education, and Welfare Elliot Richardson, in whose department are lodged the largest array of programs affecting the elderly, serves as chairman of this cabinet level Committee on Aging. Membership includes: Secretary of Agriculture Earl L. Butz, Secretary of Labor James D. Hodgson, Secretary of Housing and Urban Development, George W. Romney, and Secretary of Transportation John A. Volpe.

The Secretaries and Undersecretaries of the several Federal Departments concerned with meeting needs of older persons have been in attendance at its sessions. It is reasonable to assume, in view of the President's personal interest and assignments he has given to the Domestic Council's Committee on Aging, that such participation by department heads will continue in the future.

It is hardly likely that any alternative to the President's Domestic Council can offer higher status to older Americans within the Federal government. The President is to be commended on this development.

Nor is it correct to assume that Presidential initiatives to sharpen Federal focus on aging have been confined to the Domestic Council committee.

President Nixon has issued a number of directives to the various cabinet members for additional attention to needs of older persons as related to services for which they, as department heads, have responsibility, some of which have been discussed earlier in this statement. It is apparent that he is determined that the movement for progress in aging, which began with his call of the White House Conference on Aging, will be pressed forward with vigor and his full personal support.

Presidential Proposals

While insisting on first priority to his recommendations for improvement in the income status of older Americans as set forth in H.R. 1, the President has offered a number of additional proposals important to them.

It is appropriate to make brief reference to them within the context of this discussion of a sharpened Federal focus on aging.

Items in his plans include:

1. A commitment to provide relief from excessive burdens of property taxes,
2. Reformation and expansion of private pension programs,
3. More lenient treatment of persons past 65 under Federal Income tax laws,
4. Elimination of the $5.80 monthly premium for the Medical Insurance program under Medicare,
5. Full Federal funding of State nursing home inspections under Medicaid, and
6. Use of money which may be transferred from the Highway Trust Fund to development of mass transportation in such a way as to help the elderly.

No. 1 Priority: Older American Gains in H.R. 1

At the time this was written, it is expected the Senate Committee on Finance will shortly report H.R. 1 for action on the Senate floor. This bill, to be known as the Social Security Amendments of 1972, has been passed by the House of Representatives.

Social Security Act changes of importance to older Americans offered by the bill will have far-reaching implications, both immediate and long range for the aged.

Its potential impact on incomes for older persons, particularly those with lowest incomes, can be greater than any other Federal legislation since 1936. It will also correct some current deficiencies in Federal medical care programs. We strongly endorse prompt action by the Senate on these vital steps forward on behalf of older Americans.

Controversial features of H.R. 1, particularly as they relate to welfare reform, should under no circumstances be permitted to interfere with favorable action on provisions related to older persons which will improve their income status or health care.

It is with regret that we note the persistent reference to H.R. 1, as a "welfare bill." We have no intention of minimizing the importance of developing a more acceptable welfare system for the young. It is unfortunate, however, that so much attention has been given to provisions of the bill related to that subject, that the true significance of its other provisions, including those of special concern to the aging have received under-emphasis in the press and elsewhere.

The most important elements in these Social Security Amendments in our judgement, are not those related to typical welfare clients, but those of concern to more than 20 million older Americans and countless millions who will become aged in the future.

Removal of most persons past 65 from the typical welfare milieu will, indeed, be one of the most dramatic results of H.R. 1 if enacted. This is precisely the purpose and thrust of the new Title XX to be authorized by the bill.

Across-the-board cash benefit increases in Old Age, Survivors and Disability Insurance benefits (OASDI) under Social Security, which we strongly support, are of great importance to all current beneficiaries.

The immediate beneficial impact of such increases is apparent and desirable.

Other changes in the Social Security Act which embody major new concepts relating to meeting income needs of older persons, however, ultimately may be at least as important in satisfaction of our national debt to the elderly.

Older Americans Income Assurance

The older Americans income assurance provisions of H.R. 1, as set forth in the proposed new Title XX constitute a major step forward in our legitimate goal of removing older persons from poverty.

When fully implemented, the new Title XX as passed by the House of Representatives would guarantee minimum income to all citizens past 65 of $150 a month for a single individual and $200 a month for a couple. This will be accomplished through provision of Federal supplements to other income of persons past 65 sufficient to attain these National standards.

Under this program, benefits will be available to all persons past 65 regardless of their Social Security status.

Most importantly it will be a long step toward meeting income problems of single and widowed older women and other persons who had little or no chance to qualify for Social Security. Among the latter are countless retired public employees—whose contribution to America has been second to none—such as policemen, firemen and teachers.

The older Americans income assurance program as passed by the House of Representatives would be administered by the Social Security Administration.

In accordance with intent of the President when he requested action in this direction and of the House in its response to his request, certification and distribution of the Federal supplement would be carried out in a manner appropriate to the dignity with which all older persons should be treated.

We are especially pleased at this imminent new development in the economics of aging because we have long espoused such an approach. It has always had the advantages of fiscal responsibility combined with compassion for the elderly in greatest need.

The concept embodied in the new Title XX of the Social Security Act was first offered as legislation by the late Senator Winston L. Prouty, who served as ranking Republican member of the Special Committee on Aging until his untimely death last year. It was promptly recognized by us as an important step forward and included in subsequent minority views of this committee.

There may be differences of opinion as to the adequacy of income levels applicable to the new Title XX. There can be no argument, however, on the desirability of its use to replace the original State administered Old Age Assistance Programs as the primary mechanism for eliminating extreme poverty among the aged.

Over 10 years ago, we expressed deep concern about the inadequacies of Old Age Assistance programs and the loss of dignity which too often accompanied their administration. While such criticisms

were not applicable to all States, they were true for most of them and still are today.

It should be noted further, however, that nothing in Title XX proposes any cutback in State assistance to the aged from levels which now prevail. It contains provisions, on the contrary, which should encourage those few States which have forthrightly met their obligations to the elderly to strengthen such supplemental efforts.

Cost-of-Living Social Security Increases

Another new Social Security provision in H.R. 1, which was first espoused by Republican members of this Committee and urged by President Nixon, calls for automatic increases in Social Security benefits based on any rise in price levels.

First introduced in the Senate by Senator Jack Miller, this proposal provides that when living costs rise as much as 3% there shall be an increase in benefits payable.

Late in 1968, this proposal became the object of bi-partisan support for which we have previously expressed our thanks.

Too often older persons, by reason of their very situation in life, cannot wait on the legislative processes to make corrections in benefit levels based on changes in living costs. Nor should any other Social Security beneficiary be expected to do so.

OASDI Increments for Those Deferring Retirement

Another concept regarding Social Security benefit levels first recommended by Republican members of this Committee which receives some recognition in H.R. 1, is our recommendation made 10 years ago that credit be given through higher benefits to persons who defer retirement to years beyond age 65.

H.R. 1 would provide for a 1 percent annual increase in OASDI benefits for each year they are deferred past 65. We do not believe this goes far enough in correcting this major inequity within Social Security, but we recognize that even this represents a beginning.

If the principle it involves is accepted now, we will have a new precedent for progress in equity to working older persons.

Ultimately we believe that the interests of all older Americans and the Nation will be served by development of fully equitable, actuarily determined increments for those who choose to work past 65.

As pointed out by us previously, there is flexibility—and should be—in Social Security benefits for those who choose to retire early.

We repeat now our earlier recommendation that similar flexibility in Social Security be provided for those who retire late.

Higher Minimum Social Security Benefits

General increases in cash benefits under Social Security will, of course, result in higher minimum benefits under H.R. 1.

The bill goes beyond this, however, in its attention to minimum benefits for those workers with many years of Social Security coverage, but at very low earning levels.

H.R. 1 introduces a new concept regarding minimum benefits.

If adopted, as passed by the House of Representatives, the 1972 Social Security Amendments would provide a minimum retirement benefit of $5 a month for each year the worker was covered under Social Security if such coverage equals a total of 15 years, up to a maximum of $150 a month.

Thus any worker paying Social Security taxes for 30 years would be eligible for the $150 new minimum benefit.

Unlike an increase in minimum benefits without regard to the duration of a worker's attachment to the work force, this change avoids windfalls to those whose Social Security coverage is so brief as to be almost incidental.

Too little attention has been paid to this new concept and what it will do for lower income workers.

Members of minority groups, who through no fault of their own have been subjected to serious adverse earning situations throughout their lives, will be among the most favorably affected older Americans. So far as it affects them, it is at least a step forward in meeting the triple jeopardy which they often face in their later years.

Over 300,000 persons, most of whom may be assumed to be in the lowest income bracket, would be recipients of increased benefits under this provision.

The Senate Committee on Finance has approved amendments to this part of H.R. 1 which would raise minimum primary benefits to $200 a month for persons with 30 years coverage.

The Finance Committee amendment would provide for a minimum monthly benefit of $10 for each year of contributions in excess of 10.

Whatever may be the ultimate outcome of conflicting House-Senate versions, such recognition of the worker with many years of covered employment is overdue.

H.R. 1 Correction of Other Inequities

Several other major Social Security inequities to which this committee has previously given attention will be the object of corrective action through adoption of H.R. 1.

One which we discussed at length in the past relates to recognition of earnings by married couples both of whom work.

Reviewing and updating what was said in the 1967 minority report of this Committee, we find that what was said then is still pertinent.

It is common practice today for both husband and wife to work—and pay Social Security taxes. Sometimes such dual taxation continues throughout their adult life. Sometimes the wife is in the work force until a baby arrives and then resumes employment after the children have grown up or entered high school or college.

In most cases, little or no additional retirement benefits are received as a result of this dual contribution.

An example can illustrate the inequity.

Let us assume one Couple (A) in which the husband, on reaching retirement has average earnings, subject to Social Security taxes, of $4,000 a year. His wife has had such average earnings of $2,000 a year.

Another Couple (B) is one in which only the husband has been employed with average earnings of $6,000 a year subject to Social Security taxes.

The couples have made identical contributions to the system, but benefits payable at 65 discriminate sharply against couple (A).

Couple (A), assuming both receive benefits, will be paid $257.25 a month. In contrast, couple (B) would receive $336.05 a month.

This problem hardly existed prior to World War II. Since then the working wife, for part or all of her married life, has become an increasingly important factor in our economy.

Already, there are many retirees who have been injured by this treatment of working couples. The number in the future will be even greater.

We believe that this inequity is completely contrary to the original spirit of Social Security.

At least partial recognition of this problem is given under H.R. 1 in its provision to permit a married couple each of whom had at least 20 years of covered earnings under Social Security after marriage to have their earnings for each year combined up to the maximum amount of taxable earnings for that year. If they so elected, each would receive a benefit equal to 75 percent of the benefit based on the combined earnings.

We fully endorse this step forward toward ultimate achievement of equity for such workers under Social Security.

100 Percent Benefits for Older Widows

We, along with all others interested in the problems of older Americans, have long been disturbed by the treatment given to older widows by Social Security through its provision that they receive only 82½ percent of their insured husband's primary benefits upon his death, while if the wife dies first, he receives 100 percent.

There has been no justification for this discrimination against widows. It has seriously injured their ability to care for themselves after demise of their spouse.

This discrimination has been a factor in placing many older women in economic circumstances of poverty and deprivation.

We have waited too long in correcting this deficiency in Social Security and action on it through H.R. 1 is most essential.

Liberalization of the Earnings Test

H.R. 1 also offers liberalization of the "retirement test" under which Social Security beneficiaries now have deducted from their benefit checks one-half of any earnings they may have between $1,680 and $2,880 during a year and all of their earnings in excess of the latter amount.

Under the proposed change, earnings up to $2,000 a year would be totally unpenalized, and the deduction would not exceed 50 percent of earnings above that amount.

This is a step forward, which we support, but there is serious question as to whether even this liberalization is sufficient.

Updating Retirement Income Tax Credit

Badly needed updating of the retirement income credit provision in the Internal Revenue Code is another important step forward offered by H.R. 1.

The purpose of the retirement income tax credit has been to provide equitable tax treatment for persons not on Social Security or Railroad Retirement or similar sources of tax-exempt pension income, by giving such persons comparable consideration for income tax purposes.

Unchanged since 1954, the basic level of income eligible for the tax credit is now $1,542. We have long advocated liberalization of this credit provision so as to re-establish equity which recognizes increases in tax-exempt retirement income generally available through programs such as Social Security and the Railroad Retirement System.

Under H.R. 1 the credit for a single person will be based upon $2,500 instead of $1,524. For a married couple, both over 65, it will be based on $3,750.

We believe the Congress should exercise continuing review of the retirement income tax credit to maintain its equity with any and all increases in Social Security.

Improvements in Railroad Retirement

It has been customary, and properly so, for Congressional action to improve benefit levels, and other provisions of the Railroad Retirement Act, to keep pace with strengthening of Social Security.

Sometimes there has been a time lag in establishing such comparability. We urge that the Congress take speedy action on improvements in the Railroad Retirement Act this session to assure that every new or increased benefit authorized for Social Security beneficiaries shall become available also under Railroad Retirement without delay.

Improvement in Medicare

There are many major changes in Medicare, such as those related to elimination of the $5.80 monthly premium, provision of out-of-hospital prescription drugs, modifications in deductible and co-insurance features, elimination of the 3 day hospitalization requirement prior to extended care services, and others which deserve serious consideration by the Congress, which are absent from H.R. 1. There are, nonethe-less, a number of steps forward offered in the bill.

Reference is made to these new provisions elsewhere in this Committee report. Several deserve additional brief comment here.

Medicare's Retroactive Denial Problem

One of the most serious problems under Medicare in the past, for providers of care, patients and their families have been those related to denial of payment for services retroactively. This has been of consequence primarily with regard to services in nursing homes or through home health care programs under extended post-hospital care provisions of Medicare.

That refusal by the government to pay for such services has been required by provisions of the Medicare law, has in no way diminished the hardship it creates.

Patients, physicians, and extended care facilities or home health care programs have filed claims in good faith for reimbursement to which they thought they were fully entitled under Medicare, only to learn later that such claims were disallowed under the law.

This problem has been discussed at length in testimony before this Committee. It is clear, despite administrative improvements, that it has been a factor in refusal by many highly qualified providers of care to participate in Medicare, as well as a source of serious financial embarrassment to patients and their families.

We believe that full review of this problem and development of sound legislative solutions to it is of high priority.

A step in the right direction, however, is offered in H.R. 1 and should not be delayed. This part of the bill provides that the Secretary of Health, Education, and Welfare be authorized to establish minimum periods of time by medical condition during which a patient would be presumed, for payment purposes, to require post-hospital extended care services or home health services.

Dropping Medicare Enrollment Restrictions

One feature of the original Medicare act is its provision that enrollment in the supplementary medical insurance program (Part B of Medicare) by otherwise eligible beneficiaries be within 3 years of when they first become eligible.

As private health insurers have justifiably accommodated their policies for persons past 65 to Medicare, this provision has worked increasing hardship on many older Americans. It has in effect often denied them protection which they should have readily available.

Under current provisions of H.R. 1 eligible beneficiaries would be permitted to enroll in the supplementary medical insurance program during any prescribed enrollment period.

Medicare Availability to the Uninsured

Many older persons, who through no fault of their own are not covered by Social Security, are now ineligible for the hospital insurance benefits under Medicare. This has been a serious shortcoming of the law, because often this has meant no health insurance for the persons so ineligible.

For them H.R. 1 offers an opportunity for voluntary enrollment in Medicare.

Persons reaching 65 otherwise ineligible for hospital insurance under Medicare would be able to enroll for hospital insurance coverage in the same way as people can now enroll under Part B, the supplementary medical insurance section of Medicare. Such enrollees would pay the full cost of the protection, initially $31 a month.

Approval of this provision will fill a serious gap in the availability of health insurance protection for the elderly.

Medicare Coverage of Spouses Under 65

Another health insurance problem which has become apparent since the beginning of Medicare is that which occurs when a man or woman is eligible, but his or her younger spouse is not, because of age.

An amendment to H.R. 1 introduced by Senator Edward J. Gurney, and already accepted by the Committee on Finance, affords an answer to this problem through voluntary enrollment privileges under Medicare for such younger wife or husband.

This amendment, which we urge be approved by the Senate and accepted by the House of Representatives, would permit a spouse of a beneficiary who is at least 60 years old, but not yet 65, to elect voluntary enrollment in the hospital and medical insurance programs on an actuarily determined cash basis.

New Eligibility for Intermediate Care

One provision of H.R. 1, as passed by the House of Representatives, on which action has already been taken is the transfer of provision for intermediate care facilities from Title XI to Title XIX (Medicaid) in the Social Security Act.

Prior to passage of Public Law 92–223, December 14, 1971, and its approval by the President, December 28, the highly important Federal provision of support to the elderly in Intermediate Care Facilities was limited to the indigent because provisions for such care are offered only through the public assistance features in Title XI of the Act.

Last year we strongly recommended that such services in Intermediate Care Facilities be transferred from Title XI to Title XIX, Medicaid. By so doing the number of older persons eligible for Intermediate Care has been substantially increased.

Intermediate Care is important, of course, because many older persons requiring sheltered care, do not need the full range of medical services offered in a skilled nursing home. A home that is less oriented to such medical care often better serves their needs, and at a considerably lower cost.

Action on H.R. 1 Essential

The foregoing review of some of the highlights in H.R. 1 does not pretend to be complete. It does indicate, however, how far-reaching are its implications for older Americans.

It is small wonder that President Nixon has given the measure highest priority. We urge enactment of at least those provisions in it which will make such a great contribution to the lives of millions of older Americans.

We do, indeed, regard enactment of these provisions as essential to an improving national policy in aging. Important as H.R. 1 is, however, we recognize that much more will have to be done in the future regarding the issues to which it is so admirably addressed. It only represents a new beginning for a new era in aging.

An Emerging Review of National Policy in Aging

It appears that a major review of national policy toward older Americans may soon develop.

Recent proposals by the President, by distinguished members of the Congress, and a host of recommendations by various sections of the 1971 White House Conference on Aging emphasize the need for a full disclosure of pertinent facts and divergent opinions on policy.

Hundreds of thousands of citizens made contributions to the White House Conference on Aging through community forums, State conferences, and ultimately in deliberations at the Nation's capitol. Anything less than a comprehensive review of national policy on aging at the highest levels of our society would be an unconscionable rejection of their efforts.

Special problems of those who are poor, those who are members of minority groups, those who are enfeebled by great age, those who are sick, and those who are isolated should be given careful and sympathetic attention. Nor should we ignore the special needs of those more able to care for themselves who are, nonetheless, victims of age discrimination.

Social and economic roles of older Americans should be reassessed. Basic attitudes toward age by all Americans need correction. Retirement and employment practices should be reviewed. The contribution which older persons may still make to family, community and nation must be given recognition, and doors opened for their involvement in America's life as fully as individual capacities and desires permit.

Need for Independent Social Security Review

Because, in both its economic and social impact, the Social Security system is a major factor in the lives of most older Americans, a reappraisal of its character deserves high priority. Such examination is equally important because of the impact it also has on the lives of those who, as members of the work force, bear a great amount of the tax burden, especially the younger workers.

With Social Security dollar flow in OASDI cash benefits currently at $37.2 billion per year, and Medicare expenditures at an annual rate of $7.9 billion per year, there is no single enterprise in America—in or out of government—which looms so large. Practically all citizens are involved, either as recipients of benefits or as tax contributors to it.

Every Social Security change—whether designed to overcome inequities, or to change benefits and taxes, or to affect the integrity of the trust funds—has serious implications for all citizens. Accordingly, each change should receive the most careful deliberation possible.

The 1971 Advisory Council on Social Security has proposed changes in financing and acturial assumptions which have potential far-reaching effects on the whole system.

Partially in consequence of such recommendations, a number of major revisions in Social Security beyond those in H.R. 1, as passed by the House of Representatives, have been proposed.

Among them is a proposal for a 20 percent across-the-board increase in benefits.

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The President has recommended that the $5.80 monthly premium for the Medical Insurance Plan (Part B) under Medicare be eliminated. He now has under consideration the question of including out-of-hospital prescription drugs as a benefit under Medicare. Application of any available funds to these purposes obviously would provide maximum help to those of greatest age and those in greatest need.

Proposals have been made for elimination of the penalty imposed on earnings by persons otherwise eligible for benefits under Social Security.

Each of these, and a host of other improvements, merit serious consideration. They compete with each other, however, for any Social Security money which may appear to be available as a result of changed financing and actuarial assumptions.

No less important a question is the integrity of the trust funds and the system's ability to continue to make equitable benefits payable over the long run.

The Advisory Council on Social Security said, in a unanimous opinion, that changes in financing and actuarial assumptions it recommended will not undermine the Trust fund's integrity. Serious questions have been raised about these assumptions, however, by other actuarial authorities and economic experts.

In simple terms, the Council proposed that use of level-earnings assumptions in cost calculations be replaced with assumptions of persistent increases in real wages and productivity. The validity of the latter has been challenged on the basis that such increases in excess of price increases, while desirable as goals and hopeful of achievement, are not sufficiently sure to warrant their use as a basis for long-range Social Security financing.

We do not presume here to evaluate these conflicting views as to actuarial assumptions. We are determined, however, to support actions designed to maintain the soundness of Social Security financing.

We believe these questions must be resolved most carefully.

Concurrent with such resolution, we believe it important to examine the entire Social Security structure to assess how well it is serving and can best serve the American people.

We believe further that such evaluations are so important that they should be an on-going, day in and day out responsibility of government.

With all due respect to the distinguished members of the 1971 Advisory Council on Social Security, and they are truly so, we do not believe such a function should be performed on a part-time or intermittent basis.

Nor do we believe that the Social Security Administration, which has responsibility for conduct of the system's operation, should be the only source of information or the primary source of policy recommendations.

We recommend, therefore, that the Congress enact legislation to create a permanent, independent, bi-partisan commission to maintain constant surveillance of Social Security, to provide opportunity for hearing all shades of expert opinion, and to provide the President, the Congress and the people with sufficient information to give maximum

assurance that all decisions related to Social Security are well taken. Such a commission should have responsibility also for constant over-view as to the Social Security system's adequacy and performance in meeting needs of the country, and might well include an additional mechanism for adjustment of grievances against the system.

Regardless of action taken by the Congress on new proposals by the President and others, we believe that a continuing, independent over-view of Social Security is necessary if judgment by the President and the Congress are to be most valid. The people as a whole have an equally important right to know the facts.

Nothing is more basic, of course, than the certainty that the Social Security trust funds will be able to meet their total obligations. For this purpose, validity of long-range actuarial assumptions is essential. It has serious implications for any of the major changes in Social Security which have been advanced during 1972.

Such expansions, including recent proposals that Social Security benefits be increased 20 or 25 percent with no substantial increase in Social Security taxes, suggest that older Americans and taxpayers may have been short-changed under the program as it has operated in the past.

The only other reasonable conclusion is that there is willingness to jeopardize the Social Security system's integrity for the future. The first responsibility of a full-time Social Security Commission would be to assure that the President, the Congress, and the people have the facts.

Social Security is too important to Americans of all ages to permit its future to depend on decisions by the Federal operating agency, a part-time advisory council, and intermittent review by the Congress. It needs continuous supervision and review by a full-time agency independent of the program's administrators.

The Senate Finance Committee and the House Ways and Means Committee have in the past done a remarkable job on Social Security It has been doubly remarkable in view of their limited staffs and their other important legislative responsibilities.

In view of the magnitude of such responsibilities, it would seem appropriate that a Commission be established to assist these committees and the President in maintaining constant and high level surveillance of the Social Security system.

Properly devised, we believe an independent bi-partisan commission can be of great service to both of these distinguished legislative committees.

One-third of income for older Americans is derived from Social Security.

For the average worker (with an income of $7,200 a year) the Social Security tax load amounts to over 90 percent of what he usually pays in Federal income tax.

Anything less than full-time surveillance of such a huge program now appears undesirable.

Regardless of improvements in Social Security enacted during this session of Congress, and we believe them essential for today's needs, the record indicates the desirability of the permanent, independent,

bi-partisan review of Social Security which we recommend. The American people, young and old, should be given the assurances about their own security that it could provide.

Tax Problems of the Elderly

As pointed out in previous reports of the Special Committee on Aging and again in some detail in Chapter II, Part One of this report many older Americans face serious problems because of high property taxes on their homes.

Without repeating what has been said elsewhere, it is clear that action to reduce the often devastating effect of rapidly rising real estate taxes as they apply to all citizens, and particularly the elderly, should receive high priority at all levels of government.

The President has announced his intention to provide leadership in serious efforts to reduce inequities in the present antiquated system. We urge the Congress to lend full support to every reasonable proposal, including revenue sharing with State and local governments, to develop a more acceptable tax base.

As in the past, we also urge State and local governments to give serious consideration to ways of lightening the property tax burden on older home owners. Some progress has been made in this direction. It should be continued and strengthened.

All individuals required to file income tax returns have faced problems because of their complexity. Special difficulties encountered by older persons have been the object of earlier consideration by the Special Committee on Aging. Such concern should be continued.

Legislation to exempt many older persons from the requirement of filing returns has obviously been helpful.

Serious efforts have been made by the Department of the Treasury to reduce problems by improvements in the tax forms. It is extremely important that this effort be pursued with constant deligence, particularly as it relates to older persons.

Extending the Older Americans Act

Even when we have achieved our goals related to fully adequate income, financing of medical care, availability of decent housing and similar items recognized as absolute necessities for older Americans, there will still remain major areas of need among the elderly which must be met.

Regardless of the speed with which we may act in providing the so-called basic necessities, we should brook no delay on action in other areas related to quality of life for older persons.

Full recognition of this was given when the Congress adopted the Older Americans Act of 1965 without a dissenting vote in either the House of Representatives or the Senate.

Without prompt action by the Congress, this important program for the elderly authorized by the 1965 Act will be subject to termination June 30.

Legislative Committees in the House and Senate recognize this and now have under consideration a number of proposals for extension of the Older Americans Act.

We recognize that the precise character of such extension has been the object of some differences of opinion. We recognize, too, that the attitude of the Executive Branch of the Federal Government will be a major factor in ultimate success for the Older Americans Act purposes regardless of the precise form the extension takes. Experience with the Older Americans Act of 1965 under both Democratic and Republican Administrations underscores the validity of that fact of governmental life.

As observed earlier in this statement of our views, we believe there is clear evidence that the present national administration is "on the move" in meeting the challenges of aging now before us.

New directions related to work of the President's Domestic Council on Aging, the Administration on Aging, and the continuous personal involvement of H.E.W. Secretary Elliott Richardson and former H.E.W. Secretary, Presidential consultant, Arthur S. Flemming are most encouraging. Recognition of these developments must be factors in action on the Older Americans Act extension.

Whatever may be the exact language of amendments to the Older Americans Act which will emerge from the Senate Committee on Labor and Public Welfare, we believe it essential that ultimate action, legislative and executive, must produce a result compatible with the original intent of Congress in 1965 that the needs and aspirations of older Americans be given a very high status and visibility within the Federal government. Any less adequate response would be regarded by us as unsatisfactory.

Research in Aging

Important too for quality of life among older Americans in the future is the potential offered by well conceived and adequately funded research.

To ignore the contributions possible to older persons by all kinds of scientific research is unrealistic.

Medical research of all types, including that directed at major sources of health problems among the elderly such as cancer, osteomyelitis, cardiovascular disease, and arthritis, obviously have major significance for older persons.

Atomic research, while less obvious in its implications, is also creating potentials for progress in aging. In truth every expansion of scientific knowledge can ultimately have an effect on older persons.

Other types of research, including that related to social aspects of aging, is also important.

While the elderly may share in benefits of all research, it still remains important, as we have said in the past, that there be adequate funding of gerontological research as a special entity.

We strongly recommend that the Congress give serious consideration to valid proposals for expanded research before it.

Whatever improvement will be afforded by action to strengthen our Nation's research related to aging, it is of paramount importance that all new knowledge so developed get to the people as promptly as possible.

Our concern with research is primarily related to its possible benefits to individual persons in their daily lives. We urge that social and scientific research personnel never forget our ultimate objective. They and all others with influence on our research projects have an obligation to shape their work for its earliest and most decisive impact on the lives of persons.

Questions on Aging in the 21st Century

While we have hopes for near-term benefits from research, it is inevitable that much of its importance will relate to years ahead. This but reinforces our belief that current deliberations regarding national policies in aging must include the long-view.

Scientists already maintain that life expectancy within 3 decades may well be closer to 90 or 100 years than to the current 70.

If there is validity to such predictions, it is apparent that the most significant gains will be those in the later years of life. Such gains, predicated at least in part on anticipated break-throughs in cancer, heart disease, osteomyelitis, and arthritis, will certainly produce a new older generation with even greater capacities and zest for life than the present one—which certainly now contrasts sharply with those of previous eras.

All of this strongly emphasizes the need for recognition that the 21st Century, but 28 years away, will pose new and serious questions related to policies in aging.

Older Americans of today, sensitive as always to needs of their children and grandchildren, would be among the first to insist that long-range considerations be acknowledged as we take forward steps on their behalf today.

Some of the implications of such considerations have been discussed in previous minority reports of this Committee, including needs for reappraisal of basic concepts regarding retirement practices. We will not repeat them here except to reiterate our belief that the challenges on aging in the future will require full application of the best brains and thinking within our society.

A Recapitulation of Recommendations

There are grounds for optimism that a number of the proposals which we have discussed in the foregoing pages—and others on which we have expressed concern in previous reports, including that of November, 1971—will be adopted, or the principles on which they are based accepted during the present session of Congress.

Fundamentally, we believe that: (1) no individual should be denied opportunity because of age, and (2) our Nation cannot afford to waste the resources of talent and experience to be found among its older citizens.

We recommend:

1. Automatic cost-of-living increases in social security, and railroad retirement benefits to keep pace with increases in cost of living;

2. Enactment of an older Americans' income assurance program, which will provide economic support sufficient to provide economic guarantee that the elderly enjoy a decent standard of living;

3. General increases in social security and railroad retirement benefits;

4. Payment of 100 percent of primary social security benefits to aged widows instead of the present 82½ percent of amounts payable to surviving covered workers;

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. Upward adjustments in social securial beenfits for married couples both of whom work and thus pay dual social security taxes without receiving higher payments when they became OASDI beneficiaries;

7. Extension of social security, financed from the general fund of the Treasury, to more people not covered by an adequate retirement program;

8. Further liberalization of the social security earnings test to permit social security beneficiaries to earn more money without penalty;

9. Revisions in the veterans pension program to protect the right of veterans to a fair share of higher income levels among older Americans;

10. Vigorous efforts to expand and improve the Nation's unique private pension system;

11. Expansion of job opportunities, full time and part-time, for older persons desiring employment;

12. Expansion of Medicare enrollment privileges so that persons over 65 not otherwise eligible under social security coverage may participate by buying into the program;

13. Expansion of Medicare enrollment privileges so that spouses of insured persons' spouses who are under 65 may enroll in the program by buying into it;

14. Removal of the present requirement that a Medicare beneficiary must necessarily have 3 days of prior hospitalization to be eligible for extended care;

15. Reexamination of coinsurance and deductible features of Medicare to determine how best the liabilities they impose on beneficiaries may be lightened without injury to the program's financial integrity;

16. Elimination of retroactive denials of extended care facility and home health agency benefits obtained in good faith under Medicare;

17. Prompt consideration of how best to relieve older people of excessive burdens imposed by costs of medical appliances, drugs, and needed professional services not now covered under Medicare;

18. Provision of an unlimited long-term institutional medical care benefit for all persons over a specified advanced age, such as 80 years;

19. Strengthening Federal support for private elderly housing under both mortgage insurance and direct loan programs;

20. Improvement of public housing programs to make them more responsive to special needs of older persons;

21. Updating of the retirement income tax credit provisions of the Internal Revenue Code;

22. Restoration of full deductibility for medical and drug expenses, subject to a reasonable ceiling, from older persons' incomes subject to Federal taxation;

23. More liberal tax incentives for persons making substantial contributions to the support of needy elderly relatives;

24. Encouragement of appropriate property tax relief measures for older persons at State and local government levels;

25. Adequate financing for research in the field of aging;

26. Creation of a Federal research agency for continuing in depth study of economic, physiological, psychological and social factors in aging as a basis for evaluating policies and programs affecting older Americans of the present and the future;

27. Expansion of economically feasible "second career" and volunteer service opportunities to enable the continued involvement of retirees in the mainstream of community life;

28. Development of transportation services with particular reference to special needs of older persons;

29. Better funding of State commissions on aging with special emphasis on community level programs such as senior centers, homemakers, meals on wheels and friendly visitor services, and educational, social and recreational activities designed to combat the twin fears of aging—loneliness and frustration;

30. Upgrading of the Administration on Aging and strengthening its ability to serve as a focal point for coordination of Federal activities and programs in behalf of older Americans;

31. Basic support of the President's efforts to control inflation, and of needed changes in policy by those in control of Congress to reduce unnecessary Federal spending; and

32. Creation of an independent, permanent bi-partisan Commission to maintain constant over-view of the Social Security system.

In view of President Nixon's personal commitment to aggressive action in the field of aging, which we are confident will be reflected in his decisions at appropriate times, the tenor of current sentiment within the Congress, and new manifestations of interest within the whole Executive Branch of the Federal government, we believe there is justification for optimism regarding the immediate future of older Americans.

At the same time, it is essential that non-governmental elements of our society recognize that attitudes on aging suitable to the 19th century cannot meet the needs of the 20th century.

We also believe that attention must be given to research—scientific and social—looking to future progress and changes needed to meet developments in the long-range future.

We believe that the wisdom, experience and talents of today's older Americans should be used fully as we develop answers to these challenges of today and tomorrow.

We share the view expressed by members of the White House Conference on Aging section on Retirement Role:

> As we grow older, we continue to need to occupy roles that are meaningful to society and satisfying to us as individuals. However, we emphasize the primacy of such basic necessities as income, health, and housing and these needs must be adequately met.
>
> Twenty million older people with talents, skills, experience and time are an inexhaustible resource in our society. We represent all segments of the population; our abilities, our educa-

tion, our occupational skills, and our cultural backgrounds are as diverse as America itself.

Given proper resources, opportunities and motivation, older persons can make a valuable contribution. We are also capable of being effective advocates of our own cause and should be included in planning, in decision making and in the implementation of programs. Choice of roles must be available to each older person despite differences in language and ethnicity, and limitation because of disability or level of income. The lives of Americans of all ages will be enriched as the Nation provides opportunities for developing and utilizing the untapped resources of the elderly.

HIRAM L. FONG,
JACK MILLER,
CLIFFORD P. HANSEN,
PAUL J. FANNIN,
EDWARD J. GURNEY,
WILLIAM B. SAXBE,
EDWARD W. BROOKE,
CHARLES H. PERCY.

INDIVIDUAL VIEWS OF MR. ROBERT T. STAFFORD

It is with a sincere regret and understanding of the position of my colleagues, that I find I am unable to join with either the minority or majority views concerning developments in aging in the United States. In truth, I find myself in almost complete agreement with most of the statements made by both the minority and majority about the unmet needs of the elderly and with most of the recommendations designed to help our senior citizens enjoy a better life in their winter years.

However, I am concerned over what I sense to be a partisan struggle to embrace the elderly as a national political bloc; a struggle to propose a Republican or a Democratic "solution" to the elderly problem. I am further concerned over what I sense to be an effort to separate completely the problems of the Nation's older citizens from those of other segments of our Nation.

As I stated with one of my colleagues and in the individual views filed with the Pre-White House Conference on the Aging report, "We think it must be honestly said that we as a society in a nation have not done enough. It is our hope that the highly political nature of these reports will not turn . . ." the need to help the elderly into a political battleground that has occurred in the past, on social programs.

It does a disservice to the elderly, I feel, to even hint at the suggestion that the elderly and their advocates strike out in competition for limited national resources at the possible expense of their children and their grandchildren.

While I agree that, because of the limited time left, there is a need for prompt action to help the elderly, it would be short-sighted national policy to deal with the problems of Americans on a crash basis only when they reach the age of 60 or 65, without regard to correcting the underlining causes which create the problems.

As I indicated earlier I do agree with the urgent need to deal with the unmet needs of the elderly *today*. However, on the long run basis, I would like to emphasize the following important points that we must consider.

It does no good to advocate a national policy that tries to treat the elderly who are ill because the national policy failed to provide them earlier in life with programs that could have kept them healthy.

It does no good to advocate a national policy to attack poverty among the aged when the national policy has failed to attack the conditions that earlier in their lives created that condition of poverty.

It does no good to advocate tax relief for our elderly if we do not undertake a meaningful and just tax reform for our whole society in which everyone bears a proportionately just burden for the support of the country.

It does no good to advocate expanded Federal programs for the elderly, such as food stamps, if hindering regulations are proposed and bureaucrats are permitted to discourage any participation within the programs for those who need them.

It does no good to advocate inadequate increases in Social Security benefits for the elderly if the burden of the tax to pay these increases falls too heavily upon the poor and the middle-income segments of the country.

It does no good to advocate a national policy that calls for a crash program to save the homesteads of the elderly when the national policy earlier ignored the conditions that created that crisis.

It does no good to advocate a transportation system for the elderly when the Nation as a whole lacks an adequate mass transportation system for the low and moderate income person.

It does no good to advocate programs that concentrate on the urban blight and poverty of the elderly at the expense of the rural areas.

It does no good to advocate increased employment of older Americans when as a Nation we have a severe unemployment problem.

In substance, I am concerned over the possible interpretation that there are some who are suggesting an advocacy for the elderly separate from that of younger families and children who are also in great need and who in turn will suffer when they are "the elderly" a generation from now.

Americans are one people. If the conditions of the older American are to be substantially improved in this generation, all America, both young and old, must move forward together or if we do not, neither segment will make any substantial progress. We must guard against the temptations that would cause us, however inadvertently, to advocate policies that would widen the generation gap through a dichotomy of government actions.

ROBERT T. STAFFORD.

APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. ACTION

JANUARY 28, 1972.

DEAR MR. CHAIRMAN: Since July 1, 1971, ACTION has been devoting itself to the task of bringing together volunteer service programs designed to aid all who need and wish to help at home and abroad. The new agency is taking what President Nixon calls "the first step toward a system of voluntary service which uses to the fullest advantage the power of all of the American people to serve . . . the nation."

ACTION brought together from throughout the federal government seven volunteer service programs whose purposes and spirit remain intact, but whose goals and effectiveness are being sharpened and expanded to deal better with the pressing social requirements of the 1970s. On both the international and the domestic fronts, ACTION programs are tailoring the experience of the past decade of volunteer service to the realities and needs of today. ACTION includes:

—VISTA (Volunteers in Service to America)—sends volunteers to work in locally sponsored projects to alleviate poverty in the United States and its territories. VISTA was previously a program of the Office of Economic Opportunity (OEO).

—PEACE CORPS—sends volunteers abroad to help the people of 56 countries of the developing world to attain a higher level of social and economic progress.

—SCORE (Service Corps of Retired Executives)—utilizes the skills and experience of America's retired businessmen and women as volunteer consultants to small businessmen with management and operating problems. Both SCORE and its complement ACE (below) came to ACTION from the Small Business Administration.

—ACE Active Corps of Executives)—provides the voluntary counsel of active executives on an "as needed" basis to small businessmen.

—FOSTER GRANDPARENT PROGRAM—enables men and women over the age of sixty to provide companionship and guidance to children in institutional settings. This well-received and mutually rewarding program was originally under the Office of Economic Opportunity and subsequently was administered by the Department of Health, Education and Welfare (HEW).

—RSVP (Retired Senior Volunteer Program)—offers opportunities for older citizens to use their talents in community service projects. This program came to ACTION from HEW.

—OFFICE OF VOLUNTARY ACTION LIAISON—encourages interest and participation from the private sector in ACTION programs; maintains liaison between ACTION and non-federal government officers and organizations; and finds and coordinates career opportunities for former volunteers. The program which has evolved from an earlier Office of Voluntary Action, was formerly carried out by HUD.

ACTION is actively seeking ways to build on the strengths of its Older Americans' Programs toward a comprehensive volunteer program for all who wish to join in service.

Pursuant to your recent request, I am enclosing a report of the programs and program accomplishments of older Americans serving in ACTION programs.

With best wishes.

Sincerely yours,

JOSEPH H. BLATCHFORD, *Director.*

[Enclosures]

ACTION/VISTA

Volunteers in Service to America (VISTA) has always sought older Americans as Volunteers. Presently more than 10% of all Volunteers are over age 50. Four hundred and twelve were serving in 155 different projects in December 1971.

A total of 3,075, or 12 percent of the overall VISTA enrollment since the program's inception, are or have been in the age 50 and over category. Nearly half have served in VISTA for more than one year. They represent every profession and skill and bring to impoverished communities a wealth of experience and workable knowledge.

VISTA is recruiting more older Volunteers. The emphasis on attracting the skilled Volunteer is opening new channels for retired specialists to contribute their abilities. In addition, VISTA has made special efforts to recruit, train and select older poor persons as Volunteers to serve in their own communities.

Most VISTA activities include reaching older persons in every community. Both older and younger Volunteers are channeling the available skills and talents of older poor persons to increase both their incomes and sense of worth. For example, younger Volunteers are working with the Missouri Associated Migrant Services in southeastern Missouri to help find markets for crafts produced by older poor persons.

In other cases, VISTA Volunteers help older persons to obtain services designed for them and perhaps even more importantly, to involve them in community activities.

Additional information and applications to become a VISTA Volunteer are available from ACTION, Washington, D.C. 20525.

INTERNATIONAL OPERATIONS

Peace Corps programs are not designed to have specific impact on the problems of the aged in America, but the Peace Corps does offer a challenging and rewarding opportunity for Volunteer service abroad to older Americans. There are now more than seventy Peace Corps Volunteers over the age of sixty serving around the world in a wide variety of Peace Corps programs. A sampling of the activities of these older Volunteers is described in the brochure, "Where Age is An Asset" (copy attached).* By serving as teachers, as technicians, as health workers, as librarians, as farm advisers, these older Americans are beginning new and exciting careers of service. And the skill and knowledge they have acquired through a lifetime of experience is being put to work on the social and economic development problems of Peace Corps Host Countries. Contact ACTION, Washington, D.C. for further information.

ACTIVE CORPS OF RETIRED EXECUTIVES (ACE)

The Active Corps of Retired Executives (ACE) supplements the expertise found in SCORE. It has approximately 2,000 men and women who are actively involved in their own businesses in a major industry or a professional field relating to small business, but who can take time to voluntarily counsel small business on an "as needed" basis in their communities.

They help the small businessman plan soundly for new ventures and counsel him on the solutions of business problems. Volunteers are recruited from local associations, service clubs, business concerns, educational institutions and civic groups.

*Retained in committee files.

Additional information may be secured by contacting the local ACTION or Small Business Administration field offices, listed in the telephone directory under U.S. Government, or by writing ACTION, Washington, D.C. 20525.

Service Corps of Retired Executives (SCORE)

The Service Corps of Retired Executives (SCORE) is a volunteer group of more than 4,000 men and women who have successfully completed their own business careers and now offer their services, without pay, to help others with management or operational problems. They are organized into over 170 chapters throughout the country.

The program is sponsored by ACTION and the Small Business Administration through their field offices in more than 70 cities. This is in support of the findings of a presidential task force which said in essence that the basic need of small business today is sound management counseling.

SCORE volunteers serve in their local communities providing valuable help to any small businessman who cannot afford a professional business consultant. The collective experience of SCORE volunteers spans the full range of American enterprise and the following will serve as examples of typical problems SCORE can and does resolve:

—The busy restaurant in Denver with delicious food and reasonable prices, but no profits.
—The grocer on main street who let credit get out of hand and faced bankruptcy.
—The retired serviceman who sought SCORE counsel on considering a franchise offer before risking his life's savings.
—The farmer in Idaho who had a business problem concerning marketing.
—A small manufacturer must diversify when his major customer is acquired by a competitor.
—The owner of a minority day-care center in Georgia whose facilities were inadequate needed SCORE help to activate change.
—A VISTA community project needed SCORE counseling in setting up an accounting system for their cooperative.
—The thousands of people each year who consider going into business and take advantage of the "Going Into Business Workshops" sponsored by SBA and SCORE in major cities.
—The veteran not long out of the service who is not making it in a hastily acquired retail gift shop.

Volunteers in SCORE work free, but are reimbursed for out-of-pocket expenses. Additional information may be secured by contacting the local ACTION or Small Business Administration field offices, listed in the telephone directory under U.S. Government, or by writing ACTION, Washington, D.C. 20525.

Retired Senior Volunteer Program

The Retired Senior Volunteer Program was authorized by the Older Americans Act Amendments of 1969. An appropriation of $500,000 was made at the end of 1970, permitting the Administration on Aging to issue Rules and Regulations and to fund eleven programs before July 1971. A study of senior volunteer programs, contracted for by the Administration on Aging with a private consulting firm, was completed in June. Their report, "Recommendations for Developing RSVP, the Retired Senior Volunteer Program", may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, for $3.00, by reference to Stock Number 5600–0001.

On July 1, in accord with Executive Reorganization Plan No. 1 of 1971, the Retired Senior Volunteer Program was transferred to ACTION, a newly formed citizens' service corps. In August an appropriation of $5 million was made for the program for fiscal year 1972. This appropriation was increased to $15 million late in December, 1971. A two-step grant application procedure was developed by ACTION, using a preliminary inquiry approach and an RSVP grant application. At the end of the year a plan for RSVP Development Grants was devised by ACTION for implementation, preferably, by State agencies on aging. The intent was to facilitate sound program development of individual projects by local communities.

The purpose of the Retired Senior Volunteer Program is to develop a recognized role in the community and a meaningful life in retirement for older adults through significant volunteer service. Retirement from work activities, combined with separation from family and loss of friends and established relationships, often deprives older adults of contacts and resources that might permit them to engage in meaningful activities. Many persons of retirement age need help to find personally satisfying opportunities to be usefully involved in community life, to contribute a full measure of their talents, abilities and experience. The focal point of RSVP activity is the needs and interests of the Senior Volunteer.

ACTION grants are awarded to support the development and operation of local programs providing community volunteer opportunities for persons 60 years of age and over, and for out-of-pocket expenses for these volunteers, covering costs incident to their service, such as transportation.

A Retired Senior Volunteer Program is inherently a local program. It is locally planned, operated, controlled and supported. During the project period, which can be as many as five years, an RSVP operates with Federal financial and technical assistance under ACTION guidelines, rules and regulations. Federal funding is provided on an annually decreasing basis, explained fully in the RSVP Program Information Statement available from ACTION.

Local Retired Senior Volunteer Programs encourage organizations and agencies to develop a wide variety of volunteer opportunities for retired persons. Volunteer opportunities are arranged to match the interests, abilities, and physical capacities of older persons who wish to become volunteers through RSVP. Older adults are actively encouraged to contribute their time, experience and skills to facilitate resolution of local problems. There are no income, education or experience requirements for a retired person to become a Senior Volunteer.

Specific assignments arranged for Senior Volunteers offer varied types of opportunities for them to serve people of any age. Assignments occur on publicly owned and operated facilities or projects and on local programs sponsored by private, nonprofit organizations (other than political parties). Examples are schools, courts, libraries, museums, hospitals, nursing homes, day care centers, institutions and programs for shut-ins. Volunteers under RSVP may not be assigned to projects involving the construction, operation, or maintenance of any part of a facility used or to be used for sectarian instruction or as a place for religious worship. Volunteers assigned under RSVP cannot displace employed workers or impair existing contracts for services.

Applications for project grants for the operation of Retired Senior Volunteer Programs may be made by local public agencies and nonprofit private organizations. Highest priority is given to those applicants which possess the greatest number of the following characteristics:

Established commitment to the needs and interests of all older adults in community without regard to income, education and experience.

Multi-purpose organization having a broad focus of involvement with community problems.

Good working relationships with a wide variety of community organizations and agencies.

Recognized capacity to operate direct community service programs.

Experience in developing volunteer service opportunities.

Strong base of local financial support and the capacity to develop additional sources of local funding.

Foster Grandparent Program

One of the best known and most successful programs of service by older persons is the Foster Grandparent program. The program was initially developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging to demonstrate the capability and willingness of older persons to make valuable contributions to their communities. The program was jointly administered by O.E.O. and D.H.E.W. until the Older Americans Act Amendments of 1969 transferred the Foster Grandparent program entirely to the Department of Health, Education, and Welfare, where funding and administration occurred through the Administration on Aging and the regional offices of the Social and Rehabilitation Service. On July 1, 1971, the Foster Grandparent program was transferred to ACTION, the newly formed citizens' service corps, in accord with Executive Reorganization Plan No. 1 of 1971.

Initially, the Foster Grandparent program explored 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. That premise was almost immediately established and the program concept has expanded to serve children in a wider range of settings including correctional institutions, hospitals, mental health clinics, Head Start programs, and classes for exceptional children.

Currently 67 Foster Grandparent projcts serving over 200 different child care settings in 40 States and Puerto Rico, are utilizing over 4,400 foster grandparents per day. Although no new projects were funded in 1971, the Fiscal Year 1972 appropriation provides for a very significant increase in the Foster Grandparent program. This increase arises from the President's announced decision at the White House Conference on Aging to increase the budget for the Foster Grandparent program to $25 million in Fiscal Year 1973, and from Congressional action which amended the FY '72 appropriation to provide the full $25 million in 1972. This appropriation will enable ACTION to increase the number of Foster Grandparent projects and it will provide funds for approximately 11,000 foster grandparents to serve 22,000 children each day and about 50,000 different children a year in over 450 child care settings.

The foster grandparents serve a total of four hours a day, five days a week and receive a stipend of $1.60 per hour for their service. In addition, the foster grandparents are reimbursed for transportation costs and, where possible, are provided with a nutritious meal daily. They are covered by accident insurance and each foster grandparent receives an annual physical examination. An extensive orientation program is provided, and through the professional staff of each program, foster grandparents receive counseling on personal matters and information regarding benefits available through Social Security, Medicare, legal services and other community, State and Federal programs. Most importantly, the Foster Grandparent program offers to older persons an opportunity to serve their communities and themselves, to live with the increased self-esteem, independence and socialability that is vital to the enjoyment of later years.

In many instances the Foster Grandparent program offers to the children served an opportunity to more fully participate in the activities and joys of life. The following stories demonstrate that foster grandparents are needed and do provide an essential service to the children with whom they work and the entire community in which they live.

Maria was four when a social worker found her closeted with her younger brother in the filthy attic of her home. Each was a virtual "wild child," incapable of walking or talking, or registering emotion. They crawled naked through litter on the floor and the mattress on which they slept.

The children and their mother, a mental retardate, were sent to the State Hospital, where a foster grandparent met Maria eight years later. Still, at twelve the girl could not speak. Her hair was disheveled, her clothes torn, her face dirty; she sat in a corner flipping a rag back and forth through her hands and slapping the floor hard.

Maria has had the same foster grandparent for three years visiting her at the hospital five days a week for two hours each day.

So great were the ravages of her early years, that Maria will probably remain in the hospital for the rest of her life. But, now she is an attractive, smiling teenager. She attends special education sessions and speech therapy classes several hours a week, and can now speak in simple phrases. Most important, she is responsive to the people around her, helpful with the younger children and with chores in the hospital laundry.

In some cases, foster grandparents have brought about the release of children from hospitals. Kelley spent two years at the State School for the Mentally Retarded when a foster grandparent assigned to him discovered he was in the wrong place; Kelley was not mentally retarded, but totally deaf. He transferred to a special institution for the deaf and now is back home with his family.

Bridget was a terribly scarred two-year-old who arrived at a county hospital in a comatose state. The child of deeply disturbed parents, she had been battered, burned and lacerated, and was given small chance to survive. Assigned to a foster grandparent, Bridget responded immediately to attention; she was out of bed in two weeks and out of the hospital and into a foster home in just four months.

National authorities on child care have commented on the excellence of the

Foster Grandparent program. Dr. Maria Piers, Dean of the Erikson Institute for Early Education and author of "Wages of Neglect" has stated:

> "As a preventive program, Foster Grandparents is the best thing known to combat the pernicious influence of neglect. Children who are ignored, cut off from adult contact and love can face a total deterioration of the intellect with lifelong crippling effects.
>
> "Foster grandparents give the children the warm, loving contact with adults that is so necessary to their growth and development.
>
> "We have seen the positive results of this program. Every institution or agency caring for children could benefit from the work of a foster grandparent in every child care unit."

The Foster Grandparent program has provided many insights into the potential utilization of the elderly in community settings. It has not only provided low income older persons with an improved standard of living, but has demonstrated that older persons have the talent, skill, experience, and desire to serve their communities by meeting some of the unmet human needs of our society. Thus, the benefits resulting from the Foster Grandparent program extend far beyond the direct gains to the children and foster grandparents who have participated.

ITEM 2. ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., March 2, 1972.

DEAR MR. CHAIRMAN: In response to your request, enclosed is a report on the activities of the Administration on Aging during 1971.

We appreciate the cooperation your Committee and others in Congress have given in our efforts in behalf of our Nation's elderly, outlined therein.

Sincerely,

JOHN B. MARTIN,
Commissioner on Aging.

[Enclosed.]

THE ADMINISTRATION ON AGING—1971

During 1971, The Administration on Aging carried out, on many different fronts, a variety of activities in behalf of older Americans.

A. STATE AND COMMUNITY PROGRAMS ON AGING

During 1971, funds were provided for three Federal matching grant programs under Title III of the Older Americans Act:

1. Statewide planning, coordination, and evaluation on behalf of the elderly.
2. Community services, planning, and training programs on behalf of the elderly. Both of these programs are administered at the State level by designated State Agencies on aging.
3. Areawide Model Project program—this program was newly authorized by the 1969 Amendments to the Older Americans Act which provide for grants to designated State Agencies on Aging on a discretionary basis. This program was first implemented during 1971.

These programs will be discussed below in the order in which they appear above.

1. STATEWIDE PLANNING, COORDINATION, AND EVALUATION

1971 was an especially active year for State Agencies on Aging. In addition to responsibilities for continuing implementation of the 1969 amendments (Public Law 91–69) to the Older Americans Act, the State Agencies exercised a major leadership role in State and local preparations for the White House Conference on Aging. State Agencies were integrally involved in organizing and carrying out the community forums and State Conferences which served to determine the preliminary issues and subject matter for the National Conferences. Many persons also were active participants in these preliminary conferences. Six thousand community forums were held throughout the nation at which the elderly voiced their pressing concerns and their hopes for action

at the National conference. Based on the results of these forums, every State subsequently conducted a statewide conference where the States' recommendations to the National Conference took final form.

Thus, the 1971 White House Conference on Aging met after intensive preparation which was due, in large measure, to the leadership and expertise exercised by the State Agencies on Aging.

Also, during the past year, State Agencies on Aging completed the initial phase of their statewide planning responsibilities which included the following:

1. The completion of a Comprehensive Study of the Status and Needs of the Elderly in the State; and

2. The completion of a report on Achievements of State Programs for the Aging.

These planning activities and achievements have equipped the State Agency with in-depth, and comprehensive knowledge of the characteristics of the elderly population and of the existing resources for the elderly which will enable the State Agency to expand its leadership capacity and planning and programming activities for the aging. Subsequent phases of statewide planning activities will build upon this data foundation.

2. COMMUNITY PROGRAM ACTIVITIES

During 1971, 800,313 older persons were served by 1,721 projects under Title III of the Older Americans Act of 1965, as amended.

Title III community grants are awarded by State Agencies to local public or private non-profit agencies to strengthen existing and to develop new community services for the elderly and to stimulate community interest to meet the identified needs of the elderly. The following were among the activities and services provided through the Community programs.

Services for independent living were offered in 235 community programs during 1971. These programs were designed to maintain independent living arrangements for the elderly and assisted in reaching a large portion of elderly shut-ins. These in-home and out-of-home services made it possible for the elderly to maintain a sense of dignity and independence in their own familiar community environment.

There were 416 community programs on aging which involved older volunteers. These volunteers assisted in such services as friendly visiting, telephone reassurances, transportation, teaching adult education courses to other older persons, preparation and delivery of meals, and were involved in the planning of community activities and services for the elderly.

Group meals and home-delivered meals were provided to 24,913 older persons to override nutritional problems of the elderly. Many older persons unable to pay received this service through such meals programs without cost. In many programs, these meals were prepared and delivered by older persons. Those served in a group setting used senior centers and other community and neighborhood facilities for preparation and serving these meals. Many persons were served at least two nutritional meals, 5 days a week. Those elderly who were isolated had benefitted from the delivery of meals to their homes on a daily basis.

Emphasis in 1971 was also placed on transportation to counteract mobility problems among the elderly. There were 247 projects with transportation as a component or provided as a sole service of the program. Many programs had one or two mini-buses which were radio-equipped; cars and other vehicles were used as well. This service enabled older persons to keep doctors appointments, to go to health clinics and food stamp offices, to make trips at a distance, and visits to senior centers for other significant activities and services.

One of the most significant roles of the elderly in 1971 was their participation in the White House Conference on Aging, serving as delegates and visitors at the conference.

At the community level, the elderly took part in pre-White House Conference planning meetings and activities in their States. Many of the older participants are actively engaged as recipients or providers of services in the local community programs. Many of the community programs initiated and were responsible for the community forums which were preliminary to the National Conference.

There were 160 projects which offered health and health-related services to older persons providing visiting nurses and in-home health aides for the home-

bound elderly. Other health-related services offered were health education, geriatric screening and referral, immunization programs, and homemaker. Other health-related programs included the promotion of prevention techniques for accidents through education, and activities which provided the means to alleviate other particular emotional or physiological health problems of the elderly. A number of programs gave particular attention to the handicapped older person such as the blind or deaf, or those reaching these stages because of age by counseling the older person in readjustment to their surroundings and homes. Often other older persons with similar handicaps provided this assistance.

Other community programs offered courses in arts and crafts, provided adult education, and provided training and employment information and referral to enable the older person to find and maintain post retirement employment. One project utilized volunteers to assemble and distribute clothes to welfare participants and with the cooperation and assitance of the Salvation Army; another bridged the generation gap with inner-city youths by engaging older persons as Den Mothers and Headmasters for Girls' and Cubs' Scouts; and several programs offered library services to those elderly who were homebound and institutionalized. Many programs included special recreation and leisure time activities for the elderly and with special facilities and activities for the elderly handicapped, such as large-print books, talking books, and braille reading materials and slide movies.

There are a total of 1,215 local agencies on aging, with 283 of these directly supported by Title III funds and the remaining 932 funded through other auspices. Approximately 75-100 percent of these agencies received financial assistance from the State Agencies on Aging in establishment of these agencies under the Title III Community Programs. These local agencies on aging were the focal point for planning, developing, and coordinating services for older persons in local communities.

With assistance under Title III, State agencies provided support for 474 senior centers which were located in public low-rent housing, churches, public and private buildings and some institutions. These senior centers have satellite centers located in neighborhoods where the elderly reside. These satellite centers provided and delivered an extension of services tailored to meet the special needs of the elderly in the community. These senior centers also trained 2,434 elderly for employment and provided opportunities for participation and active engagement in community life.

There were 335 community programs located in rural areas, 487 in urban areas and 119 located in Model Cities. Administration of Aging, through agreement between HEW and HUD, has moved ahead on programs for the elderly in concert with the Model Cities Administration.

3. AREAWIDE MODEL PROJECT PROGRAM

The Areawide Model Project Program is a new proram authorized by the 1969 Amendments to the Older Americans Act. This program provides for discretionary grants to designated State Agencies on Aging for the conduct of Areawide Model Projects in selected geographic areas. State Agencies receiving awards may operate such Projects directly or through contractural arrangements with designated local agencies.

The Areawide Model Project program seeks to develop and test innovative approaches to change those conditions that prevent or limit opportunities for older persons to live independently and participate meaningfully in community life. Each Areawide Model Project must propose realistic plans for meeting the State objectives of high priority in a community. Initially, a State Agency undertakes those activities necessary to identify or clarify a pressing need of the elderly citizens of a selected geographic area having potential for solution within the scope of this program. Secondly, a Plan of Action must be developed which describes in detail the proposed scheme to combat in a comprehensive manner the need that has been identified. Such plan must then be submitted to the Administration on Aging for approval. If approved, the project undertakes those steps necessary to implement the plan in an efficient and effective manner throughout the project area.

The objective of the planning phase and implementation of the Plan of Action is to integrate all existing services and to establish new ones to meet the identified needs of older persons. Each Areawide model project has a target population

which includes a high percentage of low income and minority group elderly. Each has an Area Task Force, members of which include older persons and representatives of major public and private agencies with programs for the elderly. The task forces participate in both planning and implementation of projects.

The Areawide Model Project program was first implemented in June, 1971 with the award of $2.2 million to 9 State Agencies on Aging. The following provides a listing and brief description of those 9 projects:

Maine.—The designated project area includes the counties of Androscoggin, Franklin and Oxford, located in Central West Maine, and combining rural and urban areas. The area also includes a Model City. The Project is focusing on improving accessibility of services for the elderly. The Project is notable for advanced statewide planning effort and commitment of State and community support. The Project is operated directly by the State Agency.

Mississippi.—The project area includes the coastal counties of Hancock, Harrison, and Jackson. This area was hard hit by Hurricane Camille two years ago and affected many elderly persons who lost their homes and are not yet successfully relocated. Poor housing conditions and lack of alternatives to institutional care have resulted in the project's focus on developing alternative living arrangements for these elderly persons affected. The State Agency has contracted with the Southern Mississippi Economic Development District for the conduct of their Project.

Nebraska.—The designated project area includes the city of Lincoln and Lancaster County. The Project is seeking to develop alternatives to unnecessary institutionalization of older people which has been a major problem, Statewide, for some time. The project will be operated out of the Office of the Mayor of Lincoln, with whom the State Agency has contracted for conducting the project.

Oregon.—The project area encompasses the city of Portland and Multnomah County. The project is seeking to develop alternatives to institutionalization of the elderly through improved health services designed to delay or prevent physical and mental deterioration. In addition to the Administration on Aging Areawide grant, the Model City Agency in Portland is making a major commitment of funds and the existing and effective City-County Council on Aging is providing support of staff and resources. The State Agency has contracted with the Council for the conduct of the Project.

Puerto Rico.—The selected area, Rio Piedras, includes the San Juan Urban Renewal Districts I and II and adjacent areas. The project is focusing on the problem of isolation of senior citizens. The older residents of the area have extremely low per capita incomes and are in need of services, particularly those related to health. Commonwealth support and wide community participation has been promised. The project is operated directly by the State Agency.

South Carolina.—The project area includes the six counties of South Carolina's Appalachian area—Anderson, Occonee, Pickens, Greenville, Spartanburg, and Cherokee. The Project is focusing on improving the level of physical and mental health of older people, through the development of linkages with existing health and related services and the development of new services. The Project is operated directly by the State Agency.

Texas.—The Project includes the City of Houston which also includes a large Model Neighborhood area. The Project has identified the isolation of the elderly as the major problem. It is attacking this problem through the development of services to prevent institutionalization, services to elderly in crises situations, and services to elderly in nursing homes. The area also includes a significant number of older Mexican-Americans. The City Demonstration Agency and other area agencies have provided large commitments of funds. The State Agency operates the project directly.

Utah.—The Project area encompasses Salt Lake County, which includes a Model City in the city of Salt Lake. The Project is seeking to develop preventative methods for unnecessary institutionalization of older persons because of the lack of alternative living arrangements. The project is also working to develop in-home supportive services. The State Agency has contracted for the conduct of the project with the Salt Lake County Council on Aging which has been an effective instrument in the past for addressing elderly needs.

Virginia.—The project area encompasses the Southeastern Virginia Planning District #20 including the cities of Norfolk, Chesapeake, and Portsmouth. Norfolk is also a Model City. The State Agency will operate the program directly; however, it contracted with the local Health, Welfare, and Recreation, Planning

Council to conduct the activities related to the first 120 day planning period. The project seeks to aid isolated and withdrawn older people and provide new, or make more accessible, existing services and programs. A heavy concentration of black elderly resides in the district.

During November and December, 1971 an additional 12 awards were made to designated State Agencies. The following lists describes the 12 new projects.

Georgia.—The selected area for this project is the City of Atlanta which covers Fulton County and a portion of De Kalb County. Atlanta has a Model Cities grant which has programs specifically for the elderly. The project seeks to provide alternatives to institutionalization. The Georgia Commission on Aging has elected to operate this program through contractual arrangements with the Community Council of Atlanta Area, Inc., he recognized social planning agency for Atlanta and Fulton County.

Hawaii.—The Hawaii Areawide Model Project area includes the City and County of Honolulu limited to the Chinatown-Kapalama area within the county where the highest concentration of elderly poor reside. This is also a Model Cities area. The focus of the project is directed toward the elimination of the psychological, sociological, physiological and economic isolation of the elderly from the mainstream of community activities. The State Agency has contracted the Honolulu Office of Human Resources to administer this project.

Maryland.—The project area encompasses the lower Eastern Shore Counties: Dorchester, Wicomico, Somerset, and Worchester. The Maryand Commission on Aging will operate the project directly and will seek to reduce the number of aged admissions to long term care facilities and to prevent needless impairment of the aged living in the community.

Missouri.—The project area includes the city of St. Louis. The project will focus on the provision of adequate community services to noninstitutionalization can be postponed or avoided. The State Agency on Aging has contracted with the City of St. Louis for the conduct of the project.

New Hampshire.—The designated project area is the southeastern corner of New Hampshire incorporating the Merrimack Valley and Sea Coast Regions. The New Hampshire State Council on Aging will operate the project which has been named "Project Access." The project will focus on the isolated elderly who do not have access to needed services and, consequently experience serious health and other problems leading to early institutionalization. The proposed solution is to link the isolated elderly with necessary services.

Ohio.—The designated area includes a segment of the City of Cleveland, located in the northcentral part of Ohio. The area selected for the Project called "One Hundred by One Hundred" is a section of Cleveland comprised by 14 Social Planning Areas extending 100 blocks East and 100 blocks West of the Cuyahoga River. The Project will seek to develop alternatives to unnecessary institutionalization of older people. The State Agency on Aging has contracted with the City of Cleveland for the conduct of the project.

Wisconsin.—The project area includes the City of Racine, located in the southeastern part of Wisconsin. The project will focus on the problem of isolation and the increasing dependency of the elderly. The State Agency on Aging will operate this project directly.

Rhode Island.—This is the only Areawide Model Project which encompasses the entire State. Included are two Model Cities Areas. The program is operated directly by the State Agency and is designed to focus on health maintenance among the elderly to prevent or delay incidence of mental or physical health problems.

Washington.—The project area includes the City of Seattle which also encompasses a Model City. The State Agency has contracted with the King County Council on Aging for operation of the project. The project will work to improve and coordinate delivery of services to homebound elderly.

Arizona.—The project area encompasses Pima County which includes the City of Tucson. The State Agency has contracted with the Tucson Council on Aging for operation of the project. The project is designed to assure that elderly citizens receive needed health care with the objective of avoiding or delaying unnecessary institutionalization. Tucson already has an experimental health program for the elderly operation in cooperation with the Council on Aging.

Louisiana.—The City of New Orleans is the designated project area. The project, operated by the State Agency in cooperation with the Metropolitan Council on Aging and the local model cities program is designed to reduce physical and social isolation, and institutionalization of older people.

New York.—The designated project area encompasses Onondaga County which includes the city of Syracuse. The State Agency has contracted with the Metropolitan Commission on the Aging for operation of the Project. The local Model Cities program will also be integrally involved in the project. The project is designed to eliminate loneliness and isolation of older persons.

B. White House Conference on Aging

The Administration on Aging continued executive direction of the White House Conference on Aging through May. At that time Dr. Arthur Flemming, who was named full time chairman by the President on April 23, established an expanded staff to organize the national Conference.

During the period from January through May, public hearings were held in eight of the ten regions under auspices of the Federal Regional Councils. Subject matter areas to be discussed in the Conference were the basis for the hearings. Involvement of the Federal Regional Councils has led to an ongoing interest in aging and in the implementation of Conference recommendations.

On April 20, President Nixon issued a proclamation designating May as Senior Citizen Month. In his proclamation the President said:

"During the last year, several hundred thousand older people wrote to officials of the Federal Government and told us in their own words—some sad, some hopeful—about what they need and what they desire. We learned once again that what they seek most of all is a continuing role in shaping the destiny of their society. We must find new ways for helping them play such a role—an undertaking which will require a basic change in the attitudes of many Americans who are not yet elderly.

"As a part of our effort to achieve such changes, our Nation each year observes the month of May as Senior Citizens Month. This is a time when we make a special effort to thank our older citizens for all they have contributed to America's progress. It is also a time for asking with special force whether they are now sharing in that progress as fully as they deserve and desire and for renewing our efforts to help them live proud and fulfilling lives.

"Senior Citizens Month, 1971, will be a particularly important time for such endeavors, for this is the year of the White House Conference on Aging. The Governor of every State has issued a call for a State Conference on Aging to be held during May. From these State Conferences will come policy recommended which will be submitted to the White House in Washington next November.

"I know that the work of these State conferences during Senior Citizens Month —like the work of the White House Conference next Autumn—will be undertaken with a high sense of discipline, commitment, and imagination. The Nation owes no less to those who have given so much to its development."

The President also stated that the theme for Senior Citizen Month would be "Toward a National Policy on Aging." He expressed appreciation to the Governors for their concern and participation in the Conference and Senior citizens Month. He then said, "I urge officials of government at all levels—national, State and local—and of voluntary organizations and private groups to give special attention to the problems of older Americans during this period."

There were forty-two State White House Conferences held in May with most of the balance in June and July. Many of the State conferences followed community or multi-county sessions. Many States followed the suggested Conference structure, using task forces to formulate policy proposals, which later went to the Conference subject matter technical committees.

Also during May, the twenty task forces whose members were appointed and underwritten by National Organizations, met either in Washington or in Chicago. Policy proposals developed by these task forces also went to the Technical Committees for combination with the State proposals and for Technical Committee comment.

After the transfer of Conference responsibility to Dr. Flemming and the Conference staff, the Administration on Aging continued to cooperate with the Conference staff in various program activities, including the development of the multi-media film presentation, and in the work with the Regions and States.

At the end of the calendar year the Administration on Aging and the Conference staffs were jointly planning the Conference follow-up during the "year of action" in the States and communities.

C. Training

The training grant program, authorized by Title V of the Older Americans Act was able to continue its support of 15 career training programs being conducted in 17 universities across the country, to add six new long-term programs, and to support six short-term projects. The continuing, long-term programs have become nationally recognized sources of well-trained personnel capable of providing a variety of professional services to the older population. In addition, staff members of the training programs are recognized increasingly as resources for professional leadership, consultation, and technical assistance within the communities, States, and regions served by their institutions. Particularly significant developments during 1971 included efforts to increase the supply of minority groups workers in the aging field, broad participation of training personnel in the White House Conference on Aging, and a major increase in the level of funding for the training grant program.

1. INVOLVEMENT OF MINORITY GROUP MEMBERS AND INSTITUTIONS

In the 1971 funding cycle substantial emphasis was placed on enhancing training opportunities in aging for minority students. This was accomplished by increasing the enrollment of minority group students in the continuing programs, but, more strikingly, by awarding support for new programs, in six black colleges. One, at Fisk University, is training students at the graduate level. The five undergraduate programs are located at: Albany State College, Albany, Georgia; Bishop College, Dallas, Texas; Federal City College, Washington, D.C.; Livingstone College, Salisbury, North Carolina; and Tennessee State University Nashville, Tennessee. The undergraduate programs are providing students with a basic knowledge of gerontology and field experience to equip them for employment in positions which offer direct and essential services for older people. Students will also be equipped to enter graduate programs which prepare them for teaching, research, and leadership positions.

Programs in the black colleges are being undertaken with high interest and enthusiasm. Opportunities have been made for directors and students in these programs to become acquainted with each other, and with their counterparts in more established aging training programs funded by Title V. These exchanges have proved to be useful in terms of the two-way learning and socialization which have taken place.

Minority group students accounted for 15 percent of the 462 students enrolled in the 22 long-term programs in the 1971–1972 academic year. It is hoped to increase this proportion in the years immediately ahead.

2. UNDERGRADUATE EDUCATION

Prior to 1971, most of the Title V support was directed to the preparation of students at the post-baccalaureate or graduate level. This focus reflected the almost totally unmet demand for personnel capable of assuming leadership and supervisory responsibilities in program planning and administration, organization of community programs, and teaching. By 1971, a number of graduate level programs had been well established, and it became possible to encourage the development of training programs at the undergraduate level. Two of the established programs added baccalaureate training and five of the six black college programs are at this level, preparing students for giving direct services to the older population. Future support will be provided at both levels and will probably go to two-year community college programs as well.

3. SHORT-TERM TRAINING

Support of short-term training projects ranging from two weeks to a year in length has been provided under the Title V program since its inception. Esnecially significant during 1971 were the University of Georgia project for increasing the competencies of retirement housing personnel for work with the elderly and the short courses in milieu therapy offered to personnel of mental hospitals by the University of Michigan-Wayne State University Institute of Gerontology. The milieu therapy project attracted several teams of mental hospital personnel, including psychiatrists, nurses, social workers, and ward attendants.

The 14-week residential institutes offered by the Institute of Gerontology continued to be over-subscribed by employed personnel seeking to improve their skills and by persons desirous of launching new careers in aging. More than 80 persons were awarded certificates in one of four areas; planning, housing management, senior center direction, milieu therapy.

During 1971, support was given to the Southern Regional Education Board to inventory the findings of research and demonstration projects conducted within its 15-State region. It is planned to make the information available for use in training programs for administrators and students in aging.

A pioneering 3-year project received first-year support to give teachers information about aging which they can incorporate into their primary and secondary school teaching content. The goals of the project are to sensitize young people to the needs and conditions of the elderly, to prevent the formation of negative attitudes, and to make students aware of the possibilities of careers in aging. The project will be conducted by Ball State University for Indiana teachers.

The Administration on Aging joined with the National Institute of Child Health and Human Development at the National Institute of Mental Health in supporting a conference for college and university faculty and administrators to encourage the development of teaching and research in additional institutions of higher education. The project will be conducted by the University of Southern California's Ethel Percy Andrus Center for Gerontology early in 1972.

4. CAREER TRAINING IN AGING

The long-term, career programs in aging are having significant impact on the field. Increasingly, government agencies and voluntary organizations are looking to them for qualified personnel. Approximately 170 students were graduated during 1971. Most of them are employed in State and community planning and development, in retirement housing and homes for the aged, in senior centers and recreation, in architectural design, adult education and library work, and in a variety of other settings. Some have gone on to doctoral programs and are or will be teaching in colleges and universities.

The Placement Service in Aging, operated by the University of Michigan-Wayne State University program, is being used by potential employers and employees alike. It proved to be especially useful during the summer when the first Areawide Programs in Aging and Retired Senior Volunteer Programs were established. Approximately ten of each were funded by the Administration on Aging. The training staff viewed these as providing unique employment opportunities for graduates of Title V training programs. Accordingly, staff, in conjunction with the Placement Service in Aging, made a concerted effort both to acquaint the new programs with this potential staff resource and to inform the graduating students of the jobs in aging being created by these new programs. This effort met with considerable success.

5. PRACTICUM EXPERIENCE

Title V long-term training programs require all students to complete a period of field placement as a part of the course of study. The placements serve to provide a testing ground for classroom content and an opportunity, frequently, to work directly with older persons. Students have field placements, either on a block or concurrent basis, in a wide variety of settings.

One highly successful field placement setting has been with aging services in the Federal Government. Such placements began in the summer of 1970. From then until the end of 1971, 18 students have had such field placements, including 15 with AoA and three in aging services in two regional offices. These students, at both the master's and doctoral levels, came from seven universities. As of the end of 1971, about half were still students. Of the half who had graduated, all but one were employed in aging. The other student had excellent prospects to be so employeed. More than half of those working were with State and Federal Agencies, while the others were employed by voluntary organizations, including Title V program.

The students have proved to be bright, willing, and highly motivated to learn. The Administration on Aging has become fully convinced of the value of the practicum assignments in providing sound experience for trainees who will

eventually work in service to the elderly and as affording significant staff assistance to the units to which they are assigned. Students in the Administration on Aging, with research and demonstration, in training activities, and in the formulation of policy and development of legislation. They have had opportunities to meet informally with members of the executive staff and have attended congressional hearings and meetings within the Social and Rehabilitation Service and in the regions.

Students having non-federal field placements have obtained varied, practical, and useful experiences. These have ranged from assisting committees on aging in State legislatures to staffing municipal commissions on aging, writing grant proposals, assisting administrators of retirement housing and long-term care facilities, and working with State agencies on aging.

6. CENTRALIZATION AND REGIONALIZATION

A major share of the Training Grants staff time during 1971 was devoted to work with the Social and Rehabilitation Service Office of Manpower Development and Training. Attention focused principally on the formulation of training policy and guidelines applicable to the diverse programs encompassed by the Social and Rehabilitation Service. In the field, most of the Regional offices worked closely with the Administration on Aging central office staff on reviewing continuing programs and evaluating new applications.

7. WHITE HOUSE CONFERENCE ON AGING

The Title V staff and many faculty members and students in Title V supported programs were active in White House Conferences at community, State, and national levels. As reported last year, students helped organized Older American Forums in many communities while faculty members served as members of several of the Technical Committees. During 1971, faculty members of Administration on Aging and National Institutes of Health training programs were members of State Task Forces to formulate draft recommendations for use in State Conferences and worked as Consultants and Section and Subsection Chairmen at the National Conference. Fifty faculty members and students participated in the national meeting as Observers.

Two students and three former students were employed on the National White House Conference staff. A former Title V training program director served as Co-Director of Conference technical activities. The director of the Title V program served as associate coordinator for White House Conference technical committees, and a staff member served as management officer of the Conference section on training.

8. CONFERENCE POLICY RECOMMENDATIONS

Increased support and more programs for manpower training were prominent among the final recommendations of the White House Conference. The need for personnel at vocational, technical, paraprofessional, and professional levels was pointed up in several Conference sections. Preparation of teachers, inclusion of content on aging in the training of health, social service, and religious workers, and preparation of more researchers were emphasized. Particularly strong recommendations were made for a National Institute of Gerontology to foster research and training and for more university based centers for training, research, and technical assistance in aging.

9. INCREASED FUNDS

At the end of 1971, the Congress increased the current appropriation to the Administration on Aging including an additional $5 million for the Title V training grant program. The staff made plans at once to apportion the funds between long-term and short-term training. It will be possible to increase the number of career preparation projects, thus regaining the momentum developed during the first years of the grant program. Special effort will be made to inaugurate training facilities in regions and States having large populations of older people. Plans called for making a sizable allocation of funds for short-term training of 2,000 or more persons who will be added to State and community agencies under expanded Older American Service activities.

D. Volunteer Service Programs

1. FOSTER GRANDPARENT PROGRAM

One of the best known and most successful programs of service by older persons is the Foster Grandparent Program. The Program was initially developed in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging to demonstrate the capability and willingness of older persons to make valuable contributions to their communities. The program was jointly administered by O.E.O. and D.H.E.W. until the Older Americans Act Amendments of 1969 transferred the Foster Grandparent Program entirely to the Department of Health, Education, and Welfare, where funding and administration occurred through the Administration on Aging and the regional offices of the Social and Rehabilitation Service. On July 1, 1971, the Foster Grandparent Program was transferred to ACTION, the newly formed citizens' service corps, in accord with Executive Reorganization Plan No. 1 of 1971.

Initially, the Foster Grandparent Program explored 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. That premise was almost immediately established and the program concept has expanded to serve children in a wider range of settings including correctional institutions, hospitals, mental health clinics, Head Start programs, and classes for exceptional children.

Currently 67 foster grandparent projects serving over 200 different child care settings in 40 States and Puerto Rico, are utilizing over 4,400 foster grandparents per day. Although no new projects were funded in 1971, the Fiscal Year 1972 appropriation provides for a very significant increase in the Foster Grandparent Program. This increase arises from the President's announced decision at the White House Conference on Aging to increase the budget for the Foster Grandparent Program to $25 million in Fiscal Year 1973, and from Congressional action which amended the FY '72 appropriation to provide the full $25 million in 1972. This appropriation will enable ACTION to increase the number of Foster Grandparent Projects and it will provide funds for approximately 11,000 foster grandparents to serve 22,000 children each day and about 50,000 different children a year in over 450 child care settings.

The foster grandparents serve a total of four hours a day, five days a week and receive a stipend of $1.60 per hour for their service. In addition, the foster grandparents are reimbursed for transportation costs and, where possible, are provided with a nutritious meal daily. They are covered by accident insurance and each grandparent receives an annual physical examination. An extensive orientation program is provided, and through the professional staff of each program, foster grandparents receive counseling on personal matters and information regarding benefits available through Social Security, Medicare, legal services and other community, State and Federal programs. Most importantly, the Foster Grandparent Program offers to older persons an opportunity to serve their communities and themselves, to live with the increased self-esteem independence and socialability that is vital to the enjoyment of later years.

In many instances the Foster Grandparent Program offers to the children served an opportunity to more fully participate in the activities and joys of life. The following stories demonstrate that foster grandparents are needed and do provide an essential service to the children with whom they work and the entire community in which they live.

Maria was four when a social worker found her closeted with her younger brother in the filthy attic of her home. Each was a virtual "wild child," incapable of walking or talking, or registering emotion. They crawled naked through litter on the floor and the mattress on which they slept.

The children and their mother, a mental retardate, were sent to the State Hospital, where a foster grandparent met Maria eight years later. Still, at twelve, the girl could not speak. Her hair was disheveled, her clothes torn, her face dirty; she sat in a corner flipping a rag back and forth through her hands and slapping the floor hard.

Maria has had the same foster grandparent for three years visiting her at the hospital five days a week for two hours each day.

So great were the ravages of her early years, that Maria will probably remain in the hospital for the rest of her life. But, now she is an attractive, smiling

teenager. She attends special education sessions and speech therapy classes several hours a week, and can now speak in simple phrases. Most important, she is responsive to the people around her, helpful with the younger children and with chores in the hospital laundry.

In some cases, Foster Grandparents have brought about the release of children from hospitals. Kelley, spent two years at the State School for the Mentally Retarded when a foster grandparent assigned to him discovered he was in the wrong place; Kelley was not mentally retarded, but totally deaf. He transferred to a special institution for the deaf and now is back home with his family.

Bridget was a terribly scarred two-year-old who arrived at a county hospital in a comatose state. The child of deeply disturbed parents, she had been battered, burned and lacerated, and was given small chance to survive. Assigned to a Foster Grandparent, Bridget responded immediately to attention; she was out of bed in two weeks and out of the hospital and into a foster home in just four months.

National authorities on child care have commented on the excellence of the Foster Grandparent Program. Dr. Maria Piers, Dean of the Erikson Institute for Early Education and author of "Wages of Neglect" has stated:

"As a preventive program, foster grandparents is the best thing known to combat the pernicious influence of neglect. Children who are ignored, cut off from adult contact and love can face a total deterioration of the intellect with lifelong crippling effects.

"Foster grandparents give the children the warm, loving contact with adults that is so necessary to their growth and development.

"We have seen the positive results of this program. Every institution or agency caring for children could benefit from the work of a foster grandparent in every child care unit."

The Foster Grandparent Program has provided many insights into the potential utilization of the elderly in community settings. It has not only provided low income persons with an improved standard of living, but has demonstrated that older persons have the talent, skill, experience, and desire to serve their communities by meeting some of the unmet human needs of our society. Thus, the benefits resulting from the Foster Grandparent Program extend far beyond the direct gains to the children and foster grandparents who have participated.

2. RETIRED SENIOR VOLUNTEER PROGRAM

The Retired Senior Vounteer Program was authorized by the Older American Act Amendments of 1969. An appropriation of $500,000 was made at the end of 1970 permitting the Administration on Aging to issue Rules and Regulations and to fund eleven programs before July 1971. A study of senior volunteer programs, contracted for by the Administration on Aging with a private consulting firm, was completed in June. Their report, "Recommendations for Developing RSVP, the Retired Senior Volunteer Program", may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, for $3.00, by reference to Stock Number 5600-0001.

On July 1, in accord with Executive Reorganization Plan No. 1 of 1971, the Retired Senior Volunteer Program was transferred to ACTION, a newly formed citizens' service corps. In August an appropriation of $5 million was made for the program for fiscal year 1972. This appropriation was increased to $15 million late in December, 1971. A two-step grant application procedure was developed by ACTION, using a preliminary inquiry approach and an RSVP grant application. At the end of the year a plan for RSVP Development Grants was devised by ACTION for implementation, preferably, by State agencies on aging. The intent was to facilitate sound program development of individual projects by local communities.

The purpose of the Retired Senior Volunteer Program is to develop a recognized role in the community and a meaningful life in retirement for older adults through significant volunteer service. Retirement from work activities, combined with separation from family and loss of friends and established relationships, often deprives older adults of contacts and resources that might permit them to engage in meaningful activities. Many persons of retirement age need help to find personally satisfying opportunities to be usefully involved in community life, to contribute a full measure of their talents, abilities and experience. The focal point of RSVP activity is the needs and interests of the Senior Volunteer.

ACTION grants are awarded to support the development and operation of local programs providing community volunteer opportunities for persons 60 years of

age and over, and for out-of-pocket expenses for these volunteers, covering costs incident to their services, such as transportation.

A Retired Senior Volunteer Program is inherently a local program. It is locally planned, operated, controlled and supported. During the project period, which can be as many as five years, an RSVP operates with Federal financial and technical assistance under ACTION guidelines, rules and regulations. Federal funding is provided on an annually decreasing basis, explained fully in the RSVP Program Information Statement available from ACTION.

Local Retired Senior Volunteer Programs encourage organizations and agencies to develop a wide variety of volunteer opportunities for retired persons. Volunteer opportunities are arranged to match the interests, abilities and physical capacities of older persons who wish to become volunteers through RSVP. Older adults are actively encouraged to contribute their time, experience and skills to facilitate resolution of local problems. There are no income, education or experience requirements for a retired person to become a Senior Volunteer.

Specific assignments arranged for Senior Volunteers offer varied types of opportunities for them to serve people of any age. Assignments occur on publicly owned and operated facilities or projects and on local programs sponsored by private, nonprofit organizations (other than political parties). Examples are schools, courts, libraries, museums, hospitals, nursing homes, day care centers, institutions and programs for shut-ins. Volunteers under RSVP may not be assigned to projects involving the construction, operation, or maintenance of any part of a facility used or to be used for sectarian instruction or as a place for religious worship. Volunteers assigned under RSVP cannot displace employed workers or impair existing contracts for services.

Applications for project grants for the operation of Retired Senior Volunteer Programs may be made by local public agencies and nonprofit private organizations. Highest priority is given to those applicants which possess the greatest number of the following characteristics:

Established commitment to the needs and interests of all older adults in the community without regard to income, education and experience.

Multi-purpose organization having a broad focus of involvement with community problems.

Good working relationships with a wide variety of community organizations and agencies.

Recognized capacity to operate direct community service programs.

Experience in developing volunteer service opportunities.

Strong base of local financial support and the capacity to develop additional sources of local funding.

E. Priority Coordination

The Retired Senior Volunteer Program was authorized by the Older American operational planning system, adopted on April 27, 1971, a set of Departmental priorities and appointed priority coordinators to implement the priorities. As priority number ten, the Secretary stated that "It is extremely important we strengthen services to the aged. We must develop coordinated approaches using all relevant resources to deliver health and social services to our older citizens, thus enabling them to lead full and active lives." The Commissioner of Aging was appointed the Priority Coordinator and given his assignment in May.

The Administration on Aging reviewed the programmatic objectives submitted to the Secretary by the HEW agencies and the HEW Regional Directors. Following this analysis, the Commissioner asked each HEW agency executive to assign an agency official to work with him and his staff on the priority. Subsequently, meetings were held with the designees to discuss possible joint action in response to the Secretary's priority for older Americans.

During this period the initial projects under the new Areawide Model Program (Section 305, Title III, Older Americans Act) were funded and began the initial planning. Since it seemed appropriate to coordinate the State and community programs of the Health Services and Mental Health Administration with the Areawide Model Program negotiations proceeded along those lines. By the end of the calendar year joint planning was underway on both physical and mental health in the areas selected by AoA and HSMA.

The Administration on Aging and the National Institute of Mental Health held discussions on possible joint planning and funding of research and development projects for aging and training programs for professional personnel to

work with older persons. NIMH developed a proposal which was submitted to AoA at the end of the year.

One of the priorities submitted by the Social Security Administration called for special emphasis "on insuring that the rights of aged and infirm beneficiaries are protected and that all available resources are utilized to meet their special needs." A joint SSA–AoA demonstration had shown that older persons under supervision could assist Social Security beneficiaries in nursing homes with various needs, including service as representative payees. The Administration on Aging working with Social Security is exploring the possibilities of extending this program on a further demonstration to communities with strong aging organizations.

Another of the Secretary's priorities stated that "The Right to Read program is a national effort to ensure those who cannot read, learn to read." One of the target groups is "the 15 million adults whose limited ability to read restricts their participation as adults in our society." AoA has reported that close to 3 million older persons are "functionally illiterate," having had no schooling or less than five years. The Administration on Aging approached the Office of Education on the relationship of these two priorities, plus the multiple educational needs in the field of aging, in serving older people, and for older people generally, as well as for the balance of the population in understanding aging.

The Commissioner of Education agreed to a joint OE–AoA task force to work on possible OE programs in aging. At the end of the year the task force had developed the basis for discussion with various program bureaus in the Office of Education. Late in December the Commissioners of Education and Aging agreed to this process with a deadline of March 31, 1972, for a report from the task force to them.

F. Nursing Home Improvement

On June 25, 1971, President Nixon delivered a speech to the American Association of Retired Persons in Chicago in which he called for a national effort to upgrade nursing homes for the elderly. In the ensuing planning to fulfill the President's initiative the Administration on Aging became the spokesman for older Americans.

The President expanded on his Chicago speech in a plan for action which he released in conjunction with a nursing home visit in New Hampshire on August 6, 1971. The Administration on Aging was involved in subsequent meetings held by HEW with nursing home officials and with organizations representing consumers or potential consumers of nursing home services. AoA was also directly concerned with the President's directive that HEW "assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients."

Following a letter to the Governors from the Assistant Secretary for Health and Scientific Affairs, Dr. Merlin K. DuVal, asking them to develop plans for the investigative units in the States as requested by the President. AoA relayed the information to the State agencies on aging. At year's end several State agencies on aging were discussing the possibility of serving in this capacity.

In addition, AoA was represented on the work group on investigative units set up by the Health Services and Mental Health Administration and on the task force drafting plans for proposed demonstrations of investigative-ombudsman units concerned with problems of nursing home patients. The work group and task force had not completed their reports at the close of the calendar year.

G. Statistics

The research and statistics function was moved to Office of the Commissioner and Herman Brotman was named Assistant to the Commissioner for Statistics and Analysis. A Program Assistant (trainee) was assigned to assist Mr. Brotman.

A new series, "Facts and Figures on Older Americans," was launched to replace the series, "Useful Facts," which was discontinued in 1968. Five issues were published and distributed:

1. Measuring Adequacy of Income (March)
2. The Older Population Revisited—First Results of the 1970 Census (May)
3. Income and Poverty in 1970—Advance Report (June)
4. Federal Outlays in Aging—Fiscal Years 1967–72 (June)
5. An Overview for the Delegates to the White House Conference on Aging, 1971 (November)

Work with the Census Bureau concerning the tabulation of data about the older population from the 1970 census enumeration continued and results were analyzed and publicized as they became available. Special efforts were made to secure and distribute State data in view of the requirement that the State agencies on aging complete the first phase of their planning responsibilities before the end of the calendar year 1971. Similarly, special efforts were made to secure data, charts, and resource materials for the White House Conference on Aging which opened on November 28.

An *ad hoc* interdepartmental committee was established to examine the potential impact on population projections resulting from possible medical breakthroughs in the treatment of the chronic diseases and conditions which are the major causes of death among the older population. The committee will also examine the implications for types of housing and kinds of health services that would be needed.

Provided data, consultation, and assistance to hundreds of students, researchers, administrators, writers in all media, including several interviews and TV panel appearances and presentation of papers, etc. Prepared, on request, special materials for Federal officials, the Domestic Affairs Council, the Senate Special Committee on Aging, individual Senators and Congressmen, members of the White House Conference on Aging staff, and staff of the Administration on Aging.

H. Program and Legislative Analysis

The Administration on Aging, through its Division of Program and Legislative Analysis, makes an effort to keep in close touch with legislative proposals and other developments in Congress. It is apparently necessary for AoA to do so if it is to comply with section 202 of the Act, which makes it "the duty and function of the Administration to—

"(1) serve as a clearinghouse for information related to problems of the aged and aging;

"(2) assist the Secretary in all matters pertaining to problems of the aged and aging;

* * * * * * *

"(4) develop plans . . . in the field of aging;

"(5) provide technical assistance and consultation to States and political subdivisions thereof with respect to programs for the aged and aging;

* * * * * * *

"(8) stimulate more effective use of existing resources and available services for the aged and aging . . ."

To carry out this responsibility, AoA's Division of Program and Legislative Analysis prepared and issued a "Summary of Selected Legislative Proposals Affecting Older Americans" covering proposals introduced in Congress from January 22 through September 30, 1971. Copies were sent to State agencies on aging and others needing an overview of aging proposals before Congress to plan intelligently. The Division will issue an updated summary through February 13, 1972.

The Division also prepares and sends to State agencies on aging and others analyses of major legislation enacted or before Congress. During 1971, this was done with reference to H.R. 1, the Social Security Amendments of 1971, and P.L. 92–54, the Emergency Employment Act of 1971.

Throughout 1971, much effort went into planning legislation to be recommended to Congress to amend the Older Americans Act of 1965, in connection with the consideration Congress is giving to amending and extending the Act before expiration of its grant and contract programs on June 30, 1972. An Administration position will be submitted to Congress well before that date.

During 1971, the Division of Program and Legislative Analysis performed staff work for the Advisory Committee on Older Americans. This Committee, established by the Older Americans Act of 1965, had been meeting during the year as part of the White House Conference Planning Board. However, it met separately in September, 1971, at which time several major items were considered, including:

1. Delivery of health and social services to the elderly.
2. Additional funds to help State agencies become stronger and more effective advocates in making delivery systems responsive to needs of the elderly.
3. Report on centralized research and demonstration programs and how the aging programs benefit from coordinated staffing and funding.
4. A proposal to get aging on the agenda of the General Assembly of the United Nations as one of the current matters to be discussed in the Assembly.
5. Social effects of compulsory retirement.
6. Employment and discrimination.
7. The functions of the Advisory Committee we agreed to be to (a) act as a supportive and creative listening post, (b) be a buffer between the Executive branch and the public, (c) operate as an advocate for the Administration on Aging, (d) aid the Commissioner on Aging in his role as departmental priority coordinator, and (e) represent voters.

The Commissioner expressed his desire to continue working closely with the Advisory Committee by:

1. Meeting informally with the Committee during the White House Conference on Aging;
2. Meeting formally again early in 1972 in a post-White House Conference meeting;
3. Establishing better communications by mail, between meetings; and
4. Arranging for the Secretary of Health, Education, and Welfare to appear at a meeting with the Advisory Committee.

I. Church Activities

As a direct result of the 1970 pilot project in Indiana, through technical assistance from AoA, church involvement in community services for older Americans resulted in a state-wide Institute on Religion and Aging. The Indiana Council of Churches and the Indiana Catholic Conference recognizing the legitimate sphere for concern of the religious community with the problems of the aging, through their respective boards of directors and in conjunction with the Indiana Office of Aging, developed the Institute. This is a novel approach on a broad-scale effort, and to our knowledge, the first of its kind in the Nation. While the above two church organizations formed the Institute, other religious bodies will participate in sharing a ministry to the Aged through the Institute on Religion and Aging. The project is partially funded by a private foundation, with other funds to come from intra-church organizations. Seminars involving members of the clergy and laymen are being planned, with the first scheduled in October of 1972 at Notre Dame University. Religious bodies from other States, including Pennsylvania, Missouri and New York, are in the process of exploring ways to develop State-wide efforts to apply the resources of religious communities to the material and spiritual needs of our older citizens. Many of the National Organizations of religious groups involved in the White House Conference on Aging are now in the process of alerting their church bodies to the needs of the older citizen and the most suitable means of providing assistance.

A handbook for churches entitled "The Older Person, the Church, and the Community", prepared by AoA and published and distributed by the Indiana State Commission on Aging, has been widely circulated at the Indiana State Fair and also at the White House Conference on Aging.

J. Information Activities

The fact that it was the year of the White House Conference on Aging colored all AoA Division of Information activities during 1971.

Increased visibility of the situation and needs of the elderly throughout the country, resulting in part from preparatory Conference activities in 1970, added tremendous support, pressure, and urgency to the Information Division's 1971 operations. While increasing the burden of public inquiry and media responsibilities of a small staff, it opened a steadily increasing number of fine opportunities to advance knowledge and progress in aging.

As national concern and interest grew, the public inquiries mail (and phone calls) of the Division skyrocketed. Demands for current publications and background materials rose sharply, with waiting lists developing for new products as the Conference date approached. Larger printing runs than usual of all new publications and reprints were necessary to meet demands. Deadlines were determined by necessity to obtain delivery for Conference delegates and distribution.

1. SPECIAL CONFERENCE ACTIVITIES

In addition to a large number of publications of its own developed in relationship to (and in time for) the Conference, the AoA Information Division also assisted the White House Conference information staff by providing it with basic aging materials from various sources and by editing and publishing the Conference Program.

Beginning with the January 1971 issue of *Aging*, the AoA magazine's masthead was amended to carry a continuing banner: The Year of the White House Conference on Aging. Each issue featured major Conference developments.

The Division designed, wrote and published for the Conference, two special publications: the First Reader, spelling out the Conference 3-year schedule; and The Second Reader, subtitled "To Design A World" and covering the 14 main subject areas of the Conference.

The First Reader was carried as a special section in the January issue of *Aging*, the Second Reader in the May (Senior Citizens Month) issue and each was reprinted as a separate special publication. More than 300,000 were distributed.

The Information Division was actively involved in all stages from planning through production of a 90-minute multimedia production for the White House Conference, funded by SRS. Film materials, slides and photographs developed for it will be used by the Division in follow-up 1972 activities.

The Division arranged for the Today Show TV program the day after the Conference ended. Host Frank McGee came down from New York for Washington orientation. AoA photographs provided visual background. The program featured Conference Director (and U.S. Commissioner on Aging) John Martin; Conference Chairman Arthur Fleming; Senator Harrison Williams, and Nelson Cruickshank of NSCC. (NBC's interest grew out of a 5-morning series on Today in 1970—the Conference prolog year—planned with AoA.)

2. MAJOR PUBLICATIONS

A major publication of the year was "Let's End Isolation", a carefully researched booklet covering essential community services which can help end isolation of the elderly. Providing "good examples" of such programs now underway in some communities, it points out that they are adaptable to all and gives sources of additional information. A second printing was necessary within days of initial distribution. A slide presentation related to the booklet is in preparation.

A new series of statistical publications, Facts and Figures on Aging, long-planned, was begun as 1970 Census figures became available. Prepared by Herman Brotman, Assistant to the Commissioner (on Aging) for Statistics and Analysis, it continues and expands distribution of his earlier Useful Facts on Aging. Five titles in the series were produced in 1971.

A comprehensive publication, "Transportation and Aging", was printed in cooperation with the Departments of Housing and Urban Development and Transportation. "More Words on Aging", a promised 1971 supplement to the 1969 bibliography "Words on Aging" was produced. Additions to the nutrition subseries of Administrative Papers brought that collection of useful research and demonstration project reports to 16 at the close of 1971, with 5 additional titles at the printers.

In its continuing effort to assist with prompt research utilization, the Division published nine Information and Referral "how-to-segments", ranging from Manager's Notes to Outreach and Escort Service, all growing out of a major Title IV Research and Demonstration project. The first publication related to the new Areawide Model Project Program was published during the year and updated when new grants were funded. In loose-leaf format, it will have additions made from time to time as the program progresses.

3. OTHER INFORMATION ACTIVITIES

AoA's first Poster Series, long needed, became a reality during the year. Produced both on paper, easily shipped and carried in mailing tubes, and on railroad board for use in table top exhibits and on easels, the series covered 11 subjects important in the field of aging: The role and responsibility of AoA, Advocacy, State Agencies, Preretirement Preparation, Older People as a Resource Nutrition, Transportation, Research and Demonstration, Training, Employmen

and Volunteer Opportunities, and the Foster Grandparent Program. Enthusiastically greeted by State agencies, public and private organizations, schools, and libraries, some 6,000 sets were distributed in 1971. Additional subjects will be added as appropriate.

The Division worked with a number of television stations throughout the country, arranging for appearances by Commissioner Martin and other staff members, and providing background materials for a variety of documentaries. It helped plan and participated in production of an NBC's YOU program. "You and Everyone's Future", featuring Commissioner Martin and Dr. Nathan Shock of the Public Health Service Institute of Gerontology.

A start was made in preparation of slide presentations, with a short narration and 18 slide set concerning overall AoA responsibilities and—as mentioned—slides designed for a very brief presentation on "Let's End Isolation".

An earlier slide presentation, related to the Division's accident prevention course for older Americans, took a Federal Editor's Blue Pencil Award in May 1971.

4. SENIOR CITIZENS MONTH

Like everything else in 1971, this special month of concern for and attention to older Americans was keyed to Conference preparations. The Second Reader was the major AoA publication. The Special poster for the Month featured the Conference theme Toward a National Policy on Aging. It and the Presidential Proclamation were widely distributed. The Ad Council again gave support through its Public Affairs Media Bulletin and the National Association of Broadcasters was helpful in addressing envelopes for a special mailing of TV (with slide) and radio spots to some 8,000 radio and TV stations. Most States held State White House Conference on Aging during May.

5. AGING MAGAZINE

During the year, *Aging* Magazine celebrated its 20th anniversary with a special issue (June 1971) and an exhibit at the University of Michigan Annual Conference on Aging.

The magazine's circulation now stands at 23,000, more than 50% in paid subscriptions. Circulation came up sharply through interest in the Conference and a mail sales campaign conducted by the Government Printing Office.

K. Pre-Retirement Planning

AoA provided technical assistance in developing broadrange, pre-retirement seminars for both government and non-government groups. AoA is also in the process of evaluating pre-retirement training programs, both with respect to timing of such seminars in relation to the date of retirement and also with respect to the net results for the retiree in his attempts to adjust to the psychological and economic problems facing him in retirement. The use of retirees as seminar speakers provided important insights in this area. AoA also provided speakers for 26 pre-retirement seminars and is currently scheduling additional speaking engagements for 1972. To strengthen AoA assistance in this field, a student trainee, a recipient of Title V support, was assigned to help develop retirement planning materials as well as consult with retirees on effective and satisfying use of time and talents in the post-retirement period. Early indications suggest that employees' attention should be focused on retirement planning at least five and preferably ten years prior to the anticipated retirement date.

L. Administration

1. EVALUATION ACTIVITIES

The Administration on Aging has continued to develop specific studies dealing with the assessment and evaluation of its programs.

Planning is being completed for an evaluation of the State Social Indicators System begun during 1971. Over 30 States are using this system as the basis of their long range planning. The study will insure the systems reliability and is based on the data collected by the States.

The evaluation project to evaluate the community programs (under the Title III State grant program) is underway. Early in 1972, the contractor for the

study, will begin interviewing both grantees and users of the projects. The results of the study should be available by June, 1972.

The project to evaluate the current information clearinghouse function of AoA and to design alternative methods for handling the clearinghouse function is in progress. The final report is expected in January, 1972.

An evaluation of the areawide model projects program under Title III is planned for 1972. This evaluation will help to provide base line data and give AoA early feedback on the operations of the areawide projects funded during 1971.

2. IMPLEMENTATION OF AN INTEGRATED MANAGEMENT SYSTEM

AoA has implemented the SRS integrated management system to permit more effective operations. This system includes the budget, long range planning, the operational planning system, legislative development and the evaluation system. Within AoA these five segments have been united into a single system which coordinates each of these basic programs.

This integration permits more effective management, better decision making, more effective programs, and better responsiveness to the needs of older Americans. During the next few years this system will be sharpened, and expanded to insure improved program management.

ITEM 3. ATOMIC ENERGY COMMISSION

JANUARY 19, 1972.

DEAR SENATOR CHURCH: It is a pleasure to have this opportunity to provide information on the Atomic Energy Commission's research program on aging for inclusion in "A Report of the Special Committee on Aging of the United States Senate," under the title "Developments in Aging—1971."

During the fiscal year 1971, the Atomic Energy Commission allocated $5.6 million for research in the area of aging, particularly as aging relates to, or is a component of, the long-term effects of ionizing radiations. The projected allocation for fiscal year 1972 is approximately $5.5.

An important recent development has been the consolidation of research programs observing the long-term effects of radium in the watch dial painters into one laboratory. This restatement of problem and methodology is one of the results of a conference held at the Argonne National Laboratory on December 7–9, 1970, titled "The Estimation of Low-Level Effects in Human Populations." A copy of the proceedings of this conference is enclosed.* A conclusion of the conference was that more inclusive, more systematically devised and operated epidemiologic techniques than are now employed could yield significant advances in identifying the factors associated with aging.

The Atomic Energy Commission is charged with assuring the radiologic safety of all its activities and, therefore, is concerned with all effects of radiations on living structures and the radiobiologic phenomena underlying those effects. Studies of the long-term or chronic effects resulting from exposures to varying dose ranges of radiations arising from outside the body as well as from radionuclides distributed within the body were begun years ago in order to develop dose/effect relationships and to identify the mechanisms associated with those effects. More than adequate numbers of unirradiated control animals were included in each experimental series. Altogether, more than 4,500 beagle dogs and thousands of mice and rats, both irradiated and controls, have lived out their life spans under optimal laboratory conditions. Three general observations emerge from these experiments: (1) Experimental animals, and beagles in particular, have life spans as much as twice as long as expected when given proper housing, feeding, and veterinary care. (2) Irradiated animals have a shortened life span roughly proportional to dose. (3) Pathologic changes seen at death in the irradiated animals are analogous to those in the control animals dying spontaneously of chronologic old age: cancers, fibrotic changes, and failure of vital tissues such as the cardiovascular system, kidney and central nervous system. These are similar to the changes found in the aged man.

*Retained in Committee files.

Identification of a shortened life span for expressing the effects of irradiation is an actuarial convenience: it avoids explaining the basic mechanisms leading to death in both the irradiated and control animals. For example, if an irradiation leads to development of lethal neoplasms, the mean life span of animals so affected will be shortened, although the control animals may die later from spontaneously occurring neoplasms. This leads to the hypothesis that the irradiation has merely accelerated processes that were already in motion, processes that presumably are a "normal" part of aging. Alternatively, it may be assumed that ionizing radiation constitutes a stress that produces within the organism a given number of units of agedness which then are added to the normally accumulating burden of agedness. Hypotheses such as these clearly point to the absence of fundamental knowledge on the biochemistry and biophysics of aging cells and the need for such information as benchmarks for identification of the cellular and tissue reactions to abnormal stresses.

Twenty-three contracts with investigators in universities and research laboratories are concerned with investigating various aspects of radiation effects which must be evaluated with reference to control populations where the passage of time is an important variable and, therefore, relates in varying degrees to aging. Twenty-two percent of the $5.6 million noted above is budgeted to these studies.

Three major epidemiologic studies on the long-term effects of radiation in man should be noted. The first is a retrospective-prospective epidemiologic investigation designed to learn whether employment in the nuclear energy industry is associated with patterns of illnesses or syndromes not seen with equal frequency in several types of unexposed control populations. The unusual aspect of this investigation is that it makes use of the cohort system to follow groups of employees and controls as they progress through the years of employment and into retirement and finally to death. When the study is complete, the occupational health and mortality records of some 500,000 persons will have been compiled and compared. The program is believed to be unique in the area of occupational medicine both as to concept and dimensions. No evidence of unusual biomedical effects has been detected up to this point.

Any decrease in the life span and/or increased frequency of one or more of the common causes of death in the employee group would if discovered stimulate additional, more refined analyses of the data. A major problem in this study is the definition of satisfactory control groups matching the potentially exposed personnel in all aspects except irradiation. A further complicating factor has been the observation that many workers in the atomic energy industry have been and are exposed to several other occupational hazards in addition to whatever radiation exposures may have been experienced. Investigations such as this progress slowly; definitive reports may not be expected until much later.

The second large epidemiologic investigation in which aging is a critical factor involves the populations of Hiroshima and Nagasaki exposed to the radiations from the nuclear explosions of August 1945. The study is being carried out by the Atomic Bomb Casualty Commission which is supported jointly by the Governments of the United States and Japan. Nearly 112,000 Japanese citizens of these cities have been and are being observed for longevity and morbidity/mortality, half being survivors of various levels of radiation exposure and the other half carefully chosen matching controls. The voluntary cooperation of these people is truly unique. Twenty thousand members of this population of 112,000 were selected, half exposed and half controls, for thorough biennial medical examinations for the purpose of detecting incipient diseases and evaluating their general health status. This latter medical examination program permits closer appraisal of the progression of medical signs and possibly clinical pathological evidence of aging in a population with and without the added factor of an instantaneous radiation exposure in the past. The eventual epidemiologic data on the entire population of 112,000 should help answer the question of whether irradiation shortens life span in man as observed in certain studies with experimental animals. The ABCC study already is providing important information on the aging characteristics and morbidity/mortality patterns of post-war Japanese nationals. These observations should be continued until at least 1990 when more than half of the population will have died.

Although reliable clinical and boichemical tests for aging are being used in the biennial medical examination protocols, it is not certain that the resulting data will be able to delineate definitive quantitative relationships between physio-

logic and chronologic aging. This gives substance to the major question asked at the Argonne Conference noted above: How can physiologic aging in cells and tissues be measured quantitatively?

The third epidemiologic investigation on man is a program that has been underway since 1950 jointly at Argonne National Laboratory and Massachusetts Institute of Technology. Both laboratories have been remarkably successful in locating and carrying out epidemiological studies on persons who worked with radium and as radium dial painters before the hazards of the element were fully recognized. The health records of these people are very important radiobiologically, as they provide the data base for calculating radiologic protection data for alpha particle-emitting radionuclides. Their importance to the aging problem lies in the possibility that alpha irradiation may accelerate the aging process. This work now is being consolidated at Argonne National Laboratory in order to expedite the study of about 700 radium-contaminated persons still living. One hundred of these people may survive to 1990 and 40 to the year 2000. This investigation will document the sequence of physiologic changes and diseases in this remaining group of radium-contaminated persons as they grow older.

The staff of the Division of Biology and Medicine of the Atomic Energy Commission have contributed to the planning and development of the policy proposals in the area of Research and Demonstration in preparation for the White House Conference on Aging held in Washington, November 28 to December 2, 1971.

I hope this information will be of use to the Committee.

Sincerely,

W. W. BURR, Jr.,
(For John R. Totter, Director, Division of Biology and Medicine).

ITEM 4. DEPARTMENT OF AGRICULTURE

JANUARY 24, 1972.

DEAR SENATOR CHURCH: In response to your request of December 9, 1971, we have been asked to provide the attached statement describing the major programs and activities of the Department in assisting older Americans.

Included, also, are copies of two new publications especially directed to older people—"A Guide to Budgeting for the Retired Couple" and "Food Guide for Older Folks."*

If we can assist you further, please don't hesitate to contact Dr. Gerald F. Combs of my office.

Sincerely,

NED D. BAYLEY,
Director, Science and Education.

[Enclosure]

ACTIVITIES OF THE U.S. DEPARTMENT OF AGRICULTURE TO HELP OLDER AMERICANS

FOOD AND NUTRITION SERVICE

The U.S. Department of Agriculture's two major food assistance programs—the Food Stamp and the Food Distribution programs—serve the elderly in their homes. While a substantial number of the elderly are being reached in this way, further improvements being made will make the programs even more responsive to their needs.

Food Stamp Program.—Under this plan, coupons are provided for low-income households to spend in retail grocery stores. Families pay a portion of their income (never more than 30%) and receive a stamp allotment sufficient to purchase a nutritionally adequate diet.

The 1971 amendments to the Food Stamp Act provide that elderly participants who are so disabled or weak that they cannot adequately prepare all of their meals, may use food stamps to pay for "meals on wheels" delivered to them by

*Retained in Committee files.

nonprofit meal services. In addition, elderly householders receiving public assistance may be certified solely on the basis of information contained in an affidavit and the assistance case file. The certification of householders not receiving public assistance has been simplified so that the application may be filled out by the applicant, or by anyone he chooses, and submitted by mail. While all such households must be interviewed, the elderly who are unable to go to the certification office may be interviewed in a home visit or by telephone.

As of December 1971, over 20 States were implementing most of the newer provisions.

Food Distribution Program.—Under this program, foods are made available by USDA to low-income families in about a third of the counties not served by the Food Stamp Program, and to institutions, including those that serve the elderly.

More than 20 foods are made available to these low-income families for home use. The family distribution guides have recently been revised to permit greater flexibility at the local level, and, to conform with local food consumption habits and nutritional needs. This change is expected to benefit households of elderly persons especially, since it encourages distribution centers to make all foods available each month in small container sizes.

A pilot effort for free home delivery of donated foods to elderly shut-ins has just begun in five project areas participating in the distribution of food. This effort, called "Drive to Serve," is engaging the services of high school students in conjunction with adult volunteers from the American Red Cross or other service organizations.

A special recipe booklet geared to households of one or two people, with particular appeal to the elderly, will soon be available for "Drive to Serve" recipients and in all distribution centers.

Selected foods are also being made available under the Food Distribution Program to public and private non-profit institutions, senior centers, schools, and churches. USDA, through the years, has kept alert to the growing number of programs in these institutions, and has encouraged the cooperating State distribution agencies to be responsive to their applications for donated foods.

A survey is currently being conducted to determine how effectively the Food Distribution Program is reaching charitable institutions. The first phase consists of compiling an inventory of all participating outlets according to the kinds of services they provide, as well as the age and characteristics of the aged who are helped. The inventory will identify organizations providing non-profit food service for the elderly on a non-residential basis, and will show the number being helped. The second part of the survey will assess on a national basis the nutritional impact of USDA food donations to institutions. The survey findings will help USDA evaluate recommendations for increasing the quantity and variety of distributed foods, and other proposals for improving the program's effectiveness for the elderly.

Outreach and Nutrition Education.—As part of USDA's outreach efforts for those who receive food stamps and donated food, nutrition education materials and guides for getting more value from food expenditures are made available in English and Spanish.

Extension Service

Although the Extension Service does not earmark funds especially for work with the elderly, it does consider this age group a part of its overall responsibility and has programs that benefit the elderly.

For example, special attention is being given to education programs for the aged in three-quarters of the States. These programs cover problems with income, health, education, nutrition, housing, and continuing education, as well as with family, community, and spiritual well-being.

Many States have a staff member who gives some leadership to programs for the elderly. Some States, including Arkansas, Texas, North Carolina, and Nebraska, have full-time specialists for the aging.

The Extension Service-related National Homemakers Council, working under the leadership of Extension home economists, has committed its organization to a long-range program, giving attention to the needs of the elderly and fostering conditions to meet those needs.

The latest national study of Homemaker Club members shows that 40 percent were 50 years or older, and 18 percent were 60 and over. A recent State study shows that 17 percent of Extension Homemaker Club members were 65 or older. A sample survey of the programs includes Nutrition for the Aging, and Preparation for Aging.

In North Carolina, for example, the Home Economics Extension Program on aging is increasing awareness in the community of the special needs of the aged. Workshops, forums, regular club meetings, and the mass media in 73 counties have worked to involve the aging in educational experiences and in developing needed community service projects. Reports from long-range planning showed that 92 problems of aging have been identified. Special adjustment difficulties, including an understanding of the aging process, have been studied in 46 counties; reduced income and failing health in a third of the counties; and nutrition and housing in nearly half. Half the counties initiated action to find meaningful use of leisure time; 22 counties became involved in planning improved transportation; and 28 set up "friendly visitor" and "home companion" projects.

Nutrition for the Aging.—Home economists in the Extension Service and the land-grant colleges in most States are reaching senior citizens with food and nutrition programs designed to meet the special needs of the aging. Many methods are being used, including regular meetings, telephones, conferences, special prepared literature, newsletters, radio, TV, and newspapers.

The Expanded Food and Nutrition Education Program that began in November 1968 has made it possible for Extension professionals, Extension Program aides and volunteers to assist many more low-income aged people to acquire knowledge, skills, and motivation in improving their diets. It has helped them to learn more about food habits and food buying practices in relation to health and to management of money, and has informed them about the public and private institutions, agencies, and programs that provide services for the aging (including those of USDA).

This nutrition education program employs about 10,000 aides who work with home economists and food and nutrition specialists. Two million low-income families, including more than nine million individuals, have been reached through this effort during the past three years. Twenty-one percent of these aides are 50 years of age or older. A sample survey showed that one third of those reached through the nutrition education program were 50 years of age or older, and 20 percent were 60 or over.

Leadership Development.—In many States, Extension people, through their contacts with other community development groups, have been instrumental in helping elderly people organize into senior citizen groups, with activity centers and programs adapted to their interests. The elderly themselves take the leadership in these organizations once they are initiated, and are assisted by people trained in organization.

The Homemakers' Councils have been key groups in working with the elderly in rest homes, nursing homes, or with individuals living alone in the communities. Many 4-H Club members adopt the elderly as aunts or uncles and some provide entertainment and special services for the aging in homes for the elderly. In an effort to utilize their expertise and skills, Extension professionals recruit volunteer leaders from the aging population.

Health.—In many counties, Extension has cooperated on the Medicare program. Leaders trained by the Extension staff explain the provisions of the law, often through farm organizations and Homemakers' Clubs, or individual visits by aides.

In Vermont, for example, 29 radio scripts and 39 news stories were released concerning Medicare provisions for the aged, and 97 meetings were held. In most counties, these projects were carried out cooperatively with Extension, Social Security, and the Office of Economic Opportunity.

Improved Income.—Extension has cooperated with many groups in order to organize special craft programs or classes for the interested elderly. Local resource people are often located to give training that provides home industry incomes for many older people. Tennessee, Missouri, Arkansas, and Oklahoma have been particularly successful. Craft fairs in these States involved a large number of senior citizens who displayed their work and explained it to interested visitors. This has been an extremely important contact for the elderly in selling items they have created, and has helped a great deal in implementing their incomes, and has provided social interaction.

The advertising department of a local industry in Iowa recently contacted Extension people about the possibility of establishing a market for certain handmade articles such as bonnets and creative stitchery. Sixty women and three men, most senior citizens with quite low incomes, are now making articles for the market and have increased their incomes substantially.

Preparation for Aging.—Special programs on understanding the older person—with special attention to his physical, psychological, emotional, and social problems—have been successfully conducted in a number of States. In many instances, these have helped to bridge the differences that exist between the young, the middle-aged, and the old.

In Iowa, for example, a radio program specifically oriented toward those who are retired, or close to retirement, informs the older citizens of the needs in aging. One innovation is a monthly legislative report on new State and Federal legislation concerning the elderly. In the future, the program hopes to continue to educate the elderly, as well as to entertain and inspire them.

Housing and Management.—Special housing needs for later years were covered in many counties through cooperative programs conducted by Extension Service in connection with housing finance agencies and local bankers. Topics such as work height, storage, laundry, and other work simplification methods to help elderly people were typical items of discussion. Legal aspects of moving from one State to another, wills, estates, and tax returns were also covered.

Consumer and Marketing Service

Consumer education materials have proven especially useful to elderly persons who are concerned with getting the most for their food dollars.

Materials included five pamphlets on meat and poultry inspection, meat and poultry labeling, and how to care for meat and poultry products, and a series of "How to Buy" pamphlets that explain how USDA grades can be used as a guide to quality in shopping for food and other useful tips.

In addition, many of these materials are being translated and published in Spanish. Already issued was a bilingual teaching aid on how to buy food. This publication is intended for teachers and those dealing with consumer groups.

Economic Research Service

While the activities of the Economic Research Service are not directed toward a specific age group, the needs of the elderly are included. In demographic and housing research, studies of income and employment, and the potentials of rural development efforts, the special needs of the elderly are taken into account. In studies of rural poverty and low-income farmers, for example, particular attention is given to those beyond labor-force age for whom assistance must be quite different from that of working-age populations.

Farmers Home Administration

The Farmers Home Administration, a rural credit agency, issued a total of $356 million in initial loans for farm programs during Fiscal Year 1971. More than $3 million, or 1 percent, went to borrowers classified as elderly. Subsequent loans for the same period amounted to $187 million. Although statistics on the amount going to the elderly are not available, experience leads FHA to believe that a larger percentage went to the elderly than in the case of the initial loans.

Initial loans for housing programs in Fiscal Year 1971 totaled over $1.3 billion. Of this, more than $44 million, or 3.3 percent, was loaned to elderly citizens.

Since January 1965 and until June 30, 1971, FHA administered the economic opportunity loan program for the Office of Economic Opportunity. Although loans fell off in 1971, the percentage of elderly who received loans went up to over 14 percent.

FHA loans are also made to public and nonprofit groups to benefit entire communities. For example, such loans are made to develop community and county or multicounty water and waste disposal systems, and to develop recreation areas. In the overall population, the elderly living in these areas received a share of the advantages of such credit assistance.

Agricultural Research Service

Nutritionists obtain basic information on food consumption and diet quality for all age groups, including infants, teenagers, and the elderly, and develop educational materials for use throughout the country.

Two new publications especially aimed at older people were recently prepared for use by the White House Conference on Aging. These publications, which were set in larger type for easier reading by the elderly, included, "A Guide to Budgeting for the Retired Couple" and "Food Guide for Older Folks."

ESTIMATED USDA EXPENDITURES ON PROGRAMS FOR AGING

[In millions of dollars]

	Fiscal year—		
	1971	1972 (estimate)	1973 (estimated budget allowance)
Program:			
Food stamp program	233.6	296.3	343.5
Commodity distribution	58.3	58.6	53.4
Farm Home Administration	44.5	50.0	65.0
Research	.5	.451	.505
Extension	5.0	5.0	5.5
USDA total	341.9	410.351	467.905

ITEM 5. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT,
Washington, D.C., February 8, 1972.

DEAR MR. CHAIRMAN: Enclosed in duplicate is the Department's statement for inclusion in your report, "Developments in Aging—1971," in response to your letter of December 9, 1971.

Let us know if we can be of further assistance.

Sincerely,

GEORGE ROMNEY.

[Enclosure]

ANNUAL REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—1971 HIGHLIGHTS

INTRODUCTION

During 1971, the Department of Housing and Urban Development reaffirmed its commitment to alleviate the critical housing and community development problems faced by the elderly. This report describes the maximum departmental effort during 1971 to ensure that HUD's broad housing and community development programs respond more adequately to the special needs and concerns of our elderly citizens.

After this introduction the report proceeds with a description of goals and achievements within HUD's housing programs, follows with a discussion of achievements for the elderly in the community development, community planning and management and research areas and then concludes with a brief description of the key legislation relating to the elderly which was enacted during 1971.

The year 1971 marked the completion of nearly three years of effort to organize the Department of Housing and Urban Development along functional lines and to decentralize its operations to provide more effective service to local communities. Housing production in all programs now is the responsibility of one Assistant Secretary, housing management another Assistant Secretary. Community development programs formerly administered by three Assistant Secretaries, now are grouped under one Assistant Secretary as are all community planning and management programs. HUD's new organization pattern is reflected in this report.

Several other significant events relating to housing for the elderly took place during 1971. HUD virtually completed funding of the 35,000 unit Section 202 pipeline which existed at the beginning of fiscal year 1970. Having converted this large 202 pipeline, HUD was in a position to commence the funding of new Section 236 housing specially designed for the elderly. During the two year period when non-202 conversion elderly 236 applications were not being processed, a large backlog of such applications developed. Two-thirds of such applications were submitted by non-profit sponsors.

HUD, as requested by Congress, has earmarked $35 million of its FY 1972 Section 236 contract authority for the production of specially designed elderly 236

housing. It is expected that applications of $17.5 million can be processed and funded during FY 1972—an all-time record for private subsidized elderly housing. Non-profit sponsors under this program will be helped not only by doubled funding of the Section 106(b) seed-money loan but also by the new Section 106(a) program which will be used to provide technical assistance to non-profit sponsors of HUD-assisted housing.

Elderly minimum property standards for all multifamily programs including Section 236 were revised during 1971. A separate feasibility and processing circular for elderly 236 housing is in the final stages of preparation.

At the recent White House Conference on Aging, Secretary Romney stated that HUD would target ⅓ of all new public housing approvals for housing for the elderly.

At the Conference, Secretary Romney also announced HUD's intention to make administrative changes within the Section 235 program to enable more elderly to purchase new appropriately sized and specially designed homes.

A major effort is underway to improve public and consumer information on HUD's programs for the elderly. The results of these efforts are described in this report.

Within the housing management area, substantial progress for the elderly was made. The signing of a joint HUD/HEW agreement on welfare services will lead to important new services for many elderly living in public housing.

The elderly housing staff of the Department spent substantial time and effort in representing HUD at the White House Conference on Aging. A total of 13 HUD staff provided critical support to the Conference.

On the legislative side Public Law 92–213 was enacted which will ensure that all public housing tenants, regardless of whether they are receiving welfare assistance payments, are now entitled to a reduction in rent to ¼ of income. During 1971, HUD introduced the proposed Housing Consolidation and Simplification Act of 1971 which if enacted would go a long way in increasing the ability of HUD's housing programs to respond to special needs of the elderly. One important provision in that bill would reduce the age limit for eligibility in public housing for the elderly to 50 years.

There was considerable activity benefitting the elderly in HUD's other programs. The high percentage of elderly programming within HUD's Model Cities, Neighborhood Facilities, New Communities and Rehabilitation programs is described in the report. Implementation of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 will be of great benefit to elderly displacees in locating and affording replacement housing.

Finally, there has been considerable research relating to the elderly. Some of the most important studies relate to housing allowances and innovative public housing management proposals. The relationships of these studies to the elderly are described in this report. Specific studies relating to the elderly during 1971 included a major analysis of 1970 elderly housing census data plus Federal elderly housing programs, and the completion of a study on the causes of home accidents.

I. Housing Production and Mortgage Credit

LOW-RENT PUBLIC HOUSING PROGRAM

Presently about 39 percent of all public housing units or about 360,000 units in all are occupied by low income elderly families and individuals. (See Appendices I. III and IV). Roughly ½ of these units are specially designed for the elderly, (See Appendix II).

Additional public housing units for the elderly are provided in a number of ways:

—New housing specifically designed for the elderly through the "conventional bid" method whereby the housing authority acts as its own developer.

—The leasing of existing (including rehabilitated) or newly constructed housing from private owners.

—The acquisition (with or without rehabilitation) of existing privately owned housing.

—The construction of new housing specifically designed for the elderly through the "turnkey" method under which the local authority agrees to purchase a project from a private contractor after it is completed pursuant to agreed-upon plans and specifications.

The Secretary recently announced that a target level of ⅓ of all fiscal year 1972 public housing contract authority would be used for specially designed housing for the elderly. This authority will finance the production of about 30,000 units. In addition, a substantial number of general purpose units financed by 1972 authority will be occupied by the elderly.

SECTION 236 AND RENT SUPPLEMENTS

Section 236 was enacted in 1968 and authorizes the payment of interest reduction subsidies which reduce the effective rate of interest paid by eligible mortgagors to as low as one percent. This interest rate reduction is translated into reduced rents for lower income families who are required to pay at least 25 percent of their income for rent. (See Appendices IV and V for comparative 236 and Public Housing Occupancy data).

The rent supplement program provides for rent supplements on behalf of needy tenants. The housing is privately owned, privately operated, and primarily privately financed. A rental rate sufficient to cover total housing costs is established for each rental unit. Eligible tenants must pay 25 percent of their income toward the rental rate with the deficiency made up by a rent supplement payment directly to the project owner. However, in no case can the supplement exceed 70 percent of the economic rent.

Based on a survey made in late 1969, 36 percent of all units receiving market rate rent supplement assistance were occupied by persons 60 years of age or over.

HUD will abide by the mandate contained in the 1972 appropriations bill's conference report to earmark $35 million of the $200 million FY 1972 Section 236 contract authority exclusively for the production of elderly housing. This authority would support, at current development costs, the production of approximately 40,000 units. It is presently estimated that there will be sufficient demand to utilize at least $17.5 million of this authority during FY 1972 to support production of over 20,000 units.

It should be noted that approximately ⅔ of all pending elderly 236 applications have been proposed by non-profit as opposed to limited dividend sponsors. Extensive non-profit participation in the 236 program has been facilitated by the Section 106(b) program enacted in 1968 which provides interest-free "seed money" loans to eligible non-profit sponsors of federally-assisted housing. As of this month, 168 loan applications had been approved for aproximately $5,000,000 covering projects with almost 19,000 units. It is expected that the scope of the Section 106(b) program will continue to increase in FY 1972 and that at least $5,300,000 in new loans will be approved—double the FY 1971 level.

Moreover, non-profit participation within the Section 236 program will also be stimulated by implementation of the Section 106(a) program. Under this $1 million grant program, HUD will contract with experienced public or private non-profit organizations to provide a variety of technical assistance and information to inexperienced non-profit sponsors of low- and moderate-income housing.

During FY 1970 and 1971, 28,000 units out of an existing 35,000 unit 202 pipeline were converted to the 236 program and funded. Given the average past rate of funding under 202, it would have taken at least four years to process the pipeline under Section 202. With the additional 20,000 specially designed 236 units expected to be funded in FY 1972, the 236 program will have funded more units in three years than the 45,512 units funded during the entire 10 year life of the 202 program.

In addition to this high production level of specially-designed housing, a substantial number of general purpose 236 units will be occupied by the elderly.

HUD has put great stress on improving the quality of specially-designed elderly 236 units. For example, the minimum property standards for the elderly (HUD PG–46) have been recently revised and improved. In addition, a special processing and feasibility circular for the elderly 236 program is in the final stages of preparation.

CONGREGATE HOUSING

The 1970 Housing Act provided for congregate housing under Sections 236 and 221 of the National Housing Act as well as public housing to provide housing more particularly needed by those older people, the handicapped and displacees who require food and other supportive services. Congregate housing holds great promise as a deterrent to premature institutionalization, or as an opportunity for many to leave institutions.

HUD has for some time had in its public housing processing instructions a set of guidelines for congregate housing for the elderly. Since the 1970 Act, a further handbook dealing with congregate public housing has been in development and is about to be published. In addition, a Housing Management Circular defining those central dining facility operating costs eligible for treatment as administrative expenses within congregate public housing projects was published in 1971. Finally, a handbook which would implement the Section 236 and Rent Supplement congregate housing program is presently being developed.

SECTION 235 PROGRAM

HUD is particularly concerned with the severe problems facing present and potential elderly homeowners. Presently over ⅔ of all elderly live in owner-occupied homes. Over 80 percent of their homes are owned mortgage-free. But many of these owners are "house poor," because property taxes and other housing costs are generally rising faster than incomes. Moreover, many of these homes were built for younger and larger families and, as a result, they impose a severe financial and maintenance problem for the olderly homeowner. Many older people would like to move out of these homes into new, smaller, more appropriately-designed units, but rising costs often lock them into their present quarters.

The Section 235 program can be used to reduce interest payments on new homes to as low as one percent. Up to now, elderly participation in this subsidized housing program has been limited. (See Appendix VI.) However, our Department is presently developing administrative changes that would enable Section 235 to provide elderly with the *option* to move into new units. In some cases, participation by local housing authorities may be necessary to facilitate the sale of elderly-owned homes and to enable larger low-income families to afford these vacated units.

NURSING AND INTERMEDIATE CARE FACILITIES

As of October 1971, FHA had insured a total of 826 nursing home projects, consisting of 84,398 beds, for a total of $675,689,365 in mortgage coverage. (See Appendix VIII for general nursing home data.) Of these, 71 projects consisting of 8,885 beds are rehabilitated facilities. Detailed statistics on the non-profit and Hill-Burton portions of the nursing home program are found in Appendices IX and X.

In 1969, mortgage loan insurance for the construction or rehabilitation of intermediate care facilities, or combinations of nursing homes and intermediate care facilities was made possible. An intermediate care facility may be any facility that provides a supervised living environment for those individuals who need less than skilled nursing home care. The 1967 amendments to the Social Security Act permit intermediate care vendor payments for recipients of Old Age Assistance, Aid to the Blind, and/or Aid to the Permanently and Totally Disabled. A Bill (PL 92–223), signed into law by President Nixon on December 28, 1971, authorized care in intermediate care facilities for all recipients eligible for benefits under Title XIX (Medicaid) of the Social Security Act, if included in the State plan.

The medical and health facilities of the nursing home, with their emphasis on geriatric medicine and gerontology, can extend their services to provide like care for the elderly in the community. In some areas where medical and health care are almost nonexistent, the nursing home can also provide needed services to the underprivileged of all ages, including prenatal care.

There is expanding interest in combining independent housing for the elderly, with congregate housing and a long-term care facility. Several non-proprietary church-related sponsors are currently working on this concept.

Several intermediate care projects are being constructed in combination with Section 23—Leased Housing projects. The sponsor of the nursing home or intermediate care facility leases the housing portion of the facility to the local housing authority. The therapy and food services portion of the facility is operated under the authority of HUD-leased housing programs.

During 1971, HUD Handbook on Administrative Procedures for Nursing Homes and/or Intermediate Care Facilities was published. A Sponsor's Guide for Nursing Homes and Intermediate Care Facilities is at the printer's office and a chart indicating sources of Federal financial assistance for the construction or rehabilitation of nursing homes and intermediate care facilities was produced and distributed.

HOSPITALS

The 1968 Housing Act authorized FHA to insure mortgage loans up to $25 million on non-profit hospitals for construction or rehabilitation, including equipment to be used in the operation, under Section 242. In 1970, Section 242 was amended to allow proprietary hospitals and increased the maximum mortgage to $50 million.

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. Comment is also solicited from the 314b agencies (local health planning bodies).

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 office, 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 for non-profit hospitals and in November 1971 for proprietary hospitals. As of December 1971 HUD has either insured or issued a commitment to insure approximately 43 hospitals. These hospitals range in size from 32 beds to 1,154 beds. A number of additional hospital proposals are being processed by HEW and FHA.

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 conveniently available, particularly to the elderly. In addition, costly hospitalization can be significantly reduced where the group practice is combined with a comprehensive prepayment plan. This FHA program was conceived in recognition of the potential of group practice in delivering efficient, comprehensive health services of high quality.

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 presently 7 percent, plus one-half of one 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 in accordance with an OEO program for health care for low-income people. The group practice program is of particular benefit to senior citizens.

PUBLIC INFORMATION

HUD has made substantial efforts to inform the public and consumers about our elderly housing programs. We have completed a popular filmstrip entitled "A Stranger Just Once." Secondly, we recently completed a "Guide to Elderly Housing" which describes in detail how to sponsor elderly housing under HUD programs. Next, HUD published in 1971 a brochure entitled "HUD Programs for Housing and Related Facilities which are Available for the Elderly." Finally, HUD prepared for the 1971 White House Conference on Aging a statistical handbook which not only contains the latest 1971 Census elderly housing needs information but also contains data on the major elderly housing programs administered by HUD, USDA, the Veterans Administration and the Bureau of Indian Affairs.

DEPARTMENTAL DECENTRALIZATION

It is HUD's policy to decentralize its operations to bring decision-making functions to the local level. Control over housing processing and management has passed to our Area and insuring offices. Within our area offices program managers will coordinate overall HUD program response to housing and community development problems within their particular jurisdiction. The program manager has a team of functional specialists—one of the most important being the multifamily representative who will not only have expertise in elderly housing programs, but also will have particular knowledge of special elderly housing needs in his area. Responsiveness to such needs is increased by decentralization of project approval authority to the Area or insuring office director.

In addition, most HUD Regional offices have elderly housing specialists. The HUD elderly housing specialists meets with groups to facilitate the use of the Department's programs to meet the varied needs of the older population. The elderly housing specialist also acts as a special consultant to housing sponsors.

SPECIAL CONCERN FOR THE ELDERLY WITHIN ALL HUD PROGRAMS

HUD has given special impetus and coordination to HUD programs which assist the financing of housing for the elderly. The internal reorganizations of HUD have centralized housing production in one Assistant Secretary and housing management functions in another. Moreover, other assistant secretaries in the research, community planning and management, and community development areas perform key functions relating to the elderly. All of these assistant secretaries have designated staff to deal with special elderly concerns. Moreover, the Assistant Secretaries for HPMC and Housing Management have offices which deal on a full-time basis with elderly housing issues. Secretary Romney had directed all of these assistant secretaries to coordinate closely those program areas which directly relate to the elderly and to ensure that all of their programs are sensitive to the particular needs of the elderly.

PROPOSED HOUSING CONSOLIDATION AND SIMPLIFICATION ACT OF 1971 (S. 2049)

The great proliferation of special categorical programs over the past years is a major concern of this Administration. We now have a great number of individual housing programs. Many of these programs duplicate one another. Each has special requirements and provisions which are different from the others and often contradictory and confusing. This great variety of programs has produced complexity that discourages many from participating in our programs and puts strain on those in HUD who must administer these programs. This bureaucratic and legislative maze produces inefficiency and long processing delays and threatens to defeat the purposes for which the legislation was passed.

The purpose of the housing consolidation bill is to eliminate the complexities, inconsistencies, and rigidities of present programs and to make them more efficient and easier to use and to administer, as well as more flexible in their application to various types of needs.

We are convinced that this bill if enacted will make the delivery of Federal assistance for housing more effective in meeting the housing needs of all our population. We also believe that this can be accomplished without any sacrifice of the many special housing needs that our programs are designated to serve, including the special housing needs of the elderly. On the contrary, we believe that this legislative consolidation will provide improved programs with greater capacity for serving the special needs of elderly families and individuals.

One of the key provisions in the proposed bill would reduce the age limit for eligibility in housing for the elderly to 50 years. This will permit earlier planning for retirement; will fill a gap in housing resources for single persons in the middle years who now are not eligible for any HUD program; will provide an additional relocation resource; and will encourage a greater mix of different age groups in many projects.

II. Office of Housing Management

Responsibility for housing management activities assumes growing importance as almost a half million units of federally-assisted housing are added annually to the Nation's housing stock. Management must concern itself with the con-

tinued financial stability and physical maintenance of HUD-assisted housing and insure the satisfaction and well-being of its residents, including the increasing number of elderly. Presently there are an estimated 400,000 rental HUD-assisted units which are occupied by elderly families and individuals. In addition to these subsidized units, many FHA-insured but non-subsidized rental and homeownership units are occupied by the elderly.

To attain these broad objectives, an Assistant Secretary of Housing Management was appointed in 1971. Specific responsibilities include management input in the planning and production process; administering subsidies; approving budgets and modernization programs; servicing and selling HUD-held properties; providing counselling, technical assistance and evaluation of HUD housing programs; and, providing housing assistance in Presidentially-declared disasters.

Management Highlights—1971

CONTRACT FOR MANAGEMENT TRAINING

Sizable manpower needs are indicated by the volume of housing starts which HUD has in production and planned for occupancy by 1980. The forecast is that by 1980, there will be approximately 5 million government assisted rental housing units under management, housing 20 million people, many of them elderly. It is estimated that 60,000 professionals will be required by 1980 to meet the need, an increase of 40,000 over those available today. The increase in housing programs for the elderly plus the overriding social and health connotations as important management factors will cause this particular aspect of management to be of special concern. Because of this onrush of record assisted housing starts, in February 1971, HUD in conjunction with the Office of Economic Opportunity, entered into a contract with the National Corporation for Housing Partnerships to provide plans for "a full scale and continuing program to meet the urgent national need for well trained management personnel in assisted housing programs."

EFFECTS OF CRIME ON THE ELDERLY

The elderly population is particularly vulnerable and beset with fear of crime that often limits their pattern of life and mobility. In order to respond promptly to need, a HUD Guide on Security is under preparation and Minimum Property Standards are being revised to include special locking devices.

In the modernization program in low-rent public housing, security hardware, electronic, audio and video control-devices and rapid communication systems with the police are stressed. Seeking long-range solutions, a HUD contract was let in October 1971 with the Law Enforcement Assistance Administration to formulate guidelines for controlling crime in residential areas. Included will be recommended security systems to minimize risk of crime.

SERVICES IN HOUSING FOR THE ELDERLY

HUD and HEW signed a joint agreement for services on June 9, 1971, to channel social services to public housing residents. Under this agreement, the local housing authorities will contribute 25 percent of the financing and the State Department of Welfare 75 percent in Federal matching funds.

With appropriate supportive services in all housing for older people, housing can contribute to a more fulfilling life and offset premature reliance on costly medical facilities. HUD will coordinate with other agencies and with programs using volunteers to perform essential services. Many senior citizens can contribute significantly to such a service program.

FISCAL MANAGEMENT

A new financial management system in public housing will guarantee payment of the subsidies committed at the time the local housing authority budget is approved. The special family, rental assistance, and operating deficit subsidy payments, including that for the elderly, currently computed and paid individually will be converted to a single operating subsidy to fill the gap between income and operating expenses.

In preparation is a series of management guidelines for specialized program areas, including management of housing for the elderly. Highlighted will be

elements of Section 236, Rent Supplement, and public housing with specific emphasis on measures to make these programs increasingly responsive to the needs of the elderly residents.

MODERNIZATION

Through the modernization program, public housing projects are updated and rehabilitated to extend their useful life. The program also provides for expansion of community services programs and facilities, and involves tenants in the plans and programs for modernization as well as assisting low-income families to realize their potential for economic advancement.

DISASTER RELIEF

During the last two years more than 13,000 families left homeless in eight states due to hurricane, tornado, fire or earthquake have been provided temporary housing authorized by the Disaster Act of 1970. During 1971, Housing Management provided temporary housing for victims of four major disasters, contrasted with one major disaster in 1969 and three in 1970. In all cases the elderly were among the victims. For example, in the February, 1971 California earthquake, 149 elderly families (including 11 disabled) were housed by the temporary housing program. Presently 116 elderly families have found permanent housing on the private market; the remaining 33 elderly families are being housed under the leased public housing program.

1971 WHITE HOUSE CONFERENCE ON AGING

The Elderly Housing Staff of Housing Management represented HUD in preparation for the Housing Section at the recent White House Conference on Aging held in Washington, D.C., November 28 thru December 2, 1971. The Chief of the Elderly Housing Staff served as Director for the Housing Secretariate from May of 1970 until the adjournment of the Conference. HUD supplied information and referrals for use in preparing the Housing Background Paper, the Workbook on Housing, and was instrumental in drafting the Delegate's Workbook. HUD also prepared a housing statistical handbook referred to elsewhere in this report. During the Conference 13 persons from the HUD Central Office served as resource persons, monitors and staff assistants. These people were available to assist the nine housing subsections and the White House Conference Staff as needed.

III. Office of Community Development

Community Development has, at the present time, responsibility for seven major programs: Urban Renewal, Rehabilitation Loans and Grants, Water and Sewer, Public Facility Loans, Neighborhood Facilities, Open Space, and Model Cities. While all of these programs have provided substantial benefits for all age groups, three of them—Neighborhood Facilities, Model Cities and Rehabilitation Loans and Grants—impact directly on older persons by providing them with services and funds geared specifically to their needs.

MODEL CITIES

In the Model Cities program, HUD does not require or give funding priority to those cities which have specific categorical services programs for the elderly. While HUD imposes minimum requirements upon the Model City's planning and program coordination process, decisions on program priorities are delegated to local jurisdictions. One hundred sixteen City Demonstration Agencies, (out of 146) have identified the need to include programs for older persons (and all but seven city programs are operative under an allocation of approximately $13,380,000). Services provided for older persons fall largely into the traditional categories of health, recreation, nutrition, transportation, day care and foster homes. Other services include handyman, homemaker, legal aid, and limited bedside care to homebound elders so that they may remain in the home. Some examples of Model Cities programs serving the elderly are given in Appendix XIII.

While not requiring Model Cities to develop elderly programs, HUD has decided to assist and encourage those cities who wish to conduct such programs. To that end, HUD signed a $250,000 two year contract with the National Council on the Aging (NCOA) which is jointly funded by the Administration on Aging,

HEW. Through this contract, some thirty model cities have receivel intensive technical assistance in the development of local strategies and initiatives in behalf of the elderly residing in model neighborhoods.

Coordination with other agencies at the Federal level has been achieved by ongoing information exchanges with liaison persons within HEW and O.E.O., and by the existence of an inter-agency advisory committee related to the technical assistance contract with the National Council on the Aging.

NEIGHBORHOOD FACILITIES

The Neighborhood Facilities Program provides grants to assist local public bodies in financing the development of neighborhood centers to serve low and moderate income communities with health, educational, social and recreational programs.

Nearly 3/5 of these facilities (ninety of one hundred forty five) provide some services for older persons in the center usually related to social and recreational activities.

URBAN RENEWAL 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 provide substantial assistance to the elderly as indicated in Appendix XIV.

IV. Office of Community Planning and Management

The Office of Community Planning and Management embraces a series of programs and activities designed to improve the quality of life for persons of all ages. Two of these activities—National Urban Growth Policy and New Communities—have particular significance for the older population, the majority of whom reside in metropolitan areas.

URBAN GROWTH POLICY DIVISION

Title VII of the Housing and Urban Development Act of 1970 calls for the development by the Federal government of a national urban growth policy. The purpose of such a policy would be to guide Federal, State, local and private plans and actions toward achieving (1) a more balanced distribution of economic opportunity, community viability, and overall living quality among sparsely settled and heavily urbanized regions, and among urban and rural communities generally, and (2) more orderly development of urban areas. The first Presidential report on urban growth is to be transmitted to the Congress in February 1972. Subsequent reports are due every even numbered year thereafter.

A number of goals and objectives of national growth policy are relevant to the elderly relating to rural quality of life, property taxes, mass transportation and the deterioration of the central cities.

THE ELDERLY IN NEW COMMUNITIES

All new community projects for which Federal commitments have been offered under Title VII-Urban Growth and New Community Development Act of 1970. and all projects for which the Office of New Communities Development has invited applications are designed to provide a better quality of life for persons of all ages and income categories. Neither the elderly nor low income families will be segregated into isolated neighborhoods in these new communities, which will be marked by a variety in generations, outlook, income, professions, trades, skills. racial and ethnic backgrounds, and interests. Facilities and amenities designed to serve the entire community will be more adaptable to the special needs of the elderly than a typical suburban community and, in the view of this, may offer broader opportunity for age mingling to the elderly than communities designed only for retirement living.

Following are examples of features common to all new community projects under active consideration by HUD and some examples of special facilities which will be of considerable benefit to the elderly.

1. Features Common to All New Communities

a. Easy pedestrian access to shopping, public service and recreation areas, with motor and pedestrian traffic separated. Most of the pathways crossing major highways will have grade separations.

b. Pedestrian paths will be through small parks and wooded areas and removed from active play areas.

c. Town, village, and neighborhood centers will offer the physical facilities for learning crafts and skills, forming hobby clubs and continuing education.

d. Low and moderate income housing, much of it with little or no outside upkeep required, will permit the elderly to live close to grandchildren and children in a new community, but not necessarily with the younger family.

e. Internal transportation currently being proposed or explored in most eligible new community developments would provide a means of ready access between neighborhoods, villages, town centers and residences.

2. Features Specific to Particular New Communities

In our 1970 report to your committee the general advantage of balanced new communities for elderly who choose to live in them were cited as well as specific examples of elderly projects in certain of our new communities. The examples cited here only supplement this information.

a. Cedar-Riverside in Minneapolis, Minnesota, the first new-town-in-town approved under the program will serve an existing 539 unit housing complex for the elderly. In addition, 43 percent of the housing in the project will be designed for persons of low and moderate income. The developer estimates that roughly 20 percent of this amount will be for the elderly. Serving the existing elderly complex and the housing in the project which the elderly will share with others will be a physical and social plan particularly well suited for the elderly. Included in the project will be an advanced health program, associated with the two hospitals in the area, an advanced cultural program, a transit facility tied into the adjacent University of Minnesota, elevated platforms providing for a separation of pedestrian and vehicular traffic, opportunities for resident involvement, convenient commercial facilities with easy access to housing and other innovative features.

b. In Maumelle, outside of Little Rock, Arkansas, roughly 46 percent of the housing will be for persons earning less than $10,000 which includes 7 percent less than $5,000, 16 percent under $7,000 and 23 percent from $7,000 to $10,000. Riverton in the Rochester, New York area, for which a commitment has just been announced, should have roughly 40 percent of its housing serving persons of low and moderate income. No special elderly quota has been established for these new communities. However, elderly will be invited on the same basis as other lower income citizens to make use of the housing and superior level of amenities if they so choose.

c. A specific section of the new community regulations has been added which deals specifically with the elderly and handicapped. The regulations indicate that the adequacy of plans will be judged, in part, by the following factor:

"To the extent that the developer is directing a portion of his project to the needs of the aged or physically handicapped, the adequacy of special facilities to serve these families and persons and the provision of a barrier-free environment to facilitate their free movement and self-sufficiency."

d. The Department has continued to take the position that it will not segregate the elderly in entire new communities or whole sections of new communities, although it would permit the establishment of special facilities in certain neighborhoods which are specifically designed to meet elderly needs.

V. Research and Technology—the Aging

During 1971, the Office of Research and Technology continued and initiated a number of efforts which affect America's elderly citizens. The work falls into two categories: one, that which is specifically designed for the elderly, and, two, that which has significant benefit for the elderly but which was designed for other primary objectives.

Many of the problems facing the elderly are not uniquely theirs, nor are all the problems specifically housing-related. Major research efforts like Operation

Breakthrough have a number of benefits for the elderly without being earmarked as elderly programs. Most obviously, there are 206 units specifically designed for and financed under the elderly housing provision of the Low Rent Public Housing program. Additionally, 1,946 units will be rented or sold under the HUD assistance programs for rent supplement, Section 235 and Section 236. All of these become more available to the elderly than were they strictly market rate rentals and sales.

But the Breakthrough units themselves are just the most visible aspect of the program as it impacts the lives of the elderly. Other factors are:

—the prototype sites are designed so that there is readily available open space, separation of pedestrian from vehicular traffic, ease of access to shopping, recreation, transportation, etc. These innovations will benefit all residents but none more so than the elderly.

—where there are units of elderly housing, they are not relegated to the far corner of a site but are made an active part of the total community.

—the use of smoke detectors in Operation Breakthrough dwelling units of more than one story (a requirement not found in the regular codes), will be especially beneficial for the elderly who need extra warning time in case of fire. Additionally, a silent communications alarm system is being developed for the elderly housing at the Sacramento site.

—the location of units in the multi-family construction consciously places the elderly in the most physically and environmentally advantageous situation. Ease of access, quiet without isolation, proximity to transportation and medical facilities are some of the concepts all too frequently ignored in conventional design.

—the Breakthrough units are specifically designed for ease of maintenance. While everyone will benefit from this, none will do so more than the elderly for whom maintenance is often the deciding factor facing an otherwise undesirable move.

Although not yet as large as Operation Breakthrough, there are other major R&T programs which will have a significant impact on the elderly.

HOUSING ALLOWANCE EXPERIMENT

This is one aspect of a large effort to thoroughly examine alternatives to our present assistance programs. There will be consideration of the elderly designed into this experiment. Elderly residents of the experimental sites will be specifically included in both the recipient and control groups.

PUBLIC HOUSING MANAGEMENT

A program is being designed which will allow a number of local housing authorities to redesign their management systems.

A substantial number of the Local Housing Authorities' proposals contain specific elements directed to the elderly:

—Private Management Firms and Foundations which will take on the complete management of Elderly Housing. The intent is to provide management capability with a track record in delivering services to the elderly.

—Several proposers offer services to the elderly that are far beyond the norm: Consumer, Nutritional, and Health Education Programs, Adult Education Courses, and Budgeting and Credit Counselling.

—Although elderly housing projects are frequently the best maintained, the elderly will still profit from a better run Authority. Through better management producing prompt, improved services and thereby satisfying more tenants there should be reduced vandalism and improved security, both of which are of major concern to the elderly.

A number of the efforts discussed in detail in the 1970 report are continuing. This is true of:

I. The Fisk University study of Transportation Needs of the Elderly, an interagency project.

II. The Fall River, Massachusetts, Hussey Hospital effort to develop a program for local housing authorities to join with hospitals for the care of the elderly and handicapped.

III. Working through the Law Enforcement Assistance Administration, we are trying to answer one of the most pressing needs of all citizens, and one of

the greatest fears of the elderly, residential security. This project had a delayed start and will continue into FY 1972.

COMPLETED PROJECTS

I. The Brown Engineering Company completed its study on the causes of home accidents. Although not limited to the elderly, this study and the resulting design criteria alterations will be of great benefit to the elderly since they suffer a disproportionate percentage of home accidents.

II. A grant was awarded to the Bureau of the Census for the preparation of a factbook detailing the 1970 Census as it related to the elderly. The factbook became an integral part of the material distributed and discussed at the 1971 White House Conference on Aging.

One of the most significant changes from 1970 to 1971 has been the increase, especially during the last few months, in proposals concerning various aspects of aging and physical disability. These are being evaluated and those selected will become an integral part of HUD's expanded effort on behalf of the nation's elderly and handicapped.

1971 HOUSING LEGISLATION

VI. Implications for the Elderly

JOINT RESOLUTION EXTENDING AND AMENDING CERTAIN HOUSING LAWS

The Housing and Urban Development Act of 1969 amended section 2(1) of the United States Housing Act of 1937 to provide that the rent charged a public-housing tenant may not exceed one-fourth of the family's income which, as defined by the Housing Act of 1970, equals the gross income of all household adults less several exclusions and deductions, including an automatic exclusion of five percent of the family's gross income which rises to ten percent in the case of elderly families. The purpose of this amendment, often referred to as the Brooke amendment, was to assist low income families to meet their vital needs by reducing the amount of rent they were required to pay for decent, safe and sanitary dwellings, thereby increasing their means to obtain other necessities of life. The Brooke amendment, however, was never totally implemented owing to another provision of the 1969 Act which specified that the rent limitation would not apply in any case in which it would result in a reduction of welfare assistance payments received by the tenant from a public agency.

Section 9 of the Joint Resolution extending and amending certain housing laws (Public Law 92–213), signed by the President on December 22, 1971, prohibits public agencies from reducing welfare assistance payments to public housing tenants entitled to a reduction in rent to one-fourth of family income under the Housing and Urban Development Act of 1969. All public housing tenants, regardless of whether they are receiving welfare assistance payments, are now entitled to the one-fourth of income rent limitation. With regard to the many elderly families living in public on fixed incomes, the amendment will enable them to utilize the funds they would normally expend on rent to satisfy their other pressing needs.

VII. Statistical Appendices: Table of Contents

APPENDIX I

LOW-RENT PUBLIC HOUSING: OCCUPANCY BY ELDERLY HOUSEHOLDS, BY STATE, AND BY PROJECT DESIGN, JUNE 30, 1970

	Designed for the elderly								
	All units			Some units			No units		
		Elderly occupied			Elderly occupied			Elderly occupied	
	Total tenant units	Number	Percent of total	Total tenant units	Number	Percent of total	Total tenant units	Number	Percent of total
Total	84,934	84,104	99.0	152,912	64,539	42.2	558,722	153,221	27.4
Alabama	1,184	1,168	98.6	44,40	2,134	48.1	25,491	8,645	33.9
Alaska				88	46	52.3	547	73	13.3
Arizona				326	97	29.8	3,268	556	17.0
Arkansas	1,235	1,222	98.9	2,943	1,495	50.8	3,920	1,118	28.5
California	1,022	1,019	99.7	18,831	6,292	33.4	28,217	5,246	18.6
Colorado	752	751	99.9	284	149	52.5	3,497	1,120	32.0
Connecticut	2,776	2,761	99.5	1,179	530	45.0	9,365	2,422	25.9
Delaware	383	375	97.9	241	163	67.6	1,352	163	12.1
District of Columbia	1,075	1,041	96.8	1,231	449	36.5	7,523	994	13.2
Florida	2,315	2,306	99.6	2,367	798	33.7	19,661	6,752	34.3
Georgia	1,732	1,716	99.1	6,732	2,208	32.8	30,575	10,874	35.6
Hawaii	380	380	100.0	740	264	35.7	2,973	468	15.7
Idaho	170	170	100.0				197	76	38.6
Illinois	9,183	9,147	99.6	8,911	5,022	56.4	38,381	6,739	17.6
Indiana	1,611	1,548	96.1	1,247	476	38.2	6,458	1,552	24.0
Iowa	532	527	99.1	750	346	46.1			
Kansas	639	631	98.7	666	416	62.5	1,091	172	15.8
Kentucky	1,368	1,333	97.4	4,115	2,105	51.2	11,540	3,700	32.1
Louisiana	378	320	84.7	3,635	1,305	35.9	16,110	3,283	20.4
Maine	407	407	100.0	117	60	51.3	753	137	18.2
Maryland	585	569	97.3	1,174	298	25.4	11,809	2,980	25.2
Massachusetts	4,763	4,724	99.2	5,575	2,483	44.5	17,159	5,803	33.8
Michigan	3,601	3,591	99.7	1,997	833	41.7	11,593	4,225	36.4
Minnesota	4,723	4,706	99.6	4,273	3,014	70.5	3,037	740	24.4
Mississippi	30	30	100.0	331	111	33.5	6,097	2,113	34.7
Missouri	492	480	97.6	3,577	1,954	54.6	7,975	2,244	28.1
Montana	50	50	100.0	56	10	17.9	1,003	336	33.5
Nebraska	3,118	3,106	99.6	1,452	719	49.5	2,025	520	25.7
Nevada	272	269	98.9	876	280	32.0	1,094	123	11.2
New Hampshire	963	963	100.0	599	451	75.3	813	135	16.6
New Jersey	9,819	9,805	99.9	5,064	1,822	36.0	24,840	6,355	25.6
New Mexico	71	67	94.4	1,216	319	26.2	1,002	86	8.6
New York	3,156	3,125	99.0	24,547	9,256	37.7	62,183	20,176	32.4
North Carolina	906	905	99.9	4,275	1,441	33.7	13,449	3,463	25.7
North Dakota	271	266	98.2	343	170	49.6	290	40	13.8
Ohio	4,785	4,751	99.3	7,264	4,385	60.4	21,183	7,702	36.4
Oklahoma	559	550	98.4	1,883	733	38.9	1,815	391	21.5
Oregon	869	864	99.4	3,447	1,245	36.1	1,258	505	40.1
Pennsylvania	3,818	3,736	97.9	8,718	3,406	39.1	37,852	8,799	23.2
Rhode Island	2,999	2,990	99.7	62	32	51.6	3,865	1,252	32.4
South Carolina	223	223	100.0	580	208	35.9	6,543	2,195	33.5
South Dakota	45	44	97.8	349	66	18.9	554	13	2.3
Tennessee	2,234	2,160	96.7	3,662	1,621	44.3	21,294	7,209	33.9
Texas	2,871	2,833	98.7	5,597	2,996	53.5	29,583	8,568	29.0
Utah							53	0	0
Vermont	189	188	99.5	271	104	38.4	66	0	0
Virginia	49	49	100.0	268	90	33.6	13,513	2,942	21.8
Washington	2,861	2,782	97.2	1,230	598	48.6	7,145	2,430	34.0
West Virginia	348	348	100.0	579	288	49.7	2,170	856	39.4
Wisconsin	3,122	3,108	99.6	1,244	781	62.8	2,562	583	22.8
Wyoming				193	64	33.2	40	4	10.0
Guam									
Puerto Rico				2,291	257	11.2	33,421	6,248	18.7
Virgin Islands				1,076	149	13.8	526	95	18.1

Note: Of the 559,000 units in projects with no units specially designed for the elderly, over 27 percent (27.4) were occupied by elderly families. In projects where all units are designed for the elderly, the percentage was 99 percent and in those with only some units so designed, 42 percent.

APPENDIX II

LOW-RENT PUBLIC HOUSING: NUMBER OF UNITS UNDER ANNUAL CONTRIBUTIONS CONTRACTS, BY STATE, SHOWING NUMBER ESPECIALLY DESIGNED FOR THE ELDERLY, AS OF DEC. 31, 1970

State	All units under ACC		In precon-struction	Under con-struction	Under management	
	Total	Elderly			Total	Elderly
Total	1,119,618	252,514	87,147	136,148	896,323	160,401
Alabama	41,492	4,309	2,853	4,482	34,157	3,086
Alaska	945	25			945	25
Arizona	5,957	395	1,132	564	4,261	302
Arkansas	12,215	4,247	1,104	1,993	9,118	2,772
California	62,689	8,174	5,411	4,597	52,681	4,894
Colorado	6,201	1,412	569	720	4,912	956
Connecticut	17,613	5,518	1,324	1,647	14,642	3,705
Delaware	3,066	866	210	752	2,104	516
District of Columbia	13,040	2,614	570	1,037	11,433	1,894
Florida	37,622	8,450	4,790	5,350	27,482	4,882
Georgia	50,145	5,945	2,181	5,372	42,592	3,856
Hawaii	5,120	1,114	345	303	4,472	839
Idaho	981	507	266	277	438	200
Illinois	72,966	21,392	3,596	6,651	62,719	15,361
Indiana	15,844	4,966	1,823	2,684	11,337	3,130
Iowa	2,419	1,458	293	272	1,854	1,085
Kansas	5,806	2,836	546	1,702	3,558	1,404
Kentucky	21,398	5,276	977	2,626	17,795	3,291
Louisiana	29,330	3,928	1,918	5,315	22,097	2,068
Maine	2,427	1,013	241	543	1,643	657
Maryland	19,714	2,290	1,334	3,477	14,903	967
Massachusetts	39,531	10,695	4,538	4,337	30,656	6,301
Michigan	24,817	8,523	1,167	3,530	20,120	5,849
Minnesota	19,368	13,149	293	4,706	14,369	8,739
Mississippi	11,466	912	2,130	2,000	7,336	185
Missouri	21,092	5,220	1,916	2,988	16,188	2,247
Montana	1,684	106	133	255	1,296	66
Nebraska	8,310	4,877	58	1,155	7,097	4,016
Nevada	3,081	779	26	725	2,330	526
New Hampshire	3,888	2,180	541	443	2,904	1,592
New Jersey	48,067	14,336	3,930	1,185	42,952	11,567
New Mexico	5,242	664	1,345	995	2,902	366
New York	112,876	21,524	7,838	8,936	96,102	12,943
North Carolina	33,963	5,418	6,096	5,913	21,954	2,483
North Dakota	2,159	1,142	340	663	1,156	605
Ohio	48,217	14,633	3,314	6,704	38,199	9,832
Oklahoma	12,763	3,220	833	4,881	7,049	1,989
Oregon	7,964	2,220	824	1,023	6,117	1,461
Pennsylvania	70,196	14,633	3,460	7,928	58,808	8,181
Rhode Island	10,509	5,430	1,148	969	8,392	8,717
South Carolina	10,865	1,507	1,448	911	8,506	431
South Dakota	2,237	814	170	849	1,218	149
Tennessee	35,895	6,468	1,263	4,743	29,889	4,261
Texas	53,670	10,917	7,167	2,979	43,524	7,194
Utah	336	75	250	33	53	
Vermont	2,029	712	753	426	850	253
Virginia	17,213	919	602	1,257	15,354	252
Washington	15,418	5,645	334	2,153	12,931	3,889
West Virginia	5,664	2,269	256	2,188	3,220	709
Wisconsin	9,745	5,770	363	1,822	7,560	4,284
Wyoming	500	110	191	50	259	60
Guam	250			238	12	
Puerto Rico	49,047	653	2,429	6,977	39,641	205
Virgin Islands	4,566	259	508	1,822	2,236	159

Note: Units especially designed for the elderly account for 18 percent of all units under management and 23 percent of those under annual contributions contract as of Dec. 31, 1970. As may be expected, a large share of the elderly units are found in some of the most populous States; of those under management, 10 percent are in Illinois, 8 percent in New York, 7 percent in New Jersey, 6 percent in Ohio, and 5 percent each in Minnesota and Pennsylvania.

TOTAL ANNUAL FAMILY INCOME OF ELDERLY FAMILIES REEXAMINED FOR CONTINUED OCCUPANCY IN LOW-RENT HOUSING, BY NUMBER OF ADULTS, BY ASSISTANCE AND BENEFITS AND BY RACE (12 MONTHS ENDED SEPT. 30, 1970)

Total family income	Total				1 adult				2 or more adults			
	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only
Number reexamined [1]	190,527	9,523	73,940	107,064	127,894	3,827	50,687	73,380	62,633	5,696	23,253	33,684
Under $1,000	7	4	6	8	10	9	8	11	1	1	1	1
$1,000 to $1,499	30	8	38	27	42	17	52	36	6	2	7	6
$1,500 to $1,999	22	7	23	22	25	12	24	27	16	3	22	13
$2,000 to $2,499	15	6	15	15	12	9	11	14	19	4	24	19
$2,500 to $2,999	8	5	6	10	5	8	2	7	15	4	14	17
$3,000 to $3,499	5	7	4	6	2	9	1	3	11	6	10	13
$3,500 to $3,999	4	8	2	4	1	10	1	1	8	7	6	10
$4,000 to $4,499	2	7	2	2	1	7	(2)	(2)	6	6	4	6
$4,500 to $4,999	2	6	1	1	(2)	5	(2)	(2)	4	7	3	4
$5,000 to $5,999	2	11	1	2	(2)	7	(2)	(2)	5	14	3	4
$6,000 to $6,999	1	9	1	1	(2)	4	(2)	(2)	3	12	2	2
$7,000 to $7,999	1	7	(2)	(2)	(2)	2	(2)	(2)	2	11	1	1
$8,000 and over	1	16	(2)	1	(2)	2	(2)	(2)	4	26	1	2
Median income	$1,797	$4,459	$1,637	$1,843	$1,481	$2,728	$1,405	$1,551	$2,767	$5,865	$2,395	$2,829
White	116,465	4,016	35,953	76,496	81,824	1,950	25,024	54,850	34,641	2,066	10,929	21,646
Percent	100	100	100	100	100	100	100	100	100	100	100	100
Under $1,000	6	4	5	7	9	8	7	9	1	1	1	1
$1,000 to $1,499	30	9	39	28	41	18	53	36	5	1	7	5
$1,500 to $1,999	23	8	25	23	27	13	26	28	16	3	25	13
$2,000 to $2,499	15	6	16	15	13	8	11	14	21	4	27	19
$2,500 to $2,999	9	6	6	11	6	8	2	8	16	4	15	18
$3,000 to $3,499	5	8	3	6	2	11	1	3	12	6	10	14
$3,500 to $3,999	3	9	2	4	1	10	(2)	1	9	8	5	11
$4,000 to $4,499	2	7	1	2	1	7	(2)	(2)	5	6	3	6
$4,500 to $4,999	1	6	1	1	(2)	5	(2)	(2)	3	7	2	4
$5,000 to $5,999	1	10	1	1	(2)	6	(2)	(2)	4	13	2	4
$6,000 to $6,999	1	7	(2)	1	(2)	3	(2)	(2)	2	10	1	2
$7,000 to $7,999	(2)	6	(2)	(2)	(2)	1	(2)	(2)	1	10	(2)	1
$8,000 and over	1	14	(2)	1	(2)	1	(2)	(2)	3	27	1	2
Median income	$1,780	$3,959	$1,615	$1,828	$1,506	$2,620	$1,406	$1,574	$2,708	$5,773	$2,318	$2,827
Negro and other	71,575	5,402	36,911	29,261	44,612	1,843	25,050	17,719	26,962	3,559	11,861	11,542
Percent	100	100	100	100	100	100	100	100	100	100	100	100

APPENDIX III—Continued

TOTAL ANNUAL FAMILY INCOME OF ELDERLY FAMILIES REEXAMINED FOR CONTINUED OCCUPANCY IN LOW-RENT HOUSING, BY NUMBER OF ADULTS, BY ASSITANCE AND BENEFITS AND BY RACE (12 MONTHS ENDED SEPT. 30, 1970)—Continued

Total family income	Total				1 adult				2 or more adults			
	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only	Total	No benefits or assistance	Assistance with or without benefits	Benefits only
Under $1,000	8	4	7	10	11	9	9	15	1	1	2	2
$1,000 to $1,499	30	7	37	25	44	16	51	37	6	2	7	7
$1,500 to $1,999	20	6	22	20	22	11	22	24	16	3	21	14
$2,000 to $2,499	13	5	14	14	11	9	10	13	18	3	22	17
$2,500 to $2,999	8	5	6	10	4	7	3	6	13	4	14	15
$3,000 to $3,499	5	6	4	6	2	8	2	2	10	5	9	11
$3,500 to $3,999	4	7	3	4	1	9	1	1	7	6	6	8
$4,000 to $4,499	3	6	2	3	1	7	1	1	6	6	5	6
$4,500 to $4,999	2	6	2	2	1	4	(2)	(2)	4	7	4	4
$5,000 to $5,999	3	12	2	2	1	8	(2)	(2)	6	15	4	5
$6,000 to $6,999	2	10	1	1	(2)	6	(2)	(2)	4	13	3	4
$7,000 to $7,999	1	8	(2)	1	(2)	3	(2)	(2)	3	11	1	2
$8,000 and over	2	18	1	1	(2)	3	(2)	(2)	6	25	2	3
Median income	$1,821	$4,911	$1,654	$1,881	$1,441	$2,864	$1,403	$1,476	$2,851	$5,940	$2,469	$2,824

[1] Includes families for whom data on race were not available.
[2] Less than 0.5 percent.

Source: Department of Housing and Urban Development; Housing Management, Office of Program Development, Statistics Branch.

APPENDIX IV.—NUMBER EMPLOYED FROM ELDERLY HOUSEHOLDS AND MEDIAN ANNUAL FAMILY INCOME

LOW-RENT PUBLIC HOUSING: FAMILIES ADMITTED IN 1970

Number employed	Families		Median annual income
	Number	Percent of total	
Total	66,144	100	$1,798
None	59,332	90	1,724
1	6,480	10	2,814
2 or more	332	1	4,090

RENTAL HOUSING ASSISTANCE (SEC. 236): FAMILIES ELIGIBLE FOR ASSISTANCE, BY MAR. 31, 1971

Number employed	Families		Median income
	Number	Percent of total	
Total	1,455	100	$3,327
None	1,092	75	2,934
1	330	23	4,611
2 or more	33	2	5,409

Note: 9 out of 10 low-rent families admitted had no employed members as compared with 3 out of 4 families certified for sec. 236 assistance. For families with no employed members, incomes of the sec. 236 families were 70 percent higher than for public housing families.

APPENDIX V

TABLE 30.—ANNUAL INCOME, BY SIZE OF HOUSEHOLD, AND MEAN GROSS RENT OF ELDERLY HOUSEHOLDS

LOW-RENT PUBLIC HOUSING: 12 MONTHS ENDING SEPT. 30, 1970

Annual household income	Size of household				
	Total	1 person	3 persons	3 or 4 persons	5 or more persons
Households	190,527	118,505	48,616	14,828	8,227
Percent distribution	100	100	100	100	100
Under $1,000	7	10	2	1	1
$1,000 to $1,499	30	44	9	5	2
$1,500 to $1,999	22	26	20	11	4
$2,000 to $2,499	15	12	22	14	8
$2,500 to $2,999	8	5	15	15	10
$3,000 to $3,999	9	3	18	20	21
$4,000 to $4,999	4	1	7	10	18
$5,000 and over	5	(1)	6	23	37
Median income	$1,797	$1,461	$2,422	$3,144	$4,240
Mean gross rent	$43.25	$37.06	(2)	(2)	(2)

RENTAL HOUSING ASSISTANCE (SEC. 236): CUMULATIVE THROUGH MAR. 31, 1971

Households	1,455	763	496	146	48
Percent distribution	100	100	100	100	100
Under $1,000	1	2	(1)	1	
$1,000 to $1,499	7	13	2		
$1,500 to $1,999	10	17	3	3	
$2,000 to $2,499	14	22	6	3	4
$2,500 to $2,999	9	12	7	4	4
$3,000 to $3,499	12	11	14	8	4
$3 500 to $3,999	9	8	12	7	4
$4,000 to $4,999	19	11	32	15	25
$5,000 to $5,999	10	2	17	25	21
$6,000 and over	8	1	7	34	38
Median income	$3,327	$2,409	$4,196	$5,000	$4,833
Mean gross rent	$104.58	$96.55	(2)	(2)	(2)

[1] For low-rent public housing, data are for families reexamined for continued occupancy during the 12 months ended Sept. 30, 1970; for sec. 236, families certified for assistance payments from the beginning of the program through Mar. 31, 1971. The sec. 236 rent figure is the average of amounts, before rent supplement, paid by the household. The median income for the sec. 236 families is 85 percent higher than that of low-rent public housing families and gross rent is 140 percent higher.

(2) Not available.

APPENDIX VI

HOME-OWNERSHIP ASSISTANCE (SEC. 235(i)): NUMBER OF NEW AND EXISTING HOMES PURCHASED BY ELDERLY WITH FHA-INSURED MORTGAGES, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970

State	Total new and existing homes	New homes			Existing homes		
		Total	Ages 50–59	Age 60 or older	Total	Ages 50–59	Age 60 or older
Total	9,252	4,872	3,146	1,726	4,380	2,703	1,677
Alabama	563	415	274	141	148	93	55
Arizona	103	42	27	15	61	35	26
Arkansas	156	126	75	51	30	18	12
California	897	306	165	141	591	348	243
Colorado	111	53	36	17	58	32	26
Connecticut	17				17	17	
Delaware	15				15	15	
District of Columbia	55	6	6		49	49	
Florida	597	496	274	222	101	60	41
Georgia	777	533	337	196	244	140	104
Illinois	163	112	85	27	51	32	19
Indiana	131	54	32	22	77	28	49
Iowa	43	23	18	5	20	16	4
Kansas	53	11	8	3	42	21	21
Kentucky	51	18	4	14	33	14	19
Louisiana	551	421	304	117	130	85	45
Maryland	12				12	12	
Massachusetts	54				54	38	16
Michigan	533	124	87	37	409	341	68
Minnesota	70				70	42	28
Mississippi	281	242	140	102	39	30	9
Missouri	321	24	12	12	297	132	165
Nebraska	56	21	18	3	25	7	28
Nevada	122	92	46	46	30	19	11
New Hampshire	7	7	7				
New Jersey	114				114	106	8
New Mexico	108	50	25	25	58	32	26
New York	15	9	9		6	6	
North Carolina	282	145	109	36	137	99	38
Ohio	317	37	20	17	280	168	112
Oklahoma	221	80	56	24	141	59	82
Oregon	110	93	62	31	17	11	6
Pennsylvania	106	5		5	101	90	11
South Carolina	588	435	328	107	153	92	61
South Dakota	15				15	10	5
Tennessee	393	255	174	81	138	62	76
Texas	533	286	188	98	247	165	82
Utah	41	28	11	17	13	4	9
Virginia	67	42	42		25	25	
Washington	353	127	57	70	226	95	131
West Virginia	30	18	9	9	12	4	8
Wisconsin	110	26	22	4	84	51	33
Wyoming	13	13	9	4			
Puerto Rico	85	85	58	27			

Note: 9 States—Georgia, Florida, South Carolina, Louisiana, Alabama, California, Texas, Tennessee, and Mississippi—most of them located in the South, account for 70 percent of those new homes insured under sec. 235 through Dec. 1970, where heads of household are 50 years of age or older, while 7 States—California, Michigan, Missouri, Ohio, Texas, Georgia, and Washington account for more than half of the existing homes in that category.

Source: Data shown in this table are derived from a sample of sec. 235 home buyers. No information is shown separately where activity is too low to produce reliable data by State, but it is included in the U.S. total.

APPENDIX VII

ELDERLY OR HANDICAPPED HOUSING (SEC. 202): APPROVED LOANS, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970

State	Number of projects	Number of units	Aggregate amount of loans (thousands)
Total	335	45,106	$574,084
Alabama	3	598	8,120
Arizona	2	273	3,281
Arkansas	1	136	1,608
California	42	5,018	63,542
Colorado	10	936	10,645
Connecticut	5	663	9,112

APPENDIX VIII—Continued

ELDERLY OR HANDICAPPED HOUSING (SEC. 202): APPROVED LOANS, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970—Continued

State	Number of projects	Number of units	Aggregate amount of loans (thousands)
Delaware	1	236	$3,990
District of Columbia	2	300	4,310
Florida	28	5,306	66,043
Georgia	9	1,568	19,806
Hawaii	1	111	1,735
Idaho	1	65	814
Illinois	9	790	10,793
Indiana	5	315	4,067
Iowa	10	751	8,785
Kansas	3	282	3,745
Kentucky	1	143	1,958
Louisiana	3	417	5,361
Maine	3	123	1,518
Maryland	12	2,112	27,396
Massachusetts	11	1,827	24,806
Michigan	24	3,473	45,515
Minnesota	17	1,448	18,206
Mississippi	1	101	967
Missouri	7	1,188	14,272
Montana	7	472	5,854
Nebraska	2	176	2,160
New Jersey	11	2,052	26,166
New Mexico	3	306	4,097
New York	6	905	11,559
North Carolina	1	158	1,847
North Dakota	3	158	1,639
Ohio	21	3,294	42,361
Oklahoma	4	400	4,450
Oregon	3	610	7,294
Pennsylvania	19	3,462	44,828
Rhode Island	1	117	1,746
South Carolina	1	215	2,920
South Dakota	4	158	1,686
Tennessee	5	707	8,339
Texas	7	943	10,371
Utah	2	334	4,321
Virginia	2	291	4,125
Washington	9	1,237	15,297
West Virginia	2	122	1,898
Wisconsin	2	145	2,135
Wyoming	5	302	3,726
Puerto Rico	4	361	4,873

Note: Of the total number of loans approved through Dec. 31, 1970, almost 12 percent were for units located in Florida, 11 percent in California, almost 8 percent each in Michigan and Pennsylvania, and 7 percent in Ohio. States not shown are not represented in this program.

APPENDIX VIII

NURSING HOME PROJECTS (SEC. 232): MORTGAGES INSURED, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970

State	Number of projects	Number of beds	Aggregate mortgage amount (thousands)
Total	742	74,664	$571,539
Alabama	9	819	5,054
Alaska	1	100	1,601
Arizona	5	350	1,825
Arkansas	3	318	1,826
California	67	6,026	44,570
Colorado	9	1,008	6,128
Connecticut	17	1,677	11,694
Delaware	4	416	3,713
District of Columbia	2	455	4,100
Florida	40	4,229	29,034
Georgia	22	2,210	15,254
Hawaii	2	224	1,774
Idaho	7	500	2,348
Illinois	42	5,756	39,408
Indiana	11	856	5,453
Iowa	9	572	5,024

See footnote at end of Appendix.

APPENDIX VIII—Continued

NURSING HOME PROJECTS (SEC. 232): MORTGAGES INSURED, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970—Continued

State	Number of projects	Number of beds	Aggregate mortgage amount (thousands)
Kansas	7	480	$2,923
Kentucky	16	1,440	9,612
Louisiana	8	840	5,213
Maine	4	252	1,445
Maryland	10	1,293	10,275
Massachusetts	16	1,389	14,169
Michigan	39	3,338	24,170
Minnesota	7	526	3,223
Mississippi	15	911	5,763
Missouri	20	2,171	19,270
Montana	5	380	2,456
Nebraska	16	1,075	6,747
Nevada	3	239	1,972
New Hampshire	3	200	1,562
New Jersey	54	6,551	67,501
New Mexico	2	100	678
New York	35	4,860	44,939
North Carolina	4	333	2,488
North Dakota	1	71	654
Ohio	32	2,956	23,131
Oklahoma	11	794	5,894
Oregon	15	1,270	7,272
Pennsylvania	22	2,571	21,921
Rhode Island	2	253	2,568
South Carolina	16	1,098	7,513
South Dakota	3	167	1,137
Tennessee	20	1,698	14,015
Texas	45	5,009	32,273
Utah	8	679	3,953
Vermont	5	478	4,223
Virginia	8	833	6,073
Washington	16	1,833	12,329
West Virginia	7	631	5,602
Wisconsin	15	2,109	16,168
Puerto Rico	2	320	3,601

Note: 6 States (New Jersey, California, Illinois, Texas, New York, and Florida) account for almost 44 percent of the total number of beds in nursing home projects insured under sec. 232 through Dec. 31, 1970. Wyoming was the only State without FHA insured nursing home projects as of Dec. 31, 1970.

APPENDIX IX

COMMITMENTS ISSUED JANUARY THROUGH JUNE 1971, ON SEC. 232 NURSING HOME PROJECTS

State and city	Name of Project	Number of beds	Mortgage amount
California:			
Duarte	Duarte Convalescent Center	106	$810,700
San Jose	Ridge Vista Manor	116	789,100
Colorado: Denver	S Monaco Care Center	60	475,900
Georgia:			
Bainbridge	Bainbridge Convalescent	60	392,400
Donaldsonville	Seminole MNR Nursing Home	62	362,900
Waynesboro	Andress Nursing Home	100	703,600
Illinois:			
Chicago	Core Care Center	150	1,144,700
Do	Hillhaven Convalescent	147	1,200,000
Do	NW Home of the Aged	150	1,224,100
Crystal Lake	Crystal Pines	80	692,500
Godfrey	D Adrian Nursing Home	120	1,105,400
Lebanon	Bohannon Nursing Home	49	515,000
Northbrook	Northbrook Nursing Home	296	1,953,600
Robinson	Pro Care Inc	60	465,700
Zion	Park Manor	113	903,200
Maryland:			
Baltimore	Deaton Med Nursing Home	240	4,852,200
Rockville	Nursing Home	157	1,598,070
Massachusetts:			
Canton	Canton Nursing Home	120	1,852,700
Dorchester	Beatrice Maria Nursing Home	110	1,588,100
New Bedford	Brooklyn Nursing Home	120	1,394,100
Norwood	Ellis Convalescent Home	100	1,722,400

COMMITMENTS ISSUED JANUARY THROUGH JUNE 1971, ON SEC. 232 NURSING HOME PROJECTS—Continued

State and city	Name of Project	Number of beds	Mortgage amount
Mississippi:			
Kosciuska	Attala County Nursing Home	60	$453,200
Union	Hilltop Manor	60	427,500
Missouri: Nevada	Medical Lodgers	100	872,000
New Jersey: Franklin Township	Franklin House	120	1,533,600
New York:			
Endicott	Endicott Nursing Home	100	1,226,600
Long Beach	Health Related Facility	240	4,354,000
Massena	St. Regis Nursing Home	166	1,373,500
Oswego	Hillcrest Nursing Home	120	1,525,100
St. James	Health Related Facility	250	4,123,100
Woodmere	Five Towns Nursing Home	150	2,305,800
Ohio: Columbus	St. Luke Convalescent Center	120	1,844,100
Oklahoma: Moore	Sequoyah Nursing Center	103	551,800
Pennsylvania: McKees Rocks	Pennsylvania Manor Nursing Home	151	2,271,800
South Carolina: Rock Hill	Rock Hill Convalescent Center	88	718,000
Tennessee: Covington	Covington Nursing Home	60	375,900
Texas: Buffalo	Leon County Nursing Home	60	422,800
Vermont: Barre	Barre Nursing Home	100	1,117,600
Virginia:			
Norton	Clinch Valley Nursing Home	60	655,500
Stuart	Blue Ridge Nursing Home	120	1,454,900
Washington: Bellingham	Nord Convalescent Center	120	800,500
Wisconsin: Sheboygan	Medows Park Nursing Home	74	549,400
Total projects		4,938	54,703,070

APPENDIX X

NURSING HOMES WITH HILL-BURTON GRANT

[Insurance in force as of Dec. 31, 1971]

Project No.	Name	City and State	Beds	Mortgage
061-43020	Happy Haven Nursing Home	Atlanta, Ga	158	$621,000
101-43009	City Park Manor Nursing Home	Denver, Colo	120	873,200
123-43010	Tanner Chapel Manor Nursing Home	Phoenix, Ariz	50	325,000
043-43016	Wesley Glen Nursing Home	Columbus, Ohio	44	540,000
114-43010	Schlesinger's Home—Extended Care Facility	Beaumont, Tex	204	1,611,200
083-43021	Caverna Convalescent Home	Horse Cave, Ky	34	433,000
045-43011	Greenbrier County Nursing Home	Fairlea, W. Va	100	850,000
087-43010	Presbyterian Home of Tennessee	Knoxville, Tenn	200	2,498,000
066-43024	Lutheran Medical Center	Miami, Fla	197	2,137,500
023-43034	Union Mission Nursing Home, Inc	Haverhill, Mass	120	1,160,000
085-43024	Beth Haven Nursing Home	Hannibal, Mo	60	563,600
115-43016	Morningside Manor Nursing Home	San Antonio, Tex	100	600,000
052-43022	John L. Daaton Medical Nursing Hom	Baltimore, Md	240	4,852,200
044-43016	Friendship Haven	Detroit, Mich	170	2,997,000
Total			1,797	20,061,700

APPENDIX XI

ELDERLY HOUSING (SECS. 207 AND 231): MORTGAGES INSURED, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970

State	Number of projects	Number of units	Aggregate mortgage amount (thousands)
Total	286	42,593	$536,188
Alabama	1	80	763
Arizona	18	4,504	51,065
Arkansas	2	139	1,446
California	52	9,497	125,056
Colorado	22	2,146	24,529
Connecticut	5	535	8,655
Delaware	1	234	3,540

APPENDIX XI—Continued

ELDERLY HOUSING (SECS. 207 AND 231): MORTGAGES INSURED, BY STATE, CUMULATIVE THROUGH DEC. 31, 1970—Continued

State	Number of projects	Number of units	Aggregate mortgage amount (thousands)
District of Columbia	2	659	$8,667
Florida	15	4,097	50,328
Georgia	1	48	431
Idaho	1	32	317
Illinois	7	1,067	12,525
Indiana	2	348	5,000
Iowa	5	474	4,926
Kansas	5	603	8,082
Kentucky	8	788	9,200
Louisiana	5	324	3,761
Massachusetts	1	25	225
Michigan	6	1,080	11,612
Minnesota	13	872	10,921
Mississippi	2	331	3,855
Missouri	5	944	12,929
Montana	2	158	2,115
Nebraska	9	1,115	14,106
Nevada	2	394	4,480
New Hampshire	1	170	1,440
New Jersey	3	621	7,559
New Mexico	2	162	1,728
New York	4	301	3,641
North Carolina	2	264	1,350
North Dakota	2	95	1,127
Ohio	10	1,534	18,982
Oklahoma	3	261	3,480
Oregon	10	1,598	18,205
Pennsylvania	2	442	5,902
South Dakota	3	122	1,030
Tennessee	5	573	7,262
Texas	24	3,703	44,942
Utah	2	402	5,327
Virginia	2	384	6,358
Washington	9	1,685	20,653
Wisconsin	8	524	5,425
Puerto Rico	2	258	3,243

Note: California accounts for almost 22 percent of the total number of units under this program, Arizona for 10 percent Florida for 9 percent, and Texas for 8 percent. States not shown were not represented in this program as of Dec. 21, 1970

APPENDIX XII

EXAMPLES OF MODEL CITIES PROGRAMS FOR THE ELDERLY, FISCAL YEAR 1970

City	Project	Total cost	HUD share
Total		$5,450,066	$2,073,974
Akron, Ohio	Transportation	59,698	59,698
Albuquerque, N. Mex	Establishment of small service oriented businesses	,14,360	14,360
Binghamton, N.Y	Food service, recreation, transportation, health care, and homemaker services.	139,565	139,565
Boston, Mass	Development of personal and social skills	399,672	249,886
Cambridge, Mass	Multi-service center	77,023	38,218
	Outreach and group services	75,130	52,386
Compton, Calif	Expanded programs and facilities	26,703	21,878
Des Moines, Iowa	Rehabilitation of homes	60,000	60,000
	Service center	47,430	13,640
Kansas City, Mo	Satellite Golden Age	25,060	5,000
Lowell, Mass	Council on aging	66,582	16,646
Los Angeles County, Calif	Personal and home care services	43,200	,8,600
McAlester, Okla	Recreation and hobbies	46,000	12,000
Manchester, N. Hamp	Ederly council program	24,804	16,500
Martins Ferry, Ohio	Recreation	18,427	500
	Part-time employment	48,583	38,583
Minneapolis, Minn	Age and opportunity center	262,882	164,000
	Early medical care	238,000	238,000
Philadelphia, Pa	Meals on wheels	219,826	219,826
Portland, Maine	Nutritional services	123,000	20,000
	Danforth-Emery housing for elderly	2,000,000	0
Rochester, N.Y	Recreation	75,000	35,000
San Antonio, Tex	Planning and coordination of services	34,590	8,750

APPENDIX XII—Continued

EXAMPLES OF MODEL CITIES PROGRAMS FOR THE ELDERLY, FISCAL YEAR 1970—Continued

City	Project	Total cost	HUD share
Seattle, Wash	Education, employment, and recreation	$275,000	$75,000
	Foster homes	197,000	0
Smithville-DeKalb City, Tenn	Multi-purpose service center	16,000	1,000
Tampa, Fla	Employment opportunities	149,000	149,000
	Multi-purpose service center	53,000	40,000
Texarkana, Ark	Geriatric planning	56,124	14,031
	Meals on wheels	31,140	5,765
	Food services	77,000	31,000
Washington, D.C	Multi-service center	342,000	300,000
Winooski, Vt	Educational, recreational, social service, arts and crafts	50,936	11,542
Worcester, Mass	Outreach, needs-study service organization	77,331	13,600

Note: Although there is no single large-scale Model Cities program specifically designed for the elderly, local model cities projects have been initiated which are addressed to the social, medical, employment, housing, and other problems of the aged. Of the nearly $5,500,000 funded for these purposes in fiscal year 1970 more than $2,000,000 was provided by the Department of Housing and Urban Development.

APPENDIX XIII

HOUSING REHABILITATION LOANS AND GRANTS (SECS. 115 AND 312): RECIPIENTS 65 YEARS OF AGE AND OVER BY NUMBER OF DEPENDENTS, BY MINORITY GROUP, BY MONTHLY INCOME, AND BY SOURCE OF INCOME

Recipients	Number	Percent	Number	Percent
Total number	11,106	100.0	14,670	100.0
Number 62 years of age and over	1,918	17.3	8,765	59.7
Number of dependents:				
None	1,500	78.2	7,491	85.5
1 to 2	351	18.3	1,152	13.1
3 to 4	46	2.4	88	1.0
5 to 6	15	.8	24	.3
7 and over	6	.3	10	.1
Minority group:				
White (nonminority)	999	52.1	6,114	69.8
Negro/black	758	39.5	2,559	29.2
Other minority	161	8.4	92	1.0
Monthly income:				
$250 and under	1,015	52.9	7,732	88.2
$251 to $350	319	16.6	718	8.2
$351 to $500	239	12.5	244	2.8
$501 and over	345	18.0	71	.8
Source of income:				
Salary and wages	574	29.9	(1)	(1)
Pension and social security	1,144	59.7	(1)	(1)
Other sources	200	10.4	(1)	(1)

[1] Not available.

Note: A total of 1,330 elderly applicants received a combined loan and grant. Approximately 9 out of 10 grant recipients and 5 out of 10 loan recipients fell into the poverty group by the original broad gage definition, under $3,000 annual income ($250 or less per month). Negro and other minority groups elderly received nearly half of the loans but less than a 3d of the rehabilitation grants.

ITEM 6. DEPARTMENT OF LABOR

JANUARY 24, 1972.

DEAR MR. CHAIRMAN: I am enclosing the updated material which you requested for your committee's report entitled, "Developments in Aging—1971."

Of particular note this year is President Nixon's order to expand our jobs program for older persons with low incomes. As you know, this program has demonstrated that older Americans can make important contributions to community services while adding to their own incomes.

Sincerely,

J. D. HODGSON,
Secretary of Labor.

[Enclosure]

A REPORT ON PARTICIPATION BY OLDER WORKERS IN MANPOWER TRAINING AND THE OPERATION MAINSTREAM PROGRAM

The Manpower Administration has continued in its efforts to train older workers for available jobs in industry and government. In addition, it has attempted to increase the use of older trained, unemployed, or retired persons to fill the positions of supervisors, counselors, and administrators in the manpower programs. Experience has shown that older workers, especially indigenous ones, establish particularly good rapport with the enrollee. Older workers also generally establish good relationships with older enrollees or older people in the community. Operation Mainstream has been the program which provided the vehicle for older workers to improve community resources and in so doing has provided an effective avenue to jobs for older persons.

Administered by the Department of Labor, Operation Mainstream operates under Titles I–B and I–E of the Economic Opportunity Act of 1964 as amended. Operation Mainstream Title I–B funds for Fiscal Year 1972 consist of the appropriation level of $38.8 million plus a requested reprogramming of $5.9 million for the Mainstream project that was originally included in the Kentucky Concentrated Employment Program. The reprogramming of $5.4 million has also been requested to continue the operation of regional programs at their Fiscal Year 1971 levels, as well as an additional $13 million to expand jobs programs for low-income older workers as ordered by President Nixon. Operation Mainstream, Title I–B operations are shared by the regional and National Offices. The latter consists of six older worker contracts which follow the same guidelines as the regional Mainstream program with one exception: Whereas the minimum age requirement for regional Mainstream programs is 22 years with 40 percent of the enrollees 55 years and over, enrollees in nationally operated Mainstream programs must be 55 years and over.

Following are older worker projects shown with the amount of current contract funds. (National Mainstream contracts are not funded on a fiscal year basis; therefore, some funds are Fiscal Year 1971 and some are Fiscal Year 1972.)

Sponsor	Slots	Funds	Dates
National Council of Senior Citizens (NCSC).	1, 148	$3, 446, 912	May 22, 1971–May 21, 1972.
National Council on the Aging (NCOA).	572	1, 572, 608	July 30, 1971–July 31, 1972.
National Retired Teachers Association (NRTA).	355	921, 245	Sept. 22, 1971–Sept. 20, 1972.
Green Thumb/Green Light	2, 929	6, 960, 160	July 30, 1971–July 31, 1972.
Virginia State College	125	311, 906	Dec. 16, 1971–Dec. 1, 1972.
Total Action Against Poverty in Roanoke Valley.	70	300, 000	Sept. 26, 1971–Sept. 23, 1972.

1. National Farmers Union

Green Thumb—On July 30, 1971, Green Thumb was funded at level of the previous year. However, due to savings in administrative costs there was an increase of 234 enrollees.

Green Light—This component still operates in 11 of the 17 Green Thumb States. Savings in administrative costs accounted for 15 additional enrollees.

2. National Council on the Aging

A new contract was funded on July 30, 1971, at a cost to the government of $1,572,608. This was approximately the same spending level as the previous year.

3. National Retired Teachers Association

A new contract was funded to run from September 22, 1971, through September 20, 1972. Funding was increased by $182,234 to allow for a 52-week enrollment period rather than the previous period of 40 weeks duration.

4. National Council of Senior Citizens

This program is continuing at the same slot level as the previous year.

5. Virginia State College

This program is continuing at the same slot level as the previous year.

6. Total Action Against Poverty in Roanoke Valley

This program is continuing at the same slot level as last year's program.

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 citizens could overcome some of the aging problems such as fear, loneliness, and melancholy.

In Fiscal Year 1972 the Department of Labor has requested the reprogramming of $20.8 million to refund Operation Mainstream Title I–E projects for another year. The Title I–E program was designed to be used as an economic tool to create 5,367 jobs in selected areas of recession or high unemployment. Workers are concentrated in small communities and rural areas where job opportunities and training resources are limited. The design provides for substantial inputs for training and supportive services in addition to work experience. Particular attention is given to job development and placement. Mainstream I–E programs are subject to the same guidelines as Mainstream I–B programs with some exceptions. Priority areas for a Mainstream I–E program are; (1) Nonstandard metropolitan statistical areas in States eligible under the supplemental training and employment program; (2) other relatively small areas with significant increase in unemployment as compared with a year ago; (3) small areas with significant cutbacks in local defense installations, or seriously impacted by closing of or reductions in defense facilities; and (4) Indian reservations that do not have Operation Mainstream Title I–B projects.

Procedural differences are as follows; (1) Title I–E programs are of six months duration. Contract renewals beyond six months must be based on continued high unemployment rate for that area as compared to the previous year, and (2) participants are enrolled for 13-week periods with an option for one additional 13-week renewal.

ITEM 7. DEPARTMENT OF TRANSPORTATION

OFFICE OF THE SECRETARY OF TRANSPORTATION,
Washington, D.C., April 14, 1972.

DEAR SENATOR CHURCH: In response to your letter of March 24, 1972, to Secretary Volpe, I am pleased to enclose a report on the activities of this Department with respect to transportation for the elderly.

This statement is for publication in the annual report of the Senate Special Committee on Aging entitled "Developments in Aging—1971".

Please let us know if we can be of further assistance to you.

Sincerely,

JOHN HIRTEN,
(For Herbert F. DeSimone, Assistant Secretary for Environment and Urban Systems).

[Enclosure]

DEPARTMENT OF TRANSPORTATION PROGRAMS WHICH SERVE THE ELDERLY—A SUMMARY OF RECENT ACTIVITIES

PROBLEM

The problem of providing adequate public transportation for the nation's 20 million citizens over 65 has been exacerbated by the gradual erosion of public transportation combined with an ever increasing fare structure. This poses a severe problem for many of the elderly who live on moderate or inadequate incomes. A significant number of older Americans do not have access to alternate

modes of transportation. Over one-half of them do not have a car or cannot drive and are thus dependent on friends and relatives or public transportation. These factors alone have severely limited the elderly's choice of transportation mode.

The work done by the United States Senate Special Committee on Aging has confirmed that a significant proportion of the elderly population live on low and inadequate incomes and that there is continuing and growing disparity between incomes of the aged and the working population as a whole. It is therefore important to consider ways of bringing the cost of transportation in line with the elderly's ability to afford it, or vice versa. The aged, like every other population group, must depend upon the ability to travel to acquire the basic needs of food, clothing, and shelter as well as employment. The ability to travel is also necessary for the attainment of medical services, social and recreational outlet. To the extent that they are denied the opportunity to travel, they are kept from shopping at shopping centers where prices are generally lower, from going to city health clinics for physician services and medications at a reduced cost, and from receiving surplus commodities because they are unable to get back and forth to the distribution points.

Office of the Secretary

In October of 1971, the Office of the Assistant Secretary for Environment and Urban Systems awarded a contract to study the Metropolitan Washington, D.C. transportation system to determine its accessibility to the elderly and handicapped. This study, scheduled to be completed in June of 1972, will produce a set of recommendations for improving the accessibility of the area's transportation system to these groups as well as the general traveling public.

Urban Mass Transportation Administration

Section 16 of the Urban Mass Transportation Act of 1964, amended in 1970, authorizes the Secretary of Transportation to set aside one and one-half (1½) percent of the total funding of Urban Mass Transportation Administration programs to assist State and local public bodies and agencies in providing mass transportation facilities and services for elderly and handicapped passengers.

The Urban Mass Transportation Administration (UMTA) has a coordinated interdepartmental effort to provide and/or improve mass transit services for the elderly and handicapped. Its Offices of Service Development, Research, Development and Demonstration, and Program Operations are working together to overcome the barriers that inhibit the use of mass transportation by these groups.

The following are examples of UMTA funded projects designed to improve transportation services for the elderly and handicapped.

In Morgantown, West Virginia, UMTA has funded the demonstration of an advanced people mover system. This will be a totally automated system with vehicles seating 8 people; standing 10. All vehicles have extra-wide doors and wide aisles which will accommodate wheelchairs. For the demonstration, 3 stations will be operable; when the demonstration is complete and the system is owned by the City of Morgantown, it will have 6 stations all equipped with escalators or elevators which will increase accessibility to the system for the elderly and handicapped.

In an UMTA-supported Dial-A-Ride demonstration project in Haddonfield, New Jersey, one vehicle in a fleet of 12 will be especially equipped with a lift device to handle wheelchairs. This project will measure public acceptance of door-to-door service, demonstrate feeder and distribution service for a high speed rail line, measure impact on other transportation modes, determine economic and other factors, such as fares, area size, population density and expected revenue.

In the lower Naugatuck Valley in Connecticut, UMTA is funding a demonstration of a flexible transit system for residents of a "Deep Suburban" community. The system is designed primarily for transport to health and social services, but orderly expansion will enable the system to serve the general public. The project calls for modifications to presently available transit buses. These changes will aid elderly and handicapped persons using the bus without affecting general public use of the vehicles.

Helena, Montana, capital of that State and its retirement center, has no bus system. The only transportation available for the aged is by taxicab at high cost.

Accordingly, UMTA has provided a demonstration grant for a multi-modal bus system which will be demand-responsive and designed to fulfill the mobility needs of senior citizens. The operator of the system is a local taxi company and if the demonstration proves successful the city will continue operation at cessation of Federal funds.

The National Urban League has been awarded a study grant. Phase I is a literature search of all efforts dealing with marketing of transit services and providing information on transit services to the elderly and handicapped. Phase II will be a nationwide demographic identification of the transportation deprived along wth needs identification and usage.

The study will result in guidelines for improving transit knowledge of and for the elderly and handicapped.

Through an UMTA contract awarded in 1971, guidelines specifications for a 50 passenger bus have been developed. These have been sent to vehicle manufacturers in order for them to develop their own proposed design concepts for a standard bus. The guidelines call for maximum consideration to be given to the needs of the elderly and handicapped and at the very least to include wide doors, extended hand rails, public address systems for waiting passengers, large destination signs in front, side and back of bus, fewer steps and lower floor for bus entry and egress, and driver operated doors. After evaluation of the proposed designs, it is anticipated that three prototypes of buses specially configured for the elderly and handicapped will be built and demonstrated. Eventually the best design will be as a standard bus available for purchase through the UMTA Capital Grant Program.

An UMTA grant has supported a study to determine the scope, severity, dollar costs and characteristics of vandalism and passenger security on transit vehicles. This study will be followed by a number of demonstration projects designed to illustrate and measure the most effective means of vandalism control and passenger security measures. Fear of being molested and/or robbed is a constant one with the elderly, and it is hoped that with this study and subsequent demonstrations, this problem associated wtih utilization of mass transit will be alleviated.

In Chicago, UMTA demonstration funds were used to construct a new passageway connecting a major commuter rail terminal and a distributor rapid transit line. The project will assist the elderly by providing a convenient, weather protected connection complete with escalators between two rail modes of transportation.

In St. Petersburg, Florida, a popular retirement center, UMTA has funded a demonstration planning project which will lead to a definitive design of multifaceted transportation demonstration project aimed at providing improved mobility for the aged. 80% of the population in the project planning area are elderly.

In Cranston, Rhode Island, a planning grant has been awarded in order to determine the optimum system, routing and scheduling necessary to link five senior citizen public housing units plus an education and training center for mentally retarded children and adults to community social service agencies, medical facilities, employment and recreational activities.

A demonstration grant has been awarded to Klamath Falls, Oregon, which will test the feasibility of, and develop a model for, the use of school buses during idle hours for public transportation. The demonstration will serve, primarily senior citizen housing complexes.

UMTA has funded 3 demonstration projects in Model Cities neighborhoods: in Grand Rapids, Michigan; Des Moines, Iowa; and, Los Angeles, California. These projects are primarily oriented toward testing the economic feasibility of providing mass transit for inner city circulation. They offer transit services from the model neighborhoods to medical facilities and social service agencies. These projects directly serve the elderly as a large proportion of the population of inner city residents are over 65.

Federal Highway Administration

The Federal Highway Administration has continued to encourage States to design rest area and tourist facilities for use by the infirm and aged. During 1971, FHWA provided the President's Committee on Employment of the Handicapped with a list of over 330 rest areas which are barrier free, or nearly so, and which are convenient for use by persons in wheel chairs or otherwise severely handicapped.

Under Federal policy, homeowners displaced by highway construction must be provided suitable replacement housing. Relocation assistance, including acceptable replacement housing, eases the hardship for highway-displaced persons, many of whom are elderly.

When one examines the conduct of relocation advisory services in light of the intense, highly-individualized, direct counseling relationship between the displacee and the relocation specialist, the added value of the process to elderly persons is seen. More so than other age groups the olderly may require more detailed interpretations of their entitlements, assistance in selecting replacement housing and consultation with respect to mortgage, leasing or rental provisions.

The Federal Highway Administration has funded a study of transportation problems of the urban disadvantaged, including the elderly component of this group. The study will identify their transportation needs and will recommend ways of meeting those needs.

National Highway Traffic Safety Administration

The National Highway Traffic Safety Administration supported a study which was designed to determine the causes of pedestrian accidents and to develop countermeasures for accident avoidance and injury. The study results are being used in a demonstration to implement and measure the effectiveness of the countermeasures.

While the demonstration is not particularly geared to elderly pedestrians, it is expected to benefit them especially, since they, together with the very young, account for the majority of pedestrian injuries and fatalities.

The Department of Transportation served as chairman of the Transportation Secretariat of the White House Conference on Aging. The Secretariat, comprised of representatives from several Federal agencies, analyzed the policy proposals submitted by States and National organizations representing the elderly and used the data to prepare the Conference Delegate Work Book on Transportation.

The Department provided staff to the Technical Committee on Transportation during the Conference.

ITEM 8. FEDERAL TRADE COMMISSION

Federal Trade Commission,
Washington, D.C., February 28, 1972.

Dear Mr. Chairman: Pursuant to your request, there is herewith enclosed the annual report of the Federal Trade Commission on its activities pertaining to the Aging for 1971.

We hope this information will be both informative and helpful in your report. If we can be of further assistance, please let us know.

Sincerely,

Miles W. Kirkpatrick, *Chairman.*

[Enclosure.]

FEDERAL TRADE COMMISSION

The Federal Trade Commission seeks to protect and promote the interests of consumers in a free and competitive marketplace, through its authority to proceed against all unfair and deceptive acts or practices and unfair methods of competition in commerce. The Commission is concerned with those marketing practices which diminish the consumer's ability to protect his own interests, and with those competitive abuses which lessen competitive pressures to keep prices low and product quality high. To the extent that its statutory authority permits, the Commission also seeks to foster self-protection and encourage more competition by increasing the flow of relevant information about consumer products.

Most of the Commission's activities in the past year were designed to protect and promote consumer interests generally, rather than the interests of any particular segment of the population. To the extent, however, that the Commission's activities may have helped to prevent the fraudulent inducement of consumer expenditures, or may have helped to preserve competitive pressures to keep prices down, such activities would be of particular benefit to those groups of consumers with fixed and limited incomes. One such group is the aged population.

In the past year, the Commission has devoted substantial resources to the regulation of national advertising. The planning of public hearings on modern advertising practices, the inauguration of the "Advertising Substantiation Program", and the initiation of several enforcement actions and new rulemaking proceedings were all aimed at eliminating deceptive and unfair aspects of advertising, and at promoting "informative" advertising as a pro-competitive marketplace force.

The Commission also focused on abusive tactics in personal contact sales. Door-to-door salesmen and sellers of franchise outlets were subject to close scrutiny, as the Commission explored the need for trade regulation rules to govern these forms of marketing. Since the senior citizen may be particularly vulnerable to deception and high-pressure tactics in personal contact circumstances, this resource commitment may be of special benefit to the aged population.

While continuing to monitor and to act vigorously against significant instances of anticompetitive conduct in major product markets, the Commission commenced work on in-depth studies of concentrated industries—energy, drugs, electrical machinery, and automobiles, designed to explore the relationship between structure and performance and between structure and conduct in industries that appear to be non-competitive. The information and judgments derived from these studies will contribute significantly to the evolution of future enforcement policies in the antitrust area.

Although the Commission's activities are designed to promote the welfare of the consuming public generally, the Commission does occasionally embark upon programs which are specifically aimed at problems or abuses of a particular consumer group. Special concern for the aged is evidenced in the Commission's long-standing commitment to ending deceptions in the sale of hearing aids. Another special project was the recent publication of an educational pamphlet entitled "Protection for the Elderly" (F.T.C. Buyer's Guide No. 9). Beyond these specific instances in the past, the special vulnerability and needs of the aged may be a relevant factor in the selection of projects and programs in the future.

ITEM 9. FOOD AND DRUG ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
FOOD AND DRUG ADMINISTRATION,
Rockville, Md., February 24, 1972.

DEAR MR. CHAIRMAN: This is in further response to your December 9 request for information to be included in the 1971 report of the Special Committee on Aging. The information is enclosed.

Also enclosed are the background of the report of the Study of Health Practices and Opinions, which originated with a recommendation from the Committee, and a copy of the Summary and Conclusions. The 400-page report is being printed and will be sent to you as soon as it comes off the press.

Please let us know if we can be of further assistance.

Sincerely yours,

M. J. RYAN,
Director, Office of Legislative Services.

[Enclosures.]

HOW FDA PROTECTS THE OLDER CONSUMER

The Food and Drug Administration has many activities which are of special interest to the older consumer. This is so notwithstanding that the laws administered by FDA are not designed to protect any particular age group.

DRUGS

Some medications have life-or-death importance to older persons, particularly those used to treat heart disease, including digitalis, Digoxin, and Digitoxin. A special study of these drugs was made last year by the FDA National Center for Drug Analysis at St. Louis, Missouri. Serious potency variations were found in many brands on the market. The Agency's Bureau of Drugs initiated numer-

ous recalls of defective lots, on an industry-wide scale. A total of 139 such recalls had been made by the end of 1971.

To insure a safe and effective market supply of the digitalis drugs, a "voluntary certification" program was started in which the manufacturers submitted samples from each production batch for testing by the FDA laboratories, prior to shipment. Several manufacturers were still submitting samples in January 1972.

Last spring (March 1971) a serious medical emergency required the total recall of Abbott Laboratories intravenous solutions, used in hospitals for patients who have had surgery. Bacterial contamination, found to have been introduced through a new screw cap closure, necessitated a public warning and a nationwide program to recover the products. At the same time, FDA took steps to ensure adequate supplies of these vitally needed fluids.

Action began when hospitals reported septicemias and deaths of patients on IV therapy. Over 350 cases of septicemia and 9 deaths were reported by 21 hospitals. More than 5.5 million bottles of 105 different products were recovered and destroyed by the firm under FDA supervision. Production was stopped and orders channeled to other firms unless they could only be filled with Abbott products. Precautionary measures were advised in these cases. FDA monitored the conversion of the firms packaging system to eliminate the contamination problem, and its return to full production.

A boom in vitamin C, set off by press publicity on theories of Dr. Linus Pauling that it prevents colds, resulted in mass substitution of sodium ascorbate for ascorbic acid. A public warning was issued on the health danger to persons who must restrict their sodium intake. Numerous recalls of mislabeled sodium ascorbate were made, mainly from health food stores. One recall involved over 8.8 million capsules.

The Food and Drug Administration's program to insure the effectiveness of drugs continues to have the highest priority. The Agency is nearing completion on a mass evaluation of approximately 3,000 drugs approved for safety, but not effectiveness, before the passage of the Drug Amendments of 1962. Law suits filed by some drug manufacturers have challenged FDA's action, but court decisions have upheld the Government's position that manufacturers' claims must be supported by substantial scientific evidence based on controlled clinical tests.

Over 1,100 official statements were published during the fiscal year 1971 to put the drug firms on notice that better evidence to support claims must be presented the labeling changed, or the products withdrawn from the market.

The effectiveness evaluations are made under a contract with the National Academy of Sciences whose membership includes the Nation's top medical and scientific experts.

New policy on fixed combination drugs—those containing two or more active ingredients—has resulted from the reviews for effectiveness. Hazards of drug use may be increased when more than one drug is taken simultaneously. The hazards can be balanced by rational combinations of drugs to deal with specific conditions. In brief, the new policy requires that each ingredient contribute to the claimed effect of the combination, and that the combination be safe and effective for a significant number of patients who require such concurrent therapy.

Probably the most far-reaching result of the drug effectiveness program will be, not the ineffective products taken off the market, but the lasting improvement of patient care through drugs that accomplish their intended purpose.

The public, and the older generation particularly, take more doses of drugs for self-medication than by prescription. Accordingly, FDA has begun a comprehensive review of the hundreds of thousands of nonprescription drugs to assure that they are safe and effective and that the labeling of these home remedies is true and clearly understandable. Details on the scope and plans for this project were announced publicly by the Commissioner on January 4, 1972.

Foods and Nutrition

Older consumers make extensive use of convenience foods. But these heat-and-serve meals and other prepared dishes have uncertain nutritional value. The FDA acted to assure (1) adequate balanced nutrition in such products as frozen convenience dinners, and (2) labeling to enable consumers to make good selections from the growing array of prepared foods.

A special committee of the National Academy of Sciences-National Research Council, under an FDA contract with the Academy, outlined a set of principles to be used in "guidelines" for nutrition quality.

The first recommended guidelines, for frozen convenience dinners, have been published by the FDA. They set minimum levels for protein, vitamin A, thiamin (vitamin B), riboflavin (vitamin B_2), niacin and iron, based on the food's caloric content. They also call for a source of protein derived primarily from meat, poultry, fish or cheese; potatoes, rice or other cereal products; and a vegetable other than potatoes. Other food components may also be used in addition to the three named. Manufacturers complying with the guidelines would be permitted to indicate this on their labels.

To determine what kind of nutrition labeling is needed by consumers, FDA has contracted for demonstration projects now being carried on by five food chain organizations. Three specific types of labeling are being tested. Another project is a study of consumer attitudes toward nutrient labeling and its benefits aside from product sales.

Proposed FDA regulations concerning the fat content of foods would require manufacturers to disclose on labels the name and source of all fat ingredients, rather than merely to say "shortening" or "vegetable oil," as at present.

If a fat is hydrogenated, the label would be required to disclose that fact. On foods offered for special dietary purposes, the labels would also be required to give information on fatty acids present, the total fat content in percent of the food, and in percent of total calories supplied, and the number of calories in an average serving. Claims of "no cholesterol" or "less cholesterol" would continue to be prohibited as misleading. Comments on the proposal are now being considered.

Iodine deficiency goiter, almost eliminated by the introduction of iodized salt around 40 years ago, has been increasing. To help prevent it, the FDA issued a regulation requiring that iodized salt, be labeled: "This salt supplies iodide, a necessary nutrient." Non-iodized salt will bear the words: "This salt does not supply iodide, a necessary nutrient."

Devices

Eyeglasses and sunglasses are now required to have impact resistant lenses under a new FDA regulation to cut down on the many injuries resulting from broken glasses. An exception permits non-resistant lenses if the physician or optometrist finds they are necessary to meet the visual requirements of a particular patient.

The medical device field is the subject of intensive study to prepare for anticipated programs to strengthen the regulation of therapeutic devices—from hearing aids to heart-lung machines. Legislation has been introduced for this purpose.

Assisting the State of Pennsylvania in a case against Hush-Tone Speech Clarifier, Inc., FDA had clinical studies performed at a Veterans' Administration Hospital and at the Cleveland Speech and Hearing Clinic. This research showed that the device is worthless to filter out background noise and clarify speech for the deaf. Similar studies at Wayne State University (Detroit) produced the same findings. In this device, costing about 35 cents to make, audio sound activates a small tuning fork. Thousands were sold, mainly to older people for as much as $179. An FDA seizure of the device is also being contested. The State Court has not rendered its decision pending the outcome of the Federal case.

Protection of consumers from unnecessary human exposure to man-made radiation became an FDA responsibility by transferral of the Bureau of Radiological Health from the Public Health Service in May 1971. The principal source of exposure to such radiation is the use of X-ray in the healing arts. Other potential sources are electronic products such as microwave ovens and TV sets. Many programs are effectively reducing the radiation hazard, and recent studies have shown that dosage levels today are probably lower than in 1964 (the date of the last similar study) notwithstanding increased frequency of X-ray examinations. Analysis of the 1970 data is still in progress.

Study of Health Practices and Opinions

Significant information on what consumers expect from nonprescription drugs, and their reasons for taking them, is contained in the report on the Study of Health Practices and Opinions, now in press. This Study was suggested by the

Senate Committee on Aging to explore the susceptibility of consumers, particularly the elderly, to health fallacies and misinformation. Funded by seven Government agencies, it sheds new light on many health beliefs and practices.

The Study found that older persons (over 65) are generally less susceptible to health misinformation than younger ones, but their practices much reflect the health problems of this age group. An older person who has arthritis will use a treatment he knows is worthless just to be doing something. Other study findings:

1. "Rampant empiricism" is the greatest single cause of questionable health beliefs and practices in the American population.

2. Informed, systematic thinking about health is rare; few people have an organized set of health beliefs. While some act on the basis of specific beliefs, many more approach health problems from a "trial and error" standpoint, rather than with any grounding in belief or facts.

3. The attitude that "anything is worth a try" reflects the common idea that individual response to treatment is unpredictable, an overextended application of the medical truism that individual persons differ in their response to medication. Thus, what appears to work for one person may not work for someone else, and vice versa, so the only way to find out is to try it. Based on such thinking, any treatment or regimen is justified, no matter how irrational.

STUDY OF HEALTH PRACTICES AND OPINIONS: FDA CONTRACT 66–193

The Study of Health Practices and Opinions is an outcome of hearings begun in 1963 by the Senate Committee on Aging.

The hearings, held by the Subcommittee on Frauds and Misrepresentations Affecting the Elderly (later designated as Subcommittee on Consumer Interests of the Elderly), were chaired by Senator Harrison A. Williams of New Jersey. At sessions in 1964, it was estimated that a billion dollars is wasted annually on misrepresented, unnecessary or worthless health products and services. Testimony indicated that a large share of the cost was borne by older persons, especially those suffering from chronic and incurable diseases.

In 1965, a committee report recommended that a study be made of factors which predispose consumers to become victims of medical misinformation, frauds, and quackery.

In making this recommendation, the Committee said: "It became apparent during the hearings that quackery persists in this Nation because of puzzling consumer attitudes, even when facts are readily available." The following topics for study were suggested in testimony by Dr. Edward Naugler, representing the Northern California Chapter of the Arthritis and Rheumatism Foundation:

(1) What are the factors underlying the tendency of many persons to rely on self-diagnosis and treatment?

(2) What is the net effect of the advertising of medicines and health foods for specific complaints? Does such advertising contribute to the tendency for self-treatment?

(3) What is the real effect of magazine and newspaper articles on medical subjects? The physician wants an informed public, but do these articles produce the effect generally hoped for?

(4) What are the most effective methods for enabling the public to find the best kind of medical care available in the community?"

The National Institute of Mental Health was asked by Senator Williams to initiate action to carry out the Committee's recommendation. The cooperation of the Food and Drug Administration was sought because of its involvement to enforce the Federal law against misbranding of health products and because it has established a Consumer Survey Branch. Seven Government agencies joined in funding and planning the Study, with FDA as the coordinating agency, The cooperating agencies were:

Administration of Aging
Agricultural Research Service, U.S. Department of Agriculture
Food and Drug Administration
National Institute of Child Health and Human Development
National Institute of Mental Health
Veterans Administration
Vocational Rehabilitation Administration

A number of non-Government health agencies, including the American Cancer Society, the American Medical Association, the Arthritis Foundation, and the National Better Business Bureau (now Council of Better Business Bureaus) were consulted and cooperated in the planning of the project.

After competitive bidding, a fixed-price contract in the amount of $157,600 to perform the study was awarded to National Analysts, Inc., of Philadelphia (FDA Contract 66–193). Several modifications and time extensions were subsequently agreed to, most recently in August 1970, when October 30, 1970 was set as delivery date for a first draft of the final report. Subsequently, it was rewritten to include data from additional tabulations, particularly demographic data.

Areas of Inquiry

The subject, scope and content of the project were unprecedented. FDA Commissioner James L. Goddard described it in testimony before the Senate Committee on January 18, 1967. He listed five kinds of information to be sought:

(1) Attitudes, perceptions, and beliefs about the medical and quasi-medical professions, medicines on the market, druggists and pharmacists, foods on the market, and regulatory activities by Government.

(2) Sources of knowledge about health and disease.

(3) Details of respondent's experiences with, or beliefs about misrepresented products and claims.

(4) Attitudes, perceptions, and beliefs, about health, including the respondent's own health.

(5) Personal needs and psychological dispositions.

Twelve areas of inquiry were selected specifically for study, all of them involving products or services that are frequently and persistently promoted in violation of the food and drug laws, the mail fraud statute, or medical practice laws. These areas of study were as follows:

(1) Susceptibility to misinformation regarding the effectiveness of diet, special dietary foods, vitamins and minerals in self-medication.

(2) Opinions and beliefs related to the use of so-called "health foods," "organic foods," and foods in general.

(3) Beliefs and practices in the area of dieting for weight control without medical supervision.

(4) The misconception that daily bowel movements are a necessity for good health, leading to excessive use and dependance upon laxatives, special foods, or enemas, without medical supervision.

(5) The tendency of persons to prolong self-treatment, without consulting a physician, for such conditions as sore throat, coughs, sinus trouble, head colds, hay fever, skin problems, insomnia and upset or acid stomach.

(6) Self-treatment for arthritis and/or rheumatism.

(7) Reliance on and belief in unproven remedies for cancer.

(8) Belief that nonprescription treatments will cure, rather than merely provide relief for asthma, allergies, diabetes and hemorrhoids.

(9) Belief in any treatment for heart trouble and high blood pressure without medical advice.

(10) Opinions concerning health practitioners and their qualifications to treat various conditions.

(11) Attitudes toward hearing problems and the purchase of hearing aids.

(12) Use of advertised products to enable one to quit smoking.

In these areas of product experience, the study sought information on frequency of use, expectations of benefit, degree of satisfaction, and repetitive usage. Sources of information which influenced health practices were evaluated—including mass media communications, advertising, the health professions, neighbors, relatives and peers.

Psychological characteristics were also studied in regard to:

(*a*) Attitudes and subjective feelings about personal health status;

(*b*) Acceptance of beliefs concerning etiology and treatment of diseases—including scientific, cultural, and supernatural concepts, folk beliefs, etc.;

(*c*) Faith in, or resistance to, protection by the Government, the medical profession, etc.; and

(*d*) Degree of acceptance of modern medical science vs. unproven or discredited remedies or treatment.

The study also examines the relationship of demographic factors—age, sex, place of residence, economic status and education to health beliefs. Particularly,

it sought information on the susceptibility of elderly persons (over 65) to false claims and misinformation regarding health products and services.

SUMMARY AND CONCLUSIONS

Purpose of the Study

To investigate fallacious or questionable health beliefs and practices, and susceptibility to them.

Areas Investigated

Beliefs and/or practices in the following areas were singled out for investigation:

Use of vitamin pills and other nutritional supplements, especially with the expectation of specific, noticeable health improvements and without a physician's guidance.
Use of "health food".
Weight reduction practices.
Use of laxatives or other aids to bowel movements.
Self-diagnosis of ailments.
Self-medication for common ailments.
Self-medication for serious ailments.
Practices in the diagnosis and treatment of arthritis/rheumatism.
Practices in the diagnosis and treatment of cancer.
Health practitioners used.
Hearing aids and medication.
"Aids" to quitting smoking.
General health-related attitudes and opinions.

Methodology

Data were collected from two sources:

A large national survey, using area probability techniques to produce a representative sample of U.S. adults, who were interviewed with an extensive questionnaire.

Individual and group depth interviews with people known or suspected to hold questionable beliefs or to have engaged in questionable practices.

Conclusions From the Survey

"Susceptibility to health fallacies" is not an entity: tendencies to follow questionable practices in different areas are only slightly related to one another.

Questionable health practices are not consistently related to questionable beliefs. In some areas, many more people hold questionable beliefs than engage in questionable practices. In some areas, those engaged in questionable practices are no more likely than others, and sometimes less likely, to hold relevant questionable beliefs. In short, the view that fallacious practices result from specific faulty beliefs seems not very useful.

For many questionable practices large majorities of those who tried them are satisfied with the results they think they obtained.

Many people engage in questionable practices just as something "worth a try", rather than from any false conviction.

To quote in this summary estimates of the incidence rates of the various questionable practices investigated could be misleading. The incidence of a questionable practice depends upon how it is defined, and many of the definitions used are quite complex, or include necessarily arbitrary decisions on where to establish a cutting point along a continuum. However, it can be reported that for most of the areas of investigation listed above, between 4 and 12% of the sample were classified for analytic purposes as having followed questionable health practices. Over-reliance on bowel movement aids was lower, and the incidences of questionable practices in the cancer and hearing areas were very much lower. Questionable use of nutrition supplements was definitely much higher, perhaps around one-fourth of the total sample.

The demographic characteristics of followers of questionable practices change materially from one area to another. Therefore, no single set of demographic characteristics is related to questionable health behavior in general.

Some questionable practices are more characteristic of older people (over-reliance upon bowel movement aids, following questionable rather than only medically accepted arthritis treatment practices, using certain non-physician health practitioners). Others were more characteristic of younger people (unrealistic vitamin pill usage, doubtful weight reduction practices, prolonged self-medication for common ailments, purchase of hearing aids other than through a physician). Others were unrelated to age.

Some questionable practices seem more characteristic of people of lower socioeconomic status (unrealistic "tonic" use, over-reliance on bowel movement aids, some doubtful arthritis treatment practices). Others were more common among those with a higher socioeconomic status ("health food", doubtful weight reduction practices, non-physician hearing aids, anti-smoking "aids"). Others were unrelated to education and income.

Large sex differences were rare. Where they did occur, men seemed more susceptible than women in the areas of nutrition supplements and self-medication for serious ailments; women seemed more susceptible for some arthritis treatment practices and most weight reduction practices.

In several of the questionable practices investigated the followers were marked by a general tendency toward self-medication (nutrition supplements, weight reduction practices, self-diagnosis, non-physician hearing aids).

In several of the practices, the followers seem marked by a greater-than-average acceptance of advertising claims ("tonic" use, weight reduction practices, prolonged self-medication for common ailments).

For most of the practices, the followers were either more critical than most people of physicians, or more inclined to trust their own judgment of a medicine when it conflicted with that of a physician.

Followers of most questionable practices report more worry about their health than do people in general. However, they do not fit the classic definition of hypochondriacs, since they did not at the same time evaluate their health as poorer, but tended more often to evaluate it as better than did people in general.

More often than not, the "personality traits" investigated did not distinguish followers of questionable practices. For a few practices, the followers were people who are cynical and take a dim view of the world, as previous research had suggested. In some cases, the dim view of the world was coupled with a sense of deliberately trying to find a bright side to things.

Conclusions From the Depth Interviewing

While the conclusions listed below were derived mainly from the depth interviewing, many of them are consistent with trends observed in the survey data, and none are inconsistent.

Systematic thinking about health is rare, few people have an organized set of health beliefs. Therefore, to explain fallacious behavior as resulting from false belief systems is not generally useful. Of the groups investigated, false belief systems were apparent only to highly committed health food users and those who believe chiropractic treatment appropriate for virtually all conditions.

Many questionable health practices seem better accounted for by "rampant empiricism" than by specific false beliefs:

A great many people take the stance that "anything is worth a try," and approach health problems by trial and error, rather than with a grounding in belief or facts.

Rampant empiricism reflects a very literal belief that individual response to treatment is entirely unpredictable.

Rampant empiricism is thus a much overextended version of the medical truism that individual patients differ in response to medication. Many laymen are willing to justify any "treatment" or regimen, no matter how outlandish, on the grounds that what works for one person may not work for anyone else, so the *only* way to evaluate a practice is to try it.

Rampant empiricism is attractive to the mentally lazy, and to people who need the ego satisfaction of stressing their own uniqueness and judgment.

Public awareness of psychosomatic effects strengthens rampant empiricism: if faith in a treatment can result in improvement, then any treatment at all can work.

The working of the placebo effect is sufficient to prevent the trial and error process from eliminating ineffective treatments. If people think something might help them, many will actually feel relief, even with a sugar pill. Thus, trial of a health treatment selected randomly will produce a number of people attesting that it works.

Simple unaided recovery, when it happens to coincide with a trial period, will make many people believe they hit upon something that will help them.

Many people do not distinguish between a cure and symptomatic relief, and are not even aware that a distinction exists. Anything that makes them feel better is curing them.

It appears that a majority of the population overstresses the relationship between health and diet or nutrition.

Many people seem to believe that actual observed cases of poor health are more often due to "not eating right" than any other cause.

Very large numbers of people believe that almost everyone can gain noticeable improvements in vigor and energy by improving his diet or using supplements.

Thus, many people are convinced that one can "fine tune" his health by improving his diet.

Health and nutrition courses in school may contribute to these misconceptions. Since these courses concentrate on things the individual himself can do for his health, they emphasize such factors as diet and cleanlinesss, rather than such causes as bacteria and virus infection, long-term tissue degeneration, and congenital factors.

Vitamin pills are a great mass placebo. A great majority of the population believe that they provide more pep and energy to almost anyone taking them. Many physicians may encourage this misconception by using vitamins as a placebo when they think the patient is a hypochondriac, or to "pacify" a fretful patient by giving him something when the diagnosis of his run-down feeling is uncertain.

Substantial numbers of people believe that advertisers in the health field are so rigorously policed and regulated that serious distortions and fabrications are very unlikely or impossible. Even people who are skeptical of claims made in the abstract may believe that specific false claims are impossible.

Popular portrayals of "quacks" as objects of humor leads many people to believe that they are always so blatantly weird, preposterous, or hucksterish that they are easily recognizable.

Many victims of health fallacies seem to be striving for "super health".

While physicians might define good health as simply the absence of bad health, many laymen see good health as a state *beyond* the mere absence of any disorders, encompassing feelings of unlimited energy, freedom from any anxiety and depression, and the presence of contentment and happiness.

Thus, good health is not just normal health. Since it transcends the mere absence of disorder, it does not occur naturally, but must be deliberately worked at.

Since physicians do not share this orientation—and neither side understands the other—many people may look elsewhere, often to "rampant empiricism", for assistance in achieving the state they visualize.

For many people, food and nutrition become a likely route to super health.

Courses in school, with their stress upon general well-being rather than specific diseases and disorders, may also contribute to the super health orientation.

Theories of Fallacious Health Behavior

No single explanation can cover all cases of fallacious health behavior, which is not an entity.

Some people, such as those seeking a "cancer cure", those looking for a "faith healer" for paralysis, those suffering intense crippling pain of arthritis, are literally desperate. Such situations differ from most of those dealt with in this study.

Even within the purview of this study, at least two phenomena must be distinguished. Some health practices involve some specific problems, such as arthritis or overweight. Others are just general attempts to "feel better" or "be healthier". Different considerations are involved in practices in these different areas.

The following four descriptions are consistent with the type of practices dealt with in this study:

1. People with a "minor" health problem, real or fancied, who are ignorant or gullible may become convinced that some practice, which may be fallacious, will help them.
2. People with a "minor" health problem, real or fancied, may adopt the view that anything that does not cost too much in money, effort, or time is worth a try. These people tend to be "rampant empiricists", as discussed earlier. Since they can act without commitment, they are not necessarily gullible.
3. Some people with an ideal of "super health" can adopt a strategy of "rampant empiricism". Such individuals need not be especially gullible or ignorant, but there may be predisposing factors: having a preoccupation with health, in the absence of real fear, being impatient, and having a personality that sees a striving individual in a threatening world.
4. People with the "super health" ideal, if they are also gullible or ignorant, can become convinced that some practice will be beneficial.

A separation of the victims of health fallacies into segments with different underlying mechanisms, as above, is necessary to account for the diversity of behavior and orientation encountered in this study and described in detail in the survey findings.

ITEM 10. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR,
Rockville, Md., January 17, 1972.

DEAR MR. CHAIRMAN: This is in reply to your letter of December 9, 1971 concerning a report on program activities in Aging.

Enclosed is a report on these activities within the Health Services and Mental Health Administration. If we can be of any further assistance please let us know.

ROBERT VAN HOEK, M.D.
(For Vernon E. Wilson, M.D.)

[Enclosure]

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

The Health Services and Mental Health Administration is responsible for providing leadership and direction to programs and activities designed to improve general health services and mental health programs for the total population, and for achieving the development of health care and maintenance systems that are adequately financed, comprehensive, interrelated, and responsive to the needs of individuals and families in all socio-economic and ethnic groups.

Obviously, the elderly along with the rest of the population benefit from program activities geared to meeting the needs of all the people.

However, special attention to the needs of the elderly is required for certain facets of somatic and mental health services and programs. The multiplicity of illnesses which often occur in the same individual making treatment more complex, the lack of mobility which serves as a barrier to obtaining available health services, and the onset of senility are but a few problems which require special consideration in organizing health programs for delivery of health services and in preparing health personnel to deal with the aged.

To provide a focal point for the many diverse efforts in health services for the aged, the position of Coordinator for Health of the Aging was established within one of the HSMHA's major components, the Community Health Service, which is the organizational unit specifically involved in health aspects of Medicare, and which has a particular concern with the delivery of health services to the aged.

An outstanding authority in gerontology was appointed to HSMHA for the White House Conference on Aging. Working in concert with the Coordinator

for Health of the Aging, the Consultant assisted in planning and coordinating HSMHA activities for this Conference.

Particular attention to the problems of aging is incorporated into the activities of a number of major operating components within HSMHA:

Community Health Service
Comprehensive Health Planning Service
National Institute of Mental Health
National Center for Health Services Research and Development
Regional Medical Programs Service
Health Care Facilities Service
Health Maintenance Organization Service
Indian Health Service
Federal Health Programs Service
Bureau of Community Environmental Management
Center for Disease Control
National Health Service Corps
National Center for Health Statistics

The sections of the report to follow describe the activities of these programs in more detail.

Community Health Service

The Community Health Service emphasizes support for better organized and delivered health services: development and monitoring of medical care standards to insure the delivery of good quality health services in a safe environment; aiding in the improvement of health resources especially through development of training programs, educational and informational materials for administrative, professional, and auxiliary health personnel as well as the general public.

In all of these activities, recognition is given to the fact that the unique health needs of the aged often necessitate health services specially designed to meet these needs.

MEDICAL CARE STANDARDS

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national requirements for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, and particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower were also inadequate to assure a safe level of quality of services. The Division of Medical Care Standards, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Medical Care Standards is the improvement of the health status of Medicare beneficiaries by assuring that the types, quality and quantity of services provided under the program are appropriate to patients' needs. Since the onset of this program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of quality and accessibility have proved difficult. However, Medicare has helped to focus attention on problems of health manpower—from physicians to nurses aides—including their supply and adequate surveillance of the services they provide. Various techniques for assuring quality of services without unduly limiting supply are undergoing study and experimentation, and Medicare, through the Division of Medical Care Standards, is in the forefront of these efforts.

Currently the conditions of participation for providers of services are being totally revised. This is the first complete revision since the original conditions of participation were implemented more than five years ago. The Health Insurance Benefits Advisory Council has approved two sets of revised conditions and is soon to consider the remaining sets. When these have reached the regulatory stage, the Division of Medical Care Standards will assist the Bureau of Health

Insurance in the revision of guidelines and survey report forms required for implementation of the revised standards.

The Division has instituted several ongoing programs to promote and maintain the quality of care provided to elderly persons. Chief among these are the joint SSA/CHS program reviews of State Medicare agencies, during which evaluation is made of the effectiveness of program policy and guidelines, and the manner in which these are administered in the States. Of more direct benefit to program beneficiaries is the Division's promotion of utilization review, through which physicians evaluate services provided to beneficiaries to determine that such services are reasonable and necessary, rendered in appropriate settings by qualified practitioners and other health professionals, and performed at the right time, in the right amounts. The main thrust of utilization review activities will be to increase the effectiveness of surveillance of quality and appropriateness of services, particularly in those institutions and agencies in which the concept of utilization review prior to Medicare was nonexistent. A principal and rewarding function of the Division's medical staff is to provide consultation to SSA on medical problems that arise, many of which are connected with review of the appropriateness of care provided to individual Medicare beneficiaries.

Still another way in which the Division has a relationship to the health services of the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

In all of these activities, the focus of the Division is the health and safety of Medicare's elderly beneficiaries. All of its operations, planning, and evaluations are directed specifically toward this focus.

HEALTH FACILITIES SURVEY IMPROVEMENT PROGRAM

This is a comprehensive program to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and was supported by the States at a conference of State Nursing Home Licensure Personnel in Dallas, Texas, in May, 1968. Representatives from the Social Security Administration and the Social and Rehabilitation Service were conference participants and have assisted in and supported the development of this program.

The health facility surveyors or inspectors who are being trained through this program have a key responsibility for assuring that nursing homes, extended care facilities, hospitals, and home health agencies provide safe and adequate care and comply with required standards in serving Medicare and Medicaid patients.

In Chicago on June 25, 1971, in remarks to a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons, the President referred to the "depressing" nature of some nursing homes. Then in August he announced a Plan for Action to improve the quality of care provided in the nursing homes of our country. As a result of this announcement, the Federal Program (Health Facilities Survey Improvement Program) is being expanded to provide training for 2,000 State nursing home inspectors.

This additional training of State personnel will enable State governments to increase their effectiveness to bring about the improvement of existing substandard homes.

SHORT-TERM TRAINING

Since the advent of Medicare and Medicaid, extensive work with a number of major national professional societies has been undertaken. The objective of this work has been to involve the professional societies in a national effort to improve standards of care and the delivery of health care in extended care and long-term care facilities.

President Nixon, in his Plan for Action to improve nursing homes directed ". . . a new program of short-term courses for physicians, nurses, dietitians, social workers, and others who are regularly involved in furnishing services to nursing home patients . . ."

In the development of this program, various professional organizations, Social Security Administration, National Institute of Mental Health, and the Social and

Rehabilitation Service are being consulted and asked to participate in the selection of course materials, location, sponsors, and duration of short-term training courses. The objective of this program is to develop a collaborative effort in the implementation of short-term training courses for nursing home personnel so that they can more effectively meet the special needs of the elderly and improve the quality of nursing home care.

COMPREHENSIVE HEALTH SERVICES

In the Partnership for Health legislation, congress provided for project grants to encourage flexibility and innovation in health services delivery. A major purpose behind this approach was achievement of comprehensive health care for a complete target population which, of course, includes the aged.

To date, 55 comprehensive health centers, aimed at a target population of about 1 million persons, have received approximately $76 million in support. The range of services delivered includes: preventive services and health maintenance; emergency services, screening and diagnostic services; treatment services; dental care; rehabilitation; home care; immunization; pharmacy; social services and outreach programs; hospital referral. Approximately 5% of the population served by 314(e) projects is over 65 years of age.

In Kansas City, Wayne Miner Health Center has three public health nurses and eleven home health aides who conduct an outreach program that includes services to the aged and chronically ill through six outreach facilities.

In Beckley, West Virginia, the Mountaineer Family Health Center has seven district centers with outreach health services to the aged and homebound population.

The Yeatman Health Care Program in Kansas City, Missouri, has within its target population a public housing project for the aged. Its tenants are eligible for health services at the Center.

Although most of the "Partnership for Health" grants are for a broad target population, one has been made in Syracuse, New York, to provide health services for elderly tenants of a housing project. Under the direction of attending physicians, this project provides nursing, therapeutic care, social work, and motivational services to tenants. The objective of this project is to help the elderly avoid becoming bedridden, and hence institutionalized, to their own distress and at increasingly exorbitant costs.

MIGRANT HEALTH SERVICES

The Migrant Health Act authorizes provision of health services to the agricultural worker and his family. As a group, the migrant family represents an underserved segment of our population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, living in remote rural areas with no access to social services, suffers from an even more intensified deprivation. In addition, the elderly person who is no longer able to participate in the work force, may find himself left behind in a home-base area as the rest of the family travels north for three to seven months of the year looking for work.

Of the 152,270 migrants who receive medical care, about 2,800 are over 65 years of age. Most of them are women who are traveling with the families, serving as baby-sitters for their grandchildren, and doing domestic chores for the family as needed.

For the foreseeable future, the Migrant Health Program will assist the elderly migrant mainly to the extent that he requires primary (principally ambulatory) health care services. Under the present priorities, the program emphasis is on keeping the migrant worker well. Project outreach workers, however, do their best to arrange in-patient hospital and nursing home care—within the often limited availability of local resources.

PROFESSIONAL EDUCATION

The development of a comprehensive body of knowledge in applied gerontology has been completed. Entitled "Working with Older People: A Guide to Practice," the series is comprised of four volumes. These volumes are: Volume I, "The Practitioner and the Elderly"; Volume II, "Biological, Psychological, and Sociological Aspects of Aging"; Volume III, "The Aging Person: Needs and

Services"; and Volume IV, "Clinical Aspects of Aging." The fourth volume became available in August 1971.

The paucity of teaching programs in comprehensive health care is of particular importance to the aging and aged. For while this inadequacy adversely affects the health status of the total population, the impact is most severe among the aging and aged, the population segment most vulnerable to illness and disability. As a means of stimulating interest in developing undergraduate curricula that provide comprehensive patient management, contracts have been negotiated during the past six years with fourteen medical schools to develop "blueprints" for teaching the concept and methodology of comprehensive patient management. As a result of this program, several medical schools have initiated far-reaching curriculum changes.

Relationships With Other Agencies

The Coordinator for Health of the Aging has worked closely with the Administration on Aging, particularly with regard to providing consultation on the health component of AoA Areawide Model Projects relating to alternatives to institutional care. Consultation has been provided to other components of Social and Rehabilitation Service concerned with health and health-related programs for the elderly. Consultation has also been provided to the Veterans Administration, particularly with regard to development of a conference on alternatives to institutional care, and a series of seminars on orientation of health practitioners with regard to dying and death.

The Coordinator for Health of the Aging has also participated in a HUD Work Group on Congregate Housing, providing consultation on health services for this type of living arrangement.

In response to requests from voluntary organizations concerned with aging, the Coordinator for Health of the Aging has participated as a faculty member and/or resource person in various types of program activities.

Co-ordination of HSMHA Nursing Home Activities

A focal point for co-ordinating all HSMHA activities related to nursing homes including the new and expanded effort as a result of the Presidential initiative and for relating to the Special Assistant for Nursing Home affairs, Assistant Secretary for Health and Scientific Affairs office, has been established in the office of the Deputy Administrator for Health Services Delivery. Details of HSMHA activities are described elsewhere in this report.

Comprehensive Health Planning Service

Comprehensive Health Planning concerns itself with the total health needs of all the population. In Public Law 89–749, federal support for Comprehensive Health Planning was established and Congress declared: " . . . fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living. . . ." and ". . . comprehensive health planning for health services, health manpower and health facilities is essential at every level of government. . . ."

In order to operate an effective health planning organization, priorities have to be established. Planning agencies give particular attention to the indigent and high-risk groups; included among these are the aged. A majority of them have made specific recommendations for improving the level of health among this group.

An examination of nursing and domiciliary homes is one way of implementing the necessary action to solve this problem. In Jacksonville, Florida, part of a study conducted by the Environment Health Study Committee dealt with institutional sanitation; one section examined hospitals, nursing homes, day-care centers, correctional and dependency institutions, and schools. In an attempt to improve the quality of care in nursing homes, recommendations were made to correct deficiencies in operation in order to maintain a degree of dignity in the lives of the older citizens. The community, as a result of this study, has promised that these recommendations will be implemented.

An areawide agency in McComb, Mississippi, is involved in a project funded through the Mississippi Council on Aging by the Older Citizens Act. It is making

a study of the status of citizens 65 years of age and older in three counties. Once it has this inclusive data, the agency hopes to expand the study to other counties. It hopes this will be a source of data for other interested community organizations in provision of services to the aged populace.

Some other examples of CHP involvement are as follows: The Syracuse New York (b) agency, after a study of long-term care in Onondaga County, made several recommendations for the improvement of living centers for the elderly. The Des Moines, Iowa, CHP agency jointly sponsor a statewide conference on "Concern for Iowa's Aging". At this conference, a number of uncoordinated efforts to meet the problems of the aged were identified. As a result, the Nursing Home Advisory Committee was reconstituted into a committee whose membership represented the interests of elderly consumers. Two years ago, the Minnesota Statewide health planning agency completed a study of residential care which was conducted with the participation of the Minnesota Conference on Geriatric Care. One of several results was a demonstration of effective day-care programs in nursing homes.

NATIONAL INSTITUTE OF MENTAL HEALTH

The evidence is clear that the mental health needs of the elderly are inappropriately served. They are frequently isolated, are often shunted into social and psychological ghettos and provide the largest measured incidence of psychopathology of any age group. A study by the National Institute of Mental Health reported by the World Health Organization shows these comparisons:

Age range:	*New cases per 100,000 population*
Under 15	2.3
25 to 34	76.3
35 to 64	93.0
Over 65	236.1

The elderly constitute the largest age group of our state mental hospitals and those with mental health impairment provide the bulk of residents in nursing homes and related facilities serving the chronically ill.

The Institute sees its mission as providing the leadership to respond to these national needs through the totality of its programs in research, training and services within the context of a comprehensive approach.

Within the past year the Institute has focused on developing a mental health strategy for the aging with the involvement of interested professional groups and individuals. The process is in its early stages and should be completed by the end of this fiscal year.

Focus on the elderly has become a program priority of the Institute. To underscore its commitment a senior staff person has been assigned as Special Assistant for the Aging to the Director to reflect the highest level of Institute concern.

An evaluation of the aging programs within the National Institute of Mental Health is being designed and will develop concurrently with the development of the Institute's action strategy for the aging.

DATA

The Biometry Branch, Office of Program Planning and Evaluation, has prepared a detailed study of Patterns of Use of Psychiatric Facilities by the Aged for the Task Force on Aging of the American Psychological Association. This paper discussed trends in patterns of use of various types of psychiatric facilities by the aged; predictions of their future needs for mental health services; estimates of numbers of psychiatrists, psychologists, psychiatric nurses and psychiatric social workers needed to provide the needed care relative to estimates of the available supply of such professionals in 1970, 1975 and 1980, and discussed the implications of these data for planning the delivery of medical, psychiatric, psychological and related human services required to maintain and improve the mental, physical and social well being of the aged.

In addition, the Branch has collaborated with the New York State Psychiatric Institute in New York City and The Institute of Psychiatry of the University of London on a project designed to investigate the extraordinary differences reported in the diagnostic distribution of patients admitted to mental hospitals in the United States and the United Kingdom. At present, the project is completing

a pilot comparison of geriatric admissions in New York and London. Analysis of the findings will be directed toward the challenging question as to whether functional disorders in the elderly are being misdiagnosed as organic disorders in the United States, with the consequence that the patients are regarded as untreatable and valuable treatment opportunities are missed. Incomplete results from the US-UK project suggest that such misdiagnosis may be occurring frequently.

COMMUNITY MENTAL HEALTH CENTERS

On December 30, 1971, there were 303 operating community mental health centers. Fifty-two included components providing geriatric services. An additional 29 components to provide geriatric services are included in the 149 approved programs that are not yet operational.

Institutionalization of the elderly occurs frequently because of the non-existence or inadequacy of viable alternatives for their care in the community. During the 1960's thousands of geriatric patients have been transferred from State mental hospitals to nursing homes. Unfortunately, this has often been little more than exchange of one type of custodial care for another. The early expectation that community mental health centers would provide a wide spectrum of preventive, therapeutic and rehabilitative services to the catchment area population has not been met as far as the mental health needs of the aged are concerned. Only 18 percent of 452 funded community mental health centers indicate that they are providing a program for the aged and patients over 65 represent only 4 percent of their admissions. The reasons for this are complex. They include attitudes of the community at large vis a vis the aged, often shared by health professionals. They also include reluctance of many elderly persons to accept intervention by mental health professionals, lest they be branded "crazy". More important is the very complex interrelationship of mental health problems in this age group with economic problems, general health problems, social problems and the increasing difficulty of older persons to get around. A community mental health center that meets criteria of accessibility for all other age groups, is therefore often out of reach as far as the elderly are concerned.

During the past year, the National Institute of Mental Health has become increasingly aware of the seriousness of the special problems presented by the elderly and has initiated planning to increase the involvement of community mental health centers in their care. Community mental health centers will be encouraged to provide services to the aged through consultation by National Institute of Mental Health and Regional Office staff. The National Institute of Mental Health has also begun to pay special attention to the multiple relationships that must evolve between community mental health centers. State hospitals and other community agencies if the objective of comprehensiveness of care is to be attained. Of particular importance to this age group will be the development of ties between community mental health centers and the emerging Health Maintenance Organizations to assure an essential integration between physical and mental health services.

Furthermore, annual site visits to community mental health centers will focus on services to the aged as one of several areas of major concern to the Institute, thus stimulating staff and Boards of community mental health centers to take concrete steps to meet the mental health needs of the aged in their catchment area.

HEALTH INSURANCE AND MEDICAL ASSISTANCE

The National Institute of Mental Health is concerned with the development and extension of mental health services for the aged through the health insurance and medical assistance programs of Titles XVIII and XIX of P.L. 89-97. The primary goal of the Institute's efforts is to make benefits for the mentally ill aged 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 services are major concerns with NIMH addressees both alone and in collaboration with other Bureaus and Agencies of the Department of Health, Education, and Welfare.

An NIMH study is underway to determine and assess the availability and types of alternative methods of care for geriatric long term patients usually found living in public psychiatric institutions. The study includes an exploration of the elements of care that must be made available to assist patients in remaining with their families and in their home communities.

NIMH collaboration with Community Health Service and the Bureau of Health Insurance (SSA) resulted in studies of the enforcement of standards and the evaluation of quality care being provided patients in both public and private mental institutions. A review of the certification of psychiatric hospitals under Title XVIII (Medicare) has resulted in planning for changes in the psychiatric requirements as well as participation in the training programs for State survey personnel. NIMH participates with Tulane University School of Public Health in the development of indepth mental health training programs for State surveyor personnel.

A document entitled, "It Can't Be Home," has been prepared at NIMH to assist providers and State surveyor personnel in evaluating the quality of care being provided in long term care facilities. Guidelines to accompany the document are in process of development.

In cooperation with other DHEW agencies, NIMH participated in special assignments on the implementation of the President's Nursing Home Program. A task force studies the feasibility of the development on Investigative-Ombudsman Units throughout the country. A related sub-committee has developed conceptual and operational criteria from which specific proposals for pilot demonstration programs can be formalized. A survey was conducted of the current involvement of community mental health centers and State Psychiatric Hospitals in the education programs for State surveyor personnel and the nursing home treatment staff.

NIMH participated with other representatives of DHEW Agencies and Bureaus in the following:

(1) Site visits to selected ambulatory health care centers and CMHC's to ascertain problems these providers have in obtaining reimbursement for services from Titles XVIII and XIX of the Social Security legislation.

(2) A special study of CMHC's to determine the feasibility of transition from grant supplements to third party payments, Federal and non-Federal.

(3) The development of a document to serve as a guide and common ground for the discussion of issues related to patient records in psychiatric hospitals. Resource materials have been distributed to Regional Offices and State Mental Health Offices concerning policies and standards of care.

HOSPITAL STAFF DEVELOPMENT

The Hospital Staff Development program is designed to improve the quality of patient care in public mental health hospitals included in State systems of care through inservice training for personnel. It encourages hospitals to provide staff development programs at the subprofessional and professional levels through a variety of courses, such as orientation, refresher and continuation training, as well as through special courses for those who conduct the training.

The goal of this program is to increase on a continuing basis the effectiveness of available staff in hospitals for the mentally ill and to translate rapidly increasing knowledge into more effective services to patients.

During the calendar year 1971, 171 mental hospitals were awarded grants. There were only a few hospitals that mentioned the aged as the principal focal group. As the program is directed toward "total" staff development, the patients over 65 in all hospitals would benefit from these training programs.

HOSPITAL IMPROVEMENT PROGRAM

The Hospital Improvement Program is directed toward improving the treatment, care, and rehabilitation of the mentally ill in the 302 eligible State-supported mental hospitals throughout the Nation. It is specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change and the development of relationships with community mental health programs.

During calendar year 1971, seven projects were concerned with aged persons. Although each project used different methods to achieve its objectives, many noteworthy results were reported. Some of these were: minimizing the dependence on the hospital, the acquisition or relearning of social skills, restoration of physical functioning, higher rate of discharge, and remotivation in terms of individual skills and interests.

Research

The NIMH program of research in aging has as its goals: the development of knowledge about human behavior and adjustment to the aging process; the increase of knowledge necessary for the understanding, treatment, and rehabilitation of the aged; and the evaluation of services resources designed to care for the aged. Within this context many subsidiary objectives are included such as: the effects of environmental conditions on aging in hospitals, nursing homes, and other settings; the effects of retirement; psychosocial studies of adjustment to aging; studies of the terminal stages of life; and experimentation with the evaluation of new methods of serving the aged in the community and in institutional settings.

Through the support of basic behavioral science research, the program in aging encompasses studies in neuropsychology, personality and motivation, cognition and learning, and cultural variables which affect the aging process; these studies include such areas as tissue deterioration, biochemical change, perception, memory, and intelligence.

Within the program of psychopharmacological research, studies are concerned with use of psychoatictive drugs with the aged and their effects on performance and memory.

The program of clinical research supports studies relevant to aging in such areas as stress, sleep, dreaming, and the biochemistry of senility.

During 1971 there were fifteen active applied research grants in which the major focus was on aging persons. Many other research grants which are concerned with more generalized populations include aged persons among the group being studied, or are concerned with basic developmental processes that may produce information of importance to an understanding of aging or the needs of the aged population.

Among the critical areas of applied research is an increased understanding of the housing needs of the aged and experimentation with a variety of programs to meet the differential needs of segments of the population. Three current studies are being supported in New York, Philadelphia, and St. Louis that are exploring different housing programs: (1) The effectiveness of a comprehensive treatment program on the social, psychological, and physical health of aged welfare tenants occupying single rooms in hotels in mid-city; (2) the feasibility and effect on a group of older people of low cost intermediate housing as a compromise between institutional care and independent living by developing efficiency apartments in a group of row houses with supportive services supplied by a geriatric center; (3) a study to provide guidelines for matching individual needs with existing programs and resources in homes for the aged inorder to improve the living conditions of the elderly in such homes.

Other applied research projects are focused on such areas as: the coordination of community services to meet the needs of the aged; the problems of adjustment when an aged person moves from individual community housing to a group housing program; the impact of intensive treatment programs on reducing functional disability; the relationship between the use of leisure time and mental health of the aged; and the influence of architectural design on behavior of the mentally impaired aged.

Section on Mental Health of the Aging

The Section on Mental Health of the Aging within the Division of Special Mental Health Programs has the responsibility for advocating programs to improve and sustain the mental health of the aging within and outside the NIMH. The Section has concentrated on stimulating and encouraging: (a) recognition and incorporation of specific mental health considerations in programs for the aging in which mental health aspects have previously been unrecognized or unacknowledged; (b) incorporation of appropriate provisions for older people in those mental health programs in which this group has been neglected; and (c) services and research in areas in which innovative programs and knowledge are needed. The main tools of the Section presently are consultation and explication and dissemination of information on the mental health needs of the aged.

The Section has a specific program responsibility for encouraging and monitoring applied research projects funded by the Division of Extramural Research Programs.

For the purpose of disseminating knowledge, the Section contracted for the writing of the following publications: a manual for care of residents in old age homes, a guide for social workers in long-term care facilities, a guide to program development concerning the aged for use of community mental health centers, a publication on preparation for retirement, and a report on longitudinal study on aged.

The staff of the Section has participated in national, regional, and local conferences, meetings, institutes, and workshops, and worked closely with other Federal agencies and other Divisions in NIMH for the purpose of improving the mental health care of the aged.

The Division of Special Mental Health Programs within its Centers funded the following research projects concerned with aging in FY 1971:

a. Center for Minority Group Mental Health Programs: Aging and the Use of Community Resources; Roles and Resources of Older Urban Negroes.

b. Center for Studies of Suicide Prevention: Dying and Bereaved: A Cross-Ethnic Evaluation.

Training

At present the major portion of NIMH training funds concerned with aging is being used in support of training grants, including teaching costs and trainee stipends, fellowships and research development awards. There is continued interest in the curricula of mental health professionals and in the training of new types of workers to care for the aged and provide preventive mental health services. Other training efforts related to aging are ongoing in the continuing education program and the various behavioral sciences programs, including biological, social, research development and fellowships.

In 1971, 19 institutions and 68 trainees stipends were supported under the training grants program, 4 fellows in 4 institutions were supported under the fellowships program and 8 scientists in 7 institutions were supported in the research development program.

Social work traineeships

Social work schools train generalists in casework, community organization, or group work fields with a generic approach to the client.

There are 14 social work programs which are focused entirely upon the aged. Students specializing with this age group complete a field placement in a geriatric institution, a family agency, a community center, or a mental hospital, where the primary emphasis is working with aging persons.

Training in psychiatry

Support for a national program of training in the field of psychiatry is given in collaboration with the Nation's training centers and includes grants made to medical schools, hospitals, and clinics approved for residency training, or research training in special areas. All of the programs include some involvement with the care and treatment of geriatric patients and preventive mental health for the aged. Two of the programs funded by NIMH are specifically for geriatric psychiatry, one at the Duke University Medical School and one at the Illinois State Psychiatric Institute.

Training in psychiatric nursing

Grants to expand and improve training in the field of psychiatric nursing are made for undergraduate and graduate training in special areas. All training grants in the field of nursing include some aspects of caring for the geriatric patient.

New workers

An innovative program is under way which will train mental health workers to work with the aged. It creates the role of Geriatric Outreach Worker, who, as an outreach employee of a nursing home, social or public agency, will serve the aged person in his home. Under the direction of the professional health care team of the agency he will act as facilitating agent, teacher, and friend, providing or being a link to whatever services are needed to enable the older person to maintain independent living. This experimental training project is being funded at Case Western University which addresses the problem of assist-

ing older people to sustain their social, physical, and emotional functioning, enabling them to remain in their own home and community and postponing or averting the need for institutionalization.

CONTINUING EDUCATION OF MENTAL HEALTH PERSONNEL

NIMH plans, administers and coordinates a program for inservice training, staff development, postgraduate education, and adult education to upgrade the efficiency of personnel currently employed in mental health agencies and other mental health allied personnel and citizen groups.

One continuing education project grant has been renewed for the Gerontology Center at the University of Southern California to cover a multidisciplinary group of professionals including general medical practitioners, psychologists, psychiatrists, city planners, architects, etc. Another continuing education grant concerning the aging is ongoing with the Gerontological Society. Its objectives are to improve and increase mental health services to the mentally ill elderly, apply the most relevant research data to practice, and stimulate and involve more professionals in conscious innovation of services to the elderly.

Other Continuing Education grants, such as those for physicians, clergy and mental health personnel, include components on mental health problems and care of the aging. All Public Health-Mental Health graduate training grants include components on aging.

BEHAVIORAL SCIENCES

The support of biological sciences training projects includes studies on the genetics of aging, the psycho-biological functions in aging, and the ultrastructure of cells in aging. Two of these programs are at the Albert Einstein College of Medicine and the Duke University Medical Center.

Several of the training programs in clinical psychology and a number of field training centers have components which deal with aging. Training grant programs in which students have elective options for work in the area of aging include Duke University, Boston University, the University of Michigan, the West Virginia University, the University of Southern California, and the University of Chicago. Field training centers located in state hospitals almost always have a unit devoted to the treatment of the aged.

Eight investigators supported by the Research Development Program are concentrating on problems related to aging. Examples of such problems of aging are (1) the psychological and social factors related to rheumatoid arthritis, (2) the health and mental health effects of termination of employment, and (3) the study of essential hypertension, atherosclerosis and coronary heart disease by developing analogs of these illnesses in animal models. It will then be possible to study the relationships between behavioral and emotional factors and cardiovascular dysfunction.

Of the fellowships awardees, four are supported specifically in the area of the aged. Fellowship programs are developed in the following areas:

(1) Community mental health clinic screening processes; (2) psychology of aging; (3) sociology of aging; (4) community organization; and (5) advocacy planning for the aged.

A program in sociology at Duke University, Durham, North Carolina, focuses on social system analysis in medical and mental health disciplines and settings. This program has a close liaison with the training of many students at the Duke Medical School Gerontology Institute. This training program includes the psychological aspects of physiological change as a consequence of aging.

A program in family sociology at the University of Minnesota ensures that trainees focus on problems of family adjustment including adjustment to bereavement and old age. Studies under way consider the kinds of family structure which endure into the later years of life as well as substitute family networks which maintain mental health when families break up because of death, mobility, illness or other factors.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

The National Center for Health Services Research and Development supports research and development directed to general aspects of health services and major

health problems to improve the organization, delivery, and financing of health services. By improving the full range of health services in communities, the needs of all the people—including the aged—are better served.

General projects supported by the Center that have meaningful impact upon health needs of the aged include coordination of health, social, and welfare services; alternatives to hospital use such as nursing homes, intermediate care facilities, and home care; the costs of alternative methods of care; the rates of utilization associated with various social and economic factors; experimental medical care review organizations which test alternative approaches and systematic methods in the review of medical care; identifying and demonstrating where and under what conditions health care technology can bring about meaningful reductions in the cost of services; and the testing of R&D components in community laboratories to determine the health care requirements of people in relation to existing community resources.

In 1971, HSMHA initiated the Experimental Health Services Delivery Systems program for which the NCHSRD was designated "lead agency." The goal of this program is to support and assist communities in coordinating their public, private, and voluntary resources to design, implement, and manage a system directed to improving access to needed personal health services for all segments of the population, moderating costs, and assuring quality. Twelve communities—ranging in size from a three-county rural farm setting containing some 150,000 residents to entire State-wide communities—were selected to receive support during the first year of this program's operation. The aging, along with the rest of the population, benefit from these experimental delivery systems.

In one experimental system community—Tucson, Arizona—there is already active involvement with the Administration on Aging areawide demonstration program devoted to the development of alternatives to institutional care for the aged in Tucson.

The NCHSRD, under a short-term contract jointly financed with HUD, is collecting and evaluating data on residents of a HUD financed housing project for the disabled in Fall River, Massachusetts. The purpose is to evaluate the effects of such housing, located adjacent to a chronic disease and rehabilitation hospital, as an alternative to hospitalization or nursing home placement.

Seven additional projects administered by NCHSRD during 1971 were directed specifically to health services for the aged.

Regional Medical Programs

The Regional Medical Programs seek to strengthen and improve the Nation's personal health care system in order to bring about more accessible, efficient, and high quality health care to the American public. To accomplish these ends, the 56 individual Regional Medical Programs promote and demonstrate among providers new techniques and innovative delivery patterns; support training which results in more effective utilization of health manpower; and encourage the regionalization of health facilities, manpower, and other resources.

The RMP's develop their programs through a consortium of providers who come together to plan and implement activities to meet health needs which cannot be met by individual practitioners, health professionals, hospitals, and other institutions acting alone. The RMP provides a framework deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such it is a potentially important force for bringing about and assisting with changes in the provision of personal health services and care.

As the RMP program has broadened its concern with a comprehensive approach to personal health care, there has continued to be a strong emphasis on heart disease, cancer, stroke, kidney disease, and related diseases, all of which affect the health of the aged. The majority of disease-oriented activities are not directed solely at the aging or aged population. Nevertheless, efforts aimed at improvement of care for the aging and lessening the impact of chronic long-term illness are appearing in a number of patient care demonstration activities and training such as disease detection and prevention (screening activities), public education, follow-up, 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, hypertension, cerebrovascular disease, kidney disease, diabetes, cancer, and pulmonary problems.

In the area of stroke, for example, the use of special stroke facilities and a team approach is credited with a drop of almost a third in the death rate of stroke patients at the Columbia Hospital in central South Carolina. Before the institution of the stroke project, sponsored by the South Carolina Regional Medical Program, the death rate among patients hospitalized for stroke was 52 percent. After the opening of a special stroke unit in the hospital, the rate dropped to 19 percent. There is an extremely high incidence of acute cerebrovascular disease (stroke) in the central region of South Carolina. The stroke project makes the first comprehensive attempt in the State to improve diagnosis, management and rehabilitation of stroke patients.

Multiphasic screening projects can be beneficial to the whole age range of the population, or of special use to certain of the older groups, depending on the extent to which they concentrate on testing for heart disease and cancer. Home health aide projects are directed at training of health workers and family members to care for chronically ill long-term patients with heart disease, cancer, or stroke. Some of these activities are coordinated with the visiting nurses association, others involve public health nursing organizations, and follow-up care after discharge from community hospitals.

Efforts to develop alternatives to institutional care include an emphasis on rehabilitation. Rehabilitation activities include both the training of health professionals in the field of rehabilitation and the training of home health aides and other allied health workers for care of patients at home or in a nursing home. Physical therapists are working in rural parts of Georgia, for example, where no home care physical therapy was previously available. The therapists are part of a Georgia Regional Medical Program project involving the pooling of medical personnel to provide services to remote areas of the State.

Another effort in Missouri is developing a mobile rehabilitation service which would make such services available to rural areas of southwest Missouri. Involving teams of a physical therapist and a nurse's aide, services would be provided to both outlying hospitals and nursing homes. Concurrent training courses would be offered to the nursing staffs of the hospitals and nursing homes participating in the project.

Upgrading of care in health facilities and institutions is another area of concern. The need to improve the availability of quality care in nursing homes and other extended care facilities was recognized in the Pittsburgh area. The Western Pennsylvania RMP has undertaken a training project to improve the standards of patient care in such facilities. More than one-third of the nursing homes providing skilled care in the Region have participated in this project to improve the quality of their nursing and administrative services.

In Branson, Missouri, an effort is being made to provide immediate access to high quality, low-cost health care at the Skaggs Community Hospital, including establishment of cooperative arrangements with referral centers. Special emphasis will be placed on improving service to the large number of elderly disadvantaged and rural poor who live in the area, as it is a combination resort and retirement area. Project activities relate to the establishment of comprehensive intensive care and rehabilitation treatment capabilities.

In addition, nearly every region is supporting a demonstration or training project involving patients with cardiovascular disease. Some are based at community hospital coronary care units; others offer education and training courses at the medical center, and consultation services to smaller peripheral hospitals.

Health Care Facilities Service

Better patient care for all the people has been a major objective of the Hill-Burton program since its inception following the enactment of the Hospital Survey and Construction Act of 1946. Activities under the original legislation and subsequent amendments have centered on:

1. the award of grants for the construction of various types of health facilities needed in each State. (With the enactment of Public Law 91–296, Medical Facilities Construction and Modernization Amendments of 1970, the Program was broadened to include loan guarantees with interest subsidies for nonprofit hospitals and other health facilities and direct loans for public hospitals.)
2. the development of better planning methods to aid communities assess their overall needs and determine areas requiring greatest priority.

3. the elevation of standards of design, construction and operation of facilities through the provision of consultation services which includes the development of guide materials widely used not only in this country but by health facility planners around the world.

As of December 1, 1971, the Hill-Burton program had approved more than 1,700 projects for the construction of nearly 98,000 long-term care beds in nursing homes, chronic disease hospitals, and long-term care units of hospitals. These projects involved $527 million of Hill-Burton funds, or 14 percent of all funds expended since the beginning of the program.

Despite a continuing growth in long-term care beds within recent years, there is still a need for long-term care facilities, including extended care facilities, to be constructed and/or modernized. In fiscal year 1972 Hill-Burton funds appropriated for these facilities amounted to $175.2 million. It is estimated that this level of financial assistance will stimulate the construction of approximately 2,600 long-term care beds.

The aging and aged will benefit also from the construction or modernization of other health care facilities being assisted under the Hill-Burton program. Hospitals, out-patient facilities, public health centers, and rehabilitation facilities all provide services to the aged. In fiscal year 1972, Hill-Burton funds appropriated for these facilities amounted to $175.2 million.

Among the major activities of the Hill-Burton program is the development of guide material relating to the planning, design, equipping, and construction of various types of health care facilities. Presently, in cooperation with the Community Health Service, guidelines are being developed for the planning and design of a skilled nursing home. In addition, the Health Care Facilities Services is also developing guide material for extended care facilities.

Health Maintenance Organizations

The Health Care Strategy proposed by the President in his Health Message to the Congress contains a directive of far reaching importance to the elderly. This strategy called for medical schools, teaching hospitals, neighborhood health centers—or consortia of several of those or other elements—to form Health Maintenance Organizations, known as HMOs. The organizational format is very flexible, but through one arrangement or another, the HMO brings together a comprehensive range of medical services which it provides to all subscribers for a fixed contract fee paid in advance. The older person has the option of joining an HMO for Part A and Part B coverage of Medicare or continuing to receive services in the traditional—and often fragmented—manner.

Financial incentives for health maintenance and disease prevention embodied in the HMO represent a new departure in national health policy. Neither the medical providers nor the population at large has been willing to spend significant time or effort on the prevention or avoidance of disease. Almost none of the payment mechanisms—including Medicare and Medicaid—have included realistic incentives for patients to stay well or for the health establishment to keep them well. On the contrary, the economic levers lie dormant until the patient is sick, at which time he is eligible to seek treatment and file a claim.

Development of this method of delivery and financing of care, with built-in rewards for efficiency and emphasis placed on disease prevention and health maintenance, is of particular significance to the elderly.

The Health Maintenance Organization Service (HMOS) was established within HSMHA in 1971 to serve as the lead agency for HMO development. During calendar year 1971, the HMOS has initiated a program to expand HMO service availability by awarding over $6.000.000 in grants to assist more than 80 organizations to develop as HMO's. A technical assistance capability is being built to facilitate this development, reducing both the time and cost required to organize the components to the point of delivering services. These 80 organizations, at full enrollment, will be able to serve some 2.000,000 citizens. Plans have been made to expand this availability in coming years.

While HMO services are intended to be available to all, and not just to the elderly, the concentration on accessibility, prevention, efficiency, and cost consciousness will be of particular value to the elderly, in view of their higher-than-average utilization of services.

Indian Health Service

The Indian Health Program serves 460,000 Indians and Alaska Natives living in geographic and cultural isolation on 250 Reservations and in Indian communities located in 24 States including hundreds of villages in Alaska. Based upon 1960 U.S. Census statistics, persons aged 65 and over represent approximately 5 percent of the U.S. Indian and Alaska Native population; therefore, the Indian and Alaska people are a young segment of the U.S. population.

The approximately 24,000 aged 65 and over and the 56,100 aging, from 45 to 65 years, within the Indian Health Service population are reached through comprehensive health care provided through the Indian Health Service system of 51 hospitals, 74 field health centers, over 300 health stations located in the vicinity of Indian family groups, and through a contract medical care program. These health and health related services covering the life span of this service population have resulted in a decline of death rate of Indian Health Service beneficiaries by 15 percent from 1960 to 1968.

In order to best utilize scarce resources to meet the many health needs of all of the 460,000 Indian Health Service population, program emphasis is directed to those in the younger age group. While attending to the health needs of the elderly, a major objective of the Indian Health Service is to advance the health level of the young and to maintain their health gains thus achieving a larger older age segment of the population with improved health status.

Specific services provided by the Indian Health Service which minimize the health problems of the aging and aged include:

Identification of the aging and aged and their problems by all members of the Indian Health Service staff in the course of day-to-day operations throughout Reservations and Indian communities.

Coordinated services of the Indian Health Service physician, nurse and social work staff in meeting immediate health and social problems, preventing crises and future problems, and maintaining the health gains of the elderly.

Social assessment of the needs of the family and the lone elderly which recognizes the changing roles, functions, and status of the elderly and social planning to meet the needs of the elderly.

Services of the Indian Health Service trained Indian and Alaska Native Social Work Associates who provide a full range of social work services to their people while advancing their social work careers. These native social workers further help the elderly to interpret the differing cultural concepts of "well" and "sick" and to seek health services early.

Development of the Indian Physician Assistant and Training Program which will extend outreach Indian health services to the elderly.

Assistance by the Indian Health Service-trained Indian Community Health Representative and the Alaska Native Community Health Aide, especially in seeking out the elderly and bringing their individual problems to the attention of appropriate health and social resources, providing transportation to Indian Health Service facilities and spanning the language and cultural gap between elderly Indian patients and non-Indian professional staff when needed.

Public Health Nursing services were provided to 3,210 individuals or more than 13 percent of the Indian service population aged 65 and over. A total of 10,650 visits were made to this group or an average of over three visits to each person. Nursing consultation is provided to nursing homes on behalf of Indian patients, the majority of whom are elderly.

Counselling by Indian Health Service pharmacists to patients mainly the elderly with chronic diseases such as diabetes and heart disease on long-term drug therapy who are given priority for instruction relative to the correct use of drugs and medications and to assist the patient in understanding what to expect in results from the appropriate use of drugs.

Prevention of institutionalization of the senile and mentally ill elderly through mental health treatment and alternative social planning.

Contract health services within the funded scope of this IHS resource, including nursing home and extended medical care.

IHS medical and social service surveillance for nursing home and extended medical care patients.

Improving income levels of the elderly through application assistance for state and Federal program benefits.

Assisting the elderly to obtain services under such programs as Medicare, Medicaid, and Veterans' programs.

Environmental Health Services concerned with safe water supplies and waste disposal systems, vector control, home sanitation and safety, and correction of environmental conditions which adversely affect the physical and social environment of the elderly as well as the general public.

Nutrition and Dietetics family-centered service program of intensive education, adapting proper principles to the food habits and cultural practices of the Indian and Alaska Natives. The elderly are reached within these services to the family with special emphasis given to improving nutritional health. Individual income and nutritional quality of diet are related. Information regarding the USDA administered Food Assistance programs (food stamps, commodities and supplemental foods) is provided to as many of the aged as possible with special attention directed to the best possible utilization of these resources to improve the overall nutritional status. Nutrition consultation is provided to Department of Agriculture and other agencies working with Indians and Alaska Natives on educational activities and in group feeding programs.

IHS consultant services relative to improved and new housing for the elderly. IHS consultant services to tribal groups on all phases of planning nursing home construction and operational management and services.

Assisting Tribes in the identification and use of all community, State, and Federal financial program services needed to attack special problems affecting the aging and aged such as grants for alcoholism and nutrition projects, and resources for the development of Home Health Aide-Homemaker Services.

Health Education services directed toward Indian communities, Tribal groups, families and patients including the elderly assisting the Indian people to utilize the IHS health care system, to understand the disease process and to take preventive measures which will ensure good health.

Training Indian Health Boards in the art of program planning, financing, and operational management of the Indian Health Service.

Federal Health Programs Service

The Federal Health Programs Service has no programs which of themselves relate directly and specifically to aging. This applies to its research and clinical care programs as well as to the programs of Emergency Health Service and Federal Employee Health. For 1969, of a total of 42,046 discharges from hospitals of the FHPS, 4,359 were over 65. The average length of stay for elderly men was 24.4 days and elderly women 20.8 days, compared with an average length of stay of 17.5 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization, and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving in-patient services are American Seamen, who constitute the primary beneficiary group cared for in PHS hospitals. The problems presented by this group of patients are similar to those presented by aging patients in general with one exception: there are probably more single males in this group than in the general population. Because of this fact, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by FHPS.

FHPS has also provided professional personnel to assist other programs directly concerned with the problems of the aged. In addition, the Social Service Branch has been actively involved in a work group whose primary purpose is to develop guidelines for the establishment of demonstration Investigative-Ombudsman Units in selected States.

Bureau of Community Environmental Management

The functions of the Bureau of Community Environmental Management encompass a broad systems approach to the management of community and residential environments for the protection and enhancement of health and well-being. Emphasis is placed on the man-made or built environment as associated with the sociocultural aspects of human settlements. The Bureau's programs are oriented toward community organization for self-help.

Although the Bureau has no specific programs for the aging, consideration is given to this factor in the design of activities and programs for implementation

at the community level. These activities include the development of housing and building codes and standards, building and fire safety standards for nursing homes, and research studies directed at the cause and prevention of burns, asphyxia, falls and accidents in general.

Center for Disease Control

The activities of the Center for Disease Control, in focusing on the preventive aspects of health services delivery and the quality of delivered services, protect and benefit the general public. Normally, these activities are not specifically targeted on the aging, but because of their special health needs, this group is frequently reached with services. For example, the aging is one of the population groups with special nutrition-related health needs. Problem areas such as iron deficiency anemia could potentially be prevented by use of enriched foods. The Center has funded a demonstration project to determine the effect of food supplementation on health, through comparison of institutionalized and noninstitutionalized groups of elderly persons who have been supplied with nutritionally-supplemented foods.

National Health Service Corps

The National Health Service Corps is just beginning its operations; it is, therefore, difficult to identify aspects of its activities which impact specifically on aging populations or individuals. While there are no activities specifically earmarked for the aging, some general comments about the relationship of the program to the aging can be made.

The Corps' activities are directed to areas which are "critically short" of health personnel. While it is difficult to generalize, these areas are usually of two general types—urban inner cities or remote rural areas. Both of these types of areas have heavy concentrations of older persons who either cannot move elsewhere or do not wish to do so. The guiding principle behind the Corps is the idea that simple residence in a certain type of area should not by itself be a barrier to effective health care. By assigning its personnel to such areas, the Corps hopes not only to alleviate the immediate health care needs of the target populations, including the elderly, but by so doing to make such areas more attractive places to live for the long term.

It is not possible to project at this time what proportion of the Corps' services will be provided specifically to the elderly. However, such data will be collected in an effort to develop more effective methods for reaching these populations. The Corps will devote much attention to the problem of developing effective outreach systems for getting care to those who need it; certainly the elderly are particularly in need of such outreach. The Corps will work closely with organizations of and for the elderly wherever it can, drawing on them as other community groups, for support and assistance. It is a cardinal rule of the Corps that its services are designed by and for the communities involved. Since the elderly form a large proportion of the population in many of the areas, it is expected that they will play a major role in Corps activities.

National Center For Health Statistics

All health statistics prepared by NCHS are or can be presented in terms of specific age groups.

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45–64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements.

Also reported in the interview survey are number of physician visits, episodes of hospitalization, days of hospitalization, and expenditures for various types of health services.

The Health Examination Survey of small national samples of the noninstitutional population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people—specific types of heart disease,

hypertension, arthritis, visual and hearing defects, dental conditions. It also provides data on several physiological characteristics (height and weight, serum cholesterol level, blood glucose level, blood pressure) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status.

Separate surveys are made of the residents and patients in both long- and short-term care institutions—chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received, and costs.

The National Center for Health Statistics also produces data on causes of death by demographic characteristics and geographic distributions of the population, and the national and state life tables.

Many of the above types of data have been presented in a recent report, "Health in the Later Years of Life."

White House Conference on Aging

The 1971 White House Conference on Aging held November 26 to December 2, 1971, in Washington, D.C., demonstrated an overriding interest in health. More than one-seventh of all delegates attending the Conference participated in the Health Section, which was one of 14 Sections of the Conference.

HSMHA staff contributed substantially to preparations for the Conference, activities of the Conference, and is currently involved in plans for implementation of Conference recommendations. During the Prologue Year, the Background Paper on Health was co-authored by the HSMHA Consultant on Aging, the Coordinator for Health of the Aging, and other staff from the Community Health Service. The Coordinator for Health of the Aging established and chaired a Federal Secretariat on Health and a HSMHA Committee on Aging. The Coordinator for Health of the Aging served as Management Officer for the 500-person Section on Health, and a substantial number of HSMHA staff served as resource persons to Health Sub-Sections. The Headquarters Room of the Health Section was staffed primarily by HSMHA personnel.

The Coordinator for Health of the Aging also served as the focal point in planning activities for the Special Concern Session on Long-Term Care, which attracted 500 participants, and was by far the largest of 17 concurrently held special concerns sessions.

ITEM 11. INTERNAL REVENUE SERVICE

December 30, 1971.

Dear Senator Church: We are pleased to transmit the statement on Internal Revenue Service Activities for the annual report of the Special Committee on Aging, requested in you letter of December 9, 1971.

The Service is deeply aware of the needs of our elderly citizens in connection with the income tax. We have expanded our assistance to them, and hope that this program will continue to grow.

If we can provide other assistance to the Committee, please call upon us.

Sincerely,

Johnnie M. Walters, *Commissioner.*

[Enclosure]

Internal Revenue Service Activities Affecting the Aged

Three areas in which the Internal Revenue Service has attempted to improve its service to elderly taxpayers during 1971 are: (1) improvements in the Form 1040; (2) expansion of the taxpayer assistance training provided; and (3) expanded availability of toll-free telephone taxpayer service.

CHANGES IN FORM 1040

The changes in the 1971 Form 1040 include a simplification method of reporting income for fully taxable pensions and annuities on page 2 of Form 1040. This will enable many pension and annuity recipients to avoid the necessity of filing a separate schedule (Schedule E). Also, the retirement income credit

schedule (Schedule R) was simplified by the elimination of the surcharge computation.

Other improvements in the Form 1040 instructions include the use of larger type in both the narrative material and the tax tables, and the inclusion of an expanded index in extra large type on the back cover of the package.

The cover of the package highlights a message from the Commissioner which calls special attention to a filled in Form 1040 inside the front cover with a clear explanation of how 30 million taxpayers could use this simple format to fulfill their tax obligations. This format together with the emphasis on the Service's offer to compute the tax and the retirement income credit on returns with income from wages, pensions and annuities up to $20,000 will enable many aging American taxpayers to prepare their own returns and avoid the payment of fees to commercial preparers. This offer to compute taxes was raised from $10,000 to $20,000. In addition, the Service offered to compute the retirement income credit for those who ask for the tax computation.

TRAINING ASSISTANCE

For the second year, the Internal Revenue Service continued and expanded its nationwide effort to provide taxpayer assistance training for the elderly. An increased number of volunteer representatives of various retirement and elderly associations were given training (by IRS instructors) in the preparation and filing of Federal income tax returns to enable them to assist other members of their organizations in meeting tax filing requirements. In the training, the provisions of the law that apply specifically to elderly and retired people were emphasized. Due to its past success, this program is now an integral part of a comprehensive taxpayer education program offered annually by the Internal Revenue Service.

During the last filing period, IRS conducted more than 40 institutes specifically for retirees giving one to two days of tax training to 1,200 volunteers, an increase of 100 percent over the initial year of the program. In Florida alone, 200 volunteers participated in the program and provided assistance to 20,000 elderly taxpayers. In addition, many more senior citizens received training and in turn provided assistance through the IRS Volunteer Income Tax Assistance Program which is designed to make available free tax service to lower income and other disadvantaged citizens.

The sizeable expansion in program participation and accomplishment is due in significant part to an increasing degree of cooperation between the Internal Revenue Service and major retirement associations. In the forefront has been the leadership of the Institutes of Lifetime Learning, a service organization for the American Association of Retired Persons and the National Retired Teachers Association. Increased participation has also been provided under the auspices of the National Association of Retired Federal Employees.

Through efforts of the Institutes of Lifetime Learning, elderly tax training coordinators were appointed in 18 major cities throughout the Nation with tax counseling provides in 34 cities. Coordinators were responsible for contacting retirement groups in their areas to inform them of the elderly tax assistance program and to enlist volunteer representatives to receive training to prepare them to serve as assistors. The coordinators also served as liaison with the Internal Revenue Service in arranging training, materials, and any special assistance needed. In view of the growing awareness and acceptance of this endeavor, the Internal Revenue Service, in cooperation with retirement organizations, is planning a considerably larger program for the elderly for the 1972 filing period.

In addition to this institute program, IRS employees served as tax instructors in adult education sessions to help senior citizens prepare their own returns. These sessions ranged in length from one to four hours and were attended by more than 10,000 persons.

In an effort to help Federal employees better adjust to retirement years, IRS developed for the Civil Service Commission a preretirement counseling program on "The Federal Income Tax Implications of Civil Service Retirement." Twenty-five hundred copies of the instructor guide for this program, designed to be offered by agency retirement counselors, have been made available to all Federal departments and offices.

Documents related to those training and counseling programs for the retired and elderly are also provided by IRS. They include among others, Publication

554, Tax Benefits for Older Americans; Publication 524, Retirement Income and Retirement Income Credit; and Publication 568, Federal Tax Information for Civil Service Retirees. Copies of these and similar publications are available free of charge from IRS District Offices and major subordinate offices.

EXPANDED TELEPHONE SERVICE

IRS has installed in 22 additional States a network of toll-free lines to provide 40 hour a week telephone taxpayer service. This is especially advantageous to the elderly, many who live in areas remote from any IRS office and who in the past were able to obtain assistance only on designated days and at considerable expense either in toll fees or by traveling to the nearest IRS office.

SURVEY CONDUCTED

An interview survey was conducted for us by an independent research firm at the end of the last filing season to measure taxpayer experience with and attitudes toward the Form 1040. Although the questions were not directed specifically toward tax problems of senior citizens, some of the questions did shed light upon their problems. We found that approximately 80 percent of the taxpayers age 65 and older seek assistance from others in preparing their Federal tax returns, as compared to approximately 70 percent of the total population seeking such assistance (these figures include unpaid assistance from friends and relatives). Secondly, we found that of those taxpayers who claim the retirement income credit, less than one-half were aware that under certain circumstances IRS would compute the tax for them. The Commissioner's message and the first page of instructions for the 1971 tax return package, to be mailed out later this month, emphasize to all taxpayers, not just those over 65, that IRS will compute the tax in many cases, and that a very large number of taxpayers should be able to prepare their own return without paid assistance. Finally, 10 percent of the taxpayers who claimed the retirement income credit in both 1969 and 1970 felt that the revised 1970 Schedule R was easier to work with than the 1969 version, and none of them preferred the 1969 version. H.R. 1, which has passed the House, would provide a change in the computation of the retirement income credit, and this legislative change, if enacted, may make it possible to devise a simpler Schedule R.

ITEM 12. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
NATIONAL INSTITUTES OF HEALTH,
Bethesda, Md., January 20, 1972.

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,

ROBERT Q. MARSTON, M.D., *Director.*

[Enclosure]

THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT—THE NATIONAL INSTITUTES OF HEALTH

The success of modern science and technology has profoundly changed the medical problems faced by the United States. Spectacular progress has been made in the control of infections and nutritional diseases though problems still remain particularly among the poor. Because of this progress fewer and fewer young persons are dying. Thus the expectancy of life at birth has increased. In 1900 that expectancy was 49 years. Now it is 70 years. Naturally there are more older persons. In 1900 four percent of the population of this country was over 65. Now ten percent exceed that age. The absolute figures emphasize the change. In 1900 three million persons were over 65. Now 20 million exceed that age.

Medical science continues to advance. The Nation now looks forward confidently to the eventual control of cancer. Much is understood about atherosclerosis, and it seems improbable that it will not eventually be controlled. Hypertension is already coming under control. It seems inevitable that the life expectancy at birth will increase.

Two factors have tended to keep the fraction of the population over 65 relatively low in the past. One has been a high mortality rate. The other has been an expanding population containing many young persons. Both these factors will probably change so as to increase the fraction of older persons. The probability for improved mortality was noted above. We must also expect the population explosion to be brought under control.

Even now our mortality rates are such that a zero growth population would eventually have 15 percent of its members over 65. Decreased mortality rates are to be expected and would produce an even greater percentage of older persons. Current projections by the Census Bureau are that there will be 40 million persons over 65 years old 50 years from now, and that they will be 13 percent of the population. And that projection is based on the assumption that there will be no improvement in mortality rates.

At present the problems of the elderly are major ones. They affect not only older persons but also society as a whole. Clearly they will become progressively more important.

If atherosclerosis and cancer, now the major causes of mortality in this country, are brought largely under control, what will be the health status of the elderly spared those diseases at least until much later in life? The answer to this question lies in the way control over disease is achieved. The causes of disease can be placed in three categories. One category then contains environmental factors—nutrition, infection, etc. Another category contains a host of genetic defects. The third category contains intrinsic aging processes. The nation is gaining control over its health problems by modification of environmental factors. It is beginning to see hope for the control of genetic factors. However, little progress has been made in the understanding of aging processes and even less in the development of methods for mitigating those processes. Thus it appears that the nation is moving toward a population containing a large fraction of elderly persons disabled by intrinsic aging processes.

The emergence of a population with a very large fraction of persons over 65 creates many problems. Research should be undertaken now so that the nation can meet the current problems and be prepared for the future ones. Congress has charged NICHD with the responsibility for the development and support of research on the medical and related biological, psychological, and societal aspects of aging as they affect individuals and society.

The NICHD obligations in 1971 to carry out this responsibility were:

Mechanism:	*Funds*
Research grants	$3,801,000
Training grants	2,232,000
Contracts	240,000
Gerontology Research Center	2,636,000
Staff support	404,000
Total	9,313,000

With these funds the Institute supported extramural research on aging and training for such research at universities, hospitals, research institutions, and industry through its Adult Development and Aging Branch and also conducted an intramural program on aging at its own research facility—the Gerontology Research Center in Baltimore.

Extramural Research and Training Program

psychological and social aspects of aging

Approximately 2.5 million dollars or 40 percent of the expenditures for the extramural program were on psychological and social aspects of aging.

An area of especial concern is the deterioration that occurs in mental function with age. Senile dementias cause incapacitating loss of mental function in about half of the one million old persons institutionalized in the United States. Some of

these dementias are thought to be due to vascular disease while others appear to be due to changes in the brain cells themselves.

Work that will help unravel the many factors that contribute to impairment of mental function in the elderly is badly needed. One important discovery that came out of the longitudinal study that NICHD supports at Duke University was the finding that mental function deteriorates much more rapidly in elderly persons with hypertension than in those with normal blood pressure. This strongly suggests that the control of hypertension by procedures that are already available will slow the onset of mental deterioration.

There is some evidence that the administration of oxygen under increased pressure, a procedure known as hyperbaric oxygenation, will improve mental function and that this improvement persists for a while at least after removal from the oxygen chamber. NICHD is supporting two studies of this type of treatment, one through the State University of New York at Buffalo, and the other at the Duke School of Medicine in Durham, North Carolina. Much work remains to be done in confirming the initial observations, in determining what types of patients are benefitted by the procedure, in quantifying the degree and duration of the benefits, and in selecting the optimum pressures, concentrations of oxygen, and schedules of treatment. If such treatment proves to be truly efficacious, it may reduce the need for the institutionalization of many older persons and make it possible for them to lead lives more satisfying to themselves and more useful to society.

BIOLOGICAL ASPECTS OF AGING

The underlying changes that transform a young person into an old one occur in the cells that form the body and the extracellular materials in which they live. These aging processes are causative factors in a great many older persons' diseases—atherosclerosis, cancer, osteoporosis, osteoarthritis, senile dementia, cataracts, and others. Progress in preventing and treating them depends in part on understanding the nature of aging processes and the causative roles they play in diseases.

To encourage research on basic aging processes, NICHD currently supports a summer course in the biology of aging designed to give an overview of biological aging and a detailed analysis of selected topics. This course was held at the Jackson Laboratory, Bar Harbor, Maine in the summer of 1971, was taught by a faculty of scientists from many universities, and attended by about 20 pre- and post-doctoral students. In 1972 it will be held at the University of California at Santa Cruz.

Important extracellular materials that are involved in aging are collagen, the major structural protein of the body, the mucopolysaccharides which are associated with collagen and which hold water and thus give substance and turgor to human tissues, and the minerals that provide rigidity to bone. These materials deteriorate with age—collagen changes both quantitatively and qualitatively, mucopolysaccharides decrease in amount, and bone becomes fragile due to loss of its mineral content. Approximately $500,000 was spent to support extramural research and training for research of these extracellular substances during the fiscal year.

The changes that occur at a cellular level are being investigated in a number of programs with a total funding of about $1,700,000 for the year.

Several investigators have concentrated on age changes associated with lysosomes, the small organelles found within cells and responsible for the digestion of many of the materials that enter the cell. Some of these investigators are now studying the digestion of the cell's own protoplasm by its lysosomes. This remarkable process permits the renewal of cellular protoplasm so that although a cell may be decades old as an entity, much of its protoplasm is of recent origin.

In the process of digesting protoplasm and foreign substances the lysosomes encounter some chemicals they cannot dispose of. These accumulate in old lysosomes and some of them form lipofucsin or "aging pigment," a material that accumulates in appreciable quantities in old cells and may interfere with cellular function. Several investigators are studying various aspects of lipofucsin formation.

Studies that may throw light on the function of fibroblasts are under way. It has been shown that these cells which are responsible for the elaboration of the extracellular matrix—collagen and mucopolysaccharides—are not capable of indefinite life in tissue culture. This provides an opportunity both to vary the conditions of tissue culture in an attempt to make them live longer and to study

the abnormalities that develop in them after prolonged tissue culture. A very interesting fact is that these fibroblasts that will normally divide to form new cells only a limited number of times can be transformed into what appears to be an immortal state with ability to divide indefinitely by a virus. However, when this transformation occurs the fibroblasts become abnormal in a number of ways and probably are very similar to malignant neoplastic cells.

In order to facilitate the investigation of the changes that occur in fibroblasts *in vitro* NICHD supports the production and distribution of a line of human fibroblasts (WI–38) to interested investigators. These cells are grown to various stages of their *in vitro* lifespan and then stored frozen at subzero temperatures. The central supply of such well-characterized cells facilitates work in this area by reducing the operations that have to be carried out by the individual investigators and by assuring that different investigators are working on the same cell types.

To facilitate the transition of well-qualified scientists interested in this area, a course on cell culture for the study of cellular aging was supported in the summer of 1971 at the W. Alton Jones Cell Science Center, Lake Placid, New York.

One of the investigators supported by NICHD has shown that the production of high levels of enzymatic activity by various stimuli is greatly delayed in older animals. Studies are being continued to determine the mechanism of this abnormality which may lie behind some of the metabolic abnormalities that manifest themselves at the level of the whole organism.

It is possible that much of the impaired function of older cells is due to changes in deoxyribonucleic acid (DNA), the constituent of the cells which controls the synthesis of most of their components and which transmits genetic information. This material is renewed only when cells divide. Thus in those cells of the human body which do not divide after the first few years of life, the DNA of the cells is as old as the individual. The DNA in the nerve and muscle cells of the 80-year-old person is essentially 80 years old. DNA is a very large, complex molecule which might be expected to be altered adversely by agents in its microenvironment during this period of time and thus to deteriorate with age. Several NICHD supported investigators are studying changes with age in DNA and the enzymes and other nucleic acids that are associated with it in the process of controlling cellular activities.

There are a number of cellular changes that as currently studied manifest themselves strikingly at the level of the whole organism. These include the changes in the immunologic competence with age that make the elderly more susceptible to infections and probably to cancer, changes in endocrine function with age that modify the ability of the body to metabolize many substances such as carbohydrates effectively, and changes in the interrelationships between age and exercise. NICHD support for research on these changes was about $1,600,000.

A major problem in studying aging has been the difficulty of acquiring suitable experimental animals, a problem NICHD is attacking systematically. The major current need is for well-characterized, short-lived mammalian species. Inbred and random-bred mice and rats appear most appropriate. The Institute is supporting the production of such animals free of pathogenic organisms at the Charles River Laboratories. These animals are being characterized pathologically, microbiologically, and nutritionally and will in several years be available for sale to interested investigators.

There is a need for other vertebrate animal models for research on aging, and the Institute has given preliminary consideration to the problems involved. Among these are the relatively long lifespans of most vertebrates and the costliness of raising them to maturity and old age.

In some ways research on invertebrates might provide useful leads for studies on mammals. Many invertebrates have the great advantage for aging studies of being short-lived. However, there are also problems connected with the use of these animals. Thought is being given to the selection of suitable invertebrates for aging research.

The Gerontology Research Center

The Gerontology Research Center of the National Institute of Child Health and Human Development is the Federal Government's focal point for intramural research on aging. Studies carried out at the Baltimore Center describe the bio-

logical, physiological, and behavioral changes that take place with aging in humans. In addition to human studies, animals with relatively short lifespans are used to determine the basic genetic and cellular mechanisms involved in aging. The Center staff of 115 men and women conduct investigations into the biological, physiological, medical and psychological aspects of aging.

In addition to its own investigators, the Center provides laboratory facilities for some 50 guest workers and 6 foreign fellows and serves as a regional facility for aging research. Through this guest scientist program, the Center stimulates and fosters aging studies by non-government scientists by offering resources that may be unavailable elsewhere. For example, a primary requirement for aging studies, not available in many laboratories or institutions, is access to animals of known age. The Gerontology Research Center maintains a colony of aging rats that are made available to guest scientists working on approved projects related to aging. Guest scientist projects are reviewed by an advisory committee of non-government scientists who are knowledgeable in the field of aging. Other Center resources available to guest investigators include a specialized library of the scientific literature on aging, tissue culture rooms, data processing equipment, an animal surgical suite, highly specialized scientific equipment, and regular aging research seminars.

During 1971, Center scientists made steady progress toward gaining the basic knowledge about aging processes that can be used ultimately to help ensure an active, healthy and productive later life for all people.

Long-term investigations of individual age changes occurring in normal men continued through the Center's longitudinal study of aging. Some 600 men leading active lives in the community participate in this study initiated in 1960. The volunteers range in age from 20 to 96 years. They are all successful people with above average educational backgrounds. This population provides the opportunity to study aging under optimal conditions. Each volunteer spends two and one-half days in Baltimore every 18 months undergoing an extensive series of clinical, biochemical, physiological, and psychological tests.

While some subjects have been examined 10 times, most have been seen 3–5 times, since new volunteers have entered the study each year since its beginning in 1960. Data gathered from these studies are being systematically introduced into a specially designed computer system, but a complete longitudinal analysis will be possible only when a majority of the subjects have been followed for at least 10 years.

Preliminary results from the longitudinal study do show that cigarette smoking is associated with a reduction in lung function in men of all ages. In fact, the average lung function for cigarette smokers is about the same as that of non-smokers who are ten years older. However, tests at the Center show that when smoking is stopped, lung function recovers to near normal within 18–24 months. Nutritional records of men in the longitudinal study indicate that with increasing age the daily caloric intake is reduced in subjects who maintain a stable body weight. The lowered caloric intake noted is not due to an inability to buy food. This spontaneous reduction in caloric intake is proportional to the fall in basal oxygen consumption in physical activity which is associated with aging.

Past research has shown that the amount of blood pumped by the heart each minute diminishes with age. In 1971, studies were initiated to discover the extent to which this fall is determined by a reduction in muscular contractility of the heart. A precise answer to this question calls for inserting catheters into the heart to measure pressures during each heart beat. These techniques are not applied to normal humans. Therefore, new methods were tested to estimate the effectiveness of heart contractions by indirect means, specifically, simultaneous recording of the electrocardiogram, phonocardiogram, and carotid pulse. This method is now being applied to normal subjects in the longitudinal study. It is known that in subjects with no clinical evidence of heart disease, the heart's effectiveness declines on the average up to the age of 60. Since the average values remain stable, or tend to show some improvement after this age, scientists hypothesize that individuals fall into two groups. One group undergoes a gradual deterioration of cardiac function with age and is at increased risk of dying around age 60. The other group is made up of subjects who do not undergo deterioration with age and survive into the later decades. Support for this hypothesis will require repeated observations on the same subjects as they age. The longitudinal study population offers an excellent chance to collect this infor-

mation which could prove extremely useful for identifying individuals at high risk for the development of heart disease.

In some cases the irregularities in heart rate that occur with advancing age impair cardiac function. Consequently studies on age differences in the regulation of resting heart rate have been carried out on experimental animals. One mechanism for the control of heart rate is a slowing induced by a rise in blood pressure. In these studies, the investigators found that when the same rise in blood pressure was induced by intravenous administration of a drug in old and young rats, the slowing of the heart was greater in the young than in the old animals. The most probable mechanism for this difference is a reduced sensitivity of pressure sensitive cells in the blood vessels of the old animals. These studies serve to emphasize the important role played by regulatory mechanisms in aging of the cardiovascular system.

Research conducted over the last decade has shown that many responses, such as heart rate and brainwave activity, once regarded as automatic and involuntary can be brought under voluntary control. Investigators at the Gerontology Research Center have shown that subjects with a number of different kinds of abnormal heart rhythms can learn to control some aspects of their arrhythmias. Examples include middle-aged older patients with premature beats of the lower heart chambers (ventricles), and uncoordinated contractions of the upper heart chambers (atria). The ventricles pump oxygenated blood to the body and un-oxygenated blood to the lungs. The atria receive un-oxygenated blood from the body and oxygenated blood from the lungs. These findings have important clinical implications since one-half of all deaths in this country each year are attributable to cardiovascular diseases, and cardiac arrhythmias are involved in many of these deaths. Therefore, this continuing research is dealing not only with scientific questions but with technology and methodology that may eventually be adaptable to clinical therapy for patients with abnormal heart rhythms.

Behavioral scientists at the Gerontology Research Center are interested in changes taking place with age in an individual's ability to reason. One way to test this ability is through problem solving studies in which the subject's task is to apply whatever knowledge he already has to the solution of problems requiring logical reasoning. In order to reason, at least two items of information are required and some relationship must exist between them. Recent studies suggest that the old person experiences more difficulty maintaining items of information for a reasoning task. This is true even when the information is available for review in written form and superficially should not require remembering. This means that the elderly are not relating information effectively and this contributes to their poor reasoning performance. On the other hand, the effectiveness in relating information *per se* may not be age dependent. Perhaps it is only under a memory load, requiring full effort and attention by the old to maintain, that the relating performance declines with age. In the latter case, methods may be devised to help individuals over-learn information so that the old, as well as the young, can devote more attention to the relating aspects of a task.

Gerontology Research Center scientists also conduct investigations on the effects of aging on animal behavior. Animals give behavioral scientists a relatively simple experimental system that can be used to identify and analyze behavioral variables which change with age. They also make it possible to carry out longitudinal tests in relatively short-lived species so that many generations can be studied, and offer the opportunity to control behavior to degrees that are not possible in man.

One example of the extent to which age-related behavior can be experimentally controlled has been shown by studies involving the ability of rats to learn a complex maze. Studies of this problem solving task indicated that about 60% of a population of aged rats are unable to learn their way through the maze. One reason these animals failed to learn was that they tended to make the same error again and again. When the training procedure was modified by giving the older animals massed training sessions rather than distributed practice sessions, which aid learning in the young animals, the old rats who previously could not learn the maze were able to learn even though the total number of trials was kept constant. These findings suggest that performance decrements seen in older subjects may reflect the teaching methods used. If this is true, then the learning deficits of older subjects might be reduced substantially by altering

teaching methods from those that have proven effective for teaching children any young adults.

The reduced capacity of some organs to recover from stress or to function properly with age is believed to result from a gradual loss of cells from these organs. For example, the decreased kidney function in the aged is due in part to the progressive loss of nephrons (cells important for waste excretion). Scientists at the Gerontology Research Center investigate the biochemical changes in cells which lead to decreased cell functioning ability with age, and eventual cell death.

Some organs of the body undergo involution with increasing age. Involution refers to regressive changes in the body or its parts. Involution of the accessory sex organs, such as the prostate, can be experimentally induced in male rats by castration. A guest scientist at the Center is using this model to study senile involution. He has shown that this experimental involution is related to an increase in specific enzymes associated with the breakdown of cellular constituents. These enzymes do not seem to be specially formed during involution but represent the selective retention and redistribution of enzymes already present in the cell. Since the enzymes are located within specific components (lysosomes) contained in the cell, they probably play a key role in senile involution at the cellular level.

One of the mechanisms linked to the lowered capacity of an organism to perform muscular work with age is a decreased ability to meet the energy demands of working tissues. Center investigators, through electron microscopy, have found an age-dependent degeneration of muscle mitochondria, characterized by deformation of the inner membranes (cristae). This deformation is correlated with a decrease in biochemical function. One enzyme, cytochrome oxidase, is absent from that portion of the mitochondrion that undergoes structural change, but maintains strong activity in the undamaged portion of the mitochondria. Mitochondria containing degenerate cristae isolated from old animals showed a significantly lower rate of metabolism and less ability to control metabolism than did mitochondria from young animals. These findings indicate that the decreased capacity of mitochondria from old animals to utilize nutrients for cell energy, with an accompanying loss of the ability to control metabolism, may be accounted for by the decrease in the total number of the functional cristae in these mitochondria.

ITEM 13. OFFICE OF ECONOMIC OPPORTUNITY

EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., January 24, 1972.

DEAR MR. CHAIRMAN: We are pleased to comply with your request for a report on the activities and programs of the Office of Economic Opportunity during 1971 on behalf of the elderly poor.

In addition to the annual report, we are enclosing related documents for such use as the Committee may deem appropriate.*

Sincerely,

PHILLIP V. SANCHEZ, *Director.*

[Enclosure]

ACTIVITIES AND PROGRAMS FOR THE ELDERLY POOR—OFFICE OF ECONOMIC OPPORTUNITY—1971

INTRODUCTION

Activities and programs conducted by the Office of Economic Opportunity for the eldely poor received new impetus from the Agency during 1971. Under OEO national leadership, State Economic Opportunity Offices (SEOOs), OEO's Regional Offices, its grantees, and its contractors were made more fully aware of the problems and special needs of the estimated 1,800,000 elderly poor reached and served by activities and programs of the Office of Economic Opportunity in 1971 at an estimated cost of $100 million.

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*Retained in Committee files.

Specifically, OEO's increased emphasis on the elderly poor in 1971 was achieved by the following means:

1. New OEO policy directives affecting the elderly poor.
2. Organizational changes in OEO Headquarters and in the OEO Regions affecting the elderly poor.
3. OEO national survey and analysis of all Agency activities and programs conducted for the elderly poor.
4. Increased emphasis on OEO *Senior Opportunities and Services* programs (SOS), conducted exclusively for the elderly poor.
5. Similarly increased emphasis on OEO multi-generational programs, conducted for all categories of the poverty population, including the elderly poor.
6. OEO Special Emphasis programs conducted by OEO's Office of Legal Services and Office of Health Affairs.
7. OEO Research and Demonstration programs conducted by OEO's Office of Program Development.
8. OEO cooperation with other Federal agencies and departments in activities and programs for the elderly poor.
9. OEO support contracts with national organizations working with the elderly.
10. OEO participation in the 1971 White House Conference on the Aging.

New OEO Policy Directives for Elderly Poor, 1971

In September, 1971, the Office of Economic Opportunity issued two new Agency directives giving added emphasis and direction to OEO programs for the elderly poor.

OEO Staff Instruction 6170–1 entitled "Older Persons Policy" urges OEO Headquarters and Regional staff to adhere to the following policy guidelines:

1. "The elderly shall be included in OEO multi-generational programs in order to avoid the unnecessary reinforcement of the societal isolation from which they already suffer. At the same time, it should be understood that where there is a large geographical concentration of the elderly, or a need to meet some of the unique health, employment, legal or other needs of the elderly, some OEO demonstration programs other than Senior Opportunities and Services (SOS) should be designed exclusively for senior citizens, but with appropriate links to all-age programs.
2. The elderly require a balanced income-service strategy. The Office of Economic Opportunity shall work to assure that the elderly know about and receive the Social Security or Old Age Assistance or other income-maintenance benefits and social services for which they are eligible. At the same time, OEO shall continue devising and testing new services and their delivery systems as models for other Federal agencies and for the non-government sector as well.
3. OEO and OEO-funded grantees and contractors should give special consideration in hiring to qualified older workers, consistent with Civil Service regulations, in order to counter-balance the extensive exclusion they encounter in the general labor market."

OEO Instruction 6170–1 entitled "Guidelines for Planning and Programming for the Elderly Poor" is a guide "for professional staff and lay citizens at the community level on how an emphasis for the elderly poor as mandated by the Economic Opportunity Act can be accomplished through programs serving all ages, such as Community Action Agencies, Neighborhood Legal Services, Comprehensive Health Programs, and through programs serving only the aged funded out of Senior Opportunities and Services, local initiative money of CAAs, or research and demonstration projects."

OEO Organizational Changes Affecting Elderly Poor, 1971

OEO HEADQUARTERS

In October, 1971, responsibility for policy coordination for OEO programs for the elderly poor was transferred from the Office of Special Programs, which has now been abolished, to the new Office of Program Review. The Office of Program Review coordinates its policy function regarding the elderly with the OEO

Office of Operations which, in turn, has responsibility for administering both the Senior Opportunities and Services programs designed exclusively for the elderly poor, and the multi-generational programs which impact upon the elderly poor.

The Director of the Office of Program Review is Howard Phillips, who also serves as an Associate Director of the Office of Economic Opportunity. In addition to his responsibilities in regard to the elderly poor, Mr. Phillips is also charged with (1) reviewing the full spectrum of OEO anti-poverty activities from a program and policy perspective, and (2) developing new antipoverty strategies for the Agency.

OEO REGIONS

In 1971, administrative responsibility for program areas affecting the elderly poor was transferred, increasingly, from OEO Headquarters to the ten OEO Regional Offices. Each OEO Regional Office now has one staff specialist assigned to programs for the elderly poor. The responsibilities of the Regional Specialist on Aging include supervising the work performance of the Regional Representative of the National Council on the Aging who, under an OEO support contract, is responsible to the Agency for training and technical assistance programs affecting the elderly poor.

In 1971, the OEO Office of Operations conducted two seminars in Washington, D.C., for the new Regional Specialists on Aging to provide up-to-date information on OEO program and policy matters affecting the elderly poor, including such topics as greater use of the voluntary sector, legislation under consideration, and related topics.

As a result of the White House Conference on the Aging held in December, 1971, and of initiatives since undertaken by its Chairman, Dr. Arthur Flemming, OEO Regional Offices are beginning to participate in inter-agency task forces designed to coordinate activities and programs for the elderly poor at the Regional level, including the funding and sponsoring of inter-agency demonstration projects.

National Survey of OEO Programs for Elderly Poor, 1971

During 1971, the Office of Economic Opportunity undertook a national survey of activities and programs for the elderly poor conducted by the OEO Community Action Agencies (CAA). The survey was completed during September-October, 1971, and has yielded comprehensive data for further analysis regarding the two major OEO program categories for the elderly poor:

1. Senior Opportunities Services programs operated by Community Action Agencies.
2. Multi-generational programs for the elderly poor operated by Community Action Agencies.

Results of the national survey of "CAA Activities and Programs for Older Persons" conducted by the OEO Office of Operations appear in the following two sections of this report entitled (1) OEO Senior Opportunities and Services Programs, 1971, and (2) OEO Multi-Generational Programs for Elderly Poor, 1971.

OEO Senior Opportunities and Services Programs (SOS) 1971

President Nixon in his Address to the Closing Session of the White House Conference on the Aging on December 2, 1971, stated:

> "We can give special emphasis to services that will help people live decent and dignified lives in their own homes, services such as home health aides, homemaker and nutritional services, home-delivered meals, transportation assistance."

The Office of Economic Opportunity's SOS programs have pioneered in the program emphasis described by the President in his White House Conference on the Aging Address. SOS was created and authorized by the 1967 Amendments to the Economic Opportunity Act. It was designed to identify and meet the special economic, health, employment, welfare, and other needs of the elderly poor above the age of 60 in projects which serve and employ older persons as the exclusive or predominant participant or employee group. The projects deal with those problems of the elderly poor that cannot be met by more general programs of OEO designed to serve multi-generational groups.

Such projects develop and provide new employment, volunteer services, and referral; stimulate and create additional services and programs to remedy gaps and deficiencies in existing programs; and attempt to modify existing eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the elderly poor. The projects provide maximum opportunity for the elderly poor to develop, direct, and administer such programs, while utilizing existing services and other programs to the maximum extent feasible.

The funding level for SOS programs has risen from $6.8 million in 1970 to $8.0 million in 1971, of which $258,000 was utilized by Community Action Agencies to benefit Indian and Migrant elderly poor. During 1971, the number of SOS programs increased from 208 to *252 programs*. This expansion made it possible for one SOS program to be funded in each of 48 States, Puerto Rico, and the Trust Territory of the Pacific Islands.

Results of the 1971 national survey indicate that approximately $10.0 million in Federal funds was available to SOS programs, of which 61% represented OEO earmarked SOS appropriations; 26%, local initiative funds; 7%, Title III Administration on Aging funds; and 6% from other sources. Somewhat more than half of the OEO SOS programs are classified as rural, although rural SOS program dollars account for somewhat less than half of the total program dollars.

A significant disclosure of the national survey is the high rate of local, non-Federal support for SOS programs, which is approximately $4.0 million, or 40% of the $10.0 million in Federal funds available to SOS programs. This local support ratio far exceeds statutory requirements and suggests strong interest in SOS programs for the elderly poor by local governments, local institutions, and local communities. Other findings of the survey are described below under appropriate headings.

VOLUNTARY SERVICES

Many of the 252 SOS programs in 1971 depended significantly upon local volunteers to provide services to the elderly poor. Survey results indicate that a total of 141,000 Americans in local communities volunteered their time during 1971 to the elderly poor. The amount of aggregated volunteer time amounted to 1,000 full-time employees, or an average equivalent of four full-time persons for each SOS program.

SOS PROGRAM BENEFICIARIES

In 1971, SOS programs reached and served a total of 800,000 elderly poor—an average, approximately, of 3,000 persons in each SOS program. The SOS programs averaged 22,000 individual services, including repetitive services, for the year. Based on a study in 1970, the median age of SOS participants is 71 years.

SOS PROGRAM COSTS

The average cost annually for each individual served by SOS programs in 1971 was $12 in Federal funds and $5 in non-Federal support for the programs. This annual cost is to be compared to a cost of $5,000 or more annually for institutional care for the elderly, notwithstanding costs in human dignity and happiness. The average cost for individual services provided by SOS programs amounted in 1971 to $1.70 in Federal funds and $.68 in non-Federal funds.

PROGRAM CHARACTERISTICS

Since the elderly poor vary as much in their needs, capabilities, and aspirations as other age groups in the poverty population, the strategy behind most SOS programming efforts is to devise and to offer a multiplicity of integrated services to the elderly poor in central and convenient locations. It should be mentioned that other Federal agencies and departments, as well as State and local institutions, cooperate with the Office of Economic Opportunity in providing such services through centralized delivery systems, wherever possible.

Considering the advanced age of most participants in SOS programs (71 years of age), the major objective in SOS programming is to provide physical and psychological supporting services to the elderly poor to enable them to remain, and to function, in their own homes—thus preventing, or delaying, the unwel-

come and costly alternatives involved for the elderly when they must enter nursing homes and other such institutions.

MAJOR CATEGORIES OF SOS SERVICES

With approximately 1,000 individual SOS Senior Centers in operation during 1971, or an average of four separate centers for each SOS program in operation, the following information based on the OEO national survey indicates the number of SOS programs providing specific major categories of services:

Type of service:	*Number of SOS programs offering service*
1. Civic influence and action	159
2. Outreach and referral	213
3. Home health-aide services	78
4. Other health services	77
5. Homemaker services	83
6. Housing assistance	130
7. Home repair services	57
8. Handyman services	48
9. Transportation assistance	197
10. Legal services	71
11. Employment Training and referral	123
12. Consumer education	118
13. Other education	112
14. Credit unions, buying clubs	50
15. Home-delivered meals	60
16. Congregate meals	59
17. Other meals programs	24
18. All-season recreation programs	175
19. Handicrafts	180
20. Friendly visiting services	148
21. Telephone reassurance program	116
22. Other	58

INSTITUTIONAL CHANGE EFFECTED BY SOS

Responses to OEO survey questionnaires distributed during 1971 revealed ways in which local communities and institutions changed and improved their service delivery systems during the year, as a result of SOS activities and programs conducted in these communities. Of 228 SOS programs out of 252 that reported survey information and results, *105 SOS programs cited the following significant changes in local communities:*

1. Improved food stamp accessibility
2. Reduced transportation fares
3. County or State modifications in property tax laws
4. Construction of new housing complexes

Many of the institutional changes resulting from SOS programs benefited not only the elderly poor but all segments of the poverty population. In addition, the OEO national survey indicated that at least 66 SOS projects, or components of projects such as Senior Centers, credit unions and buying clubs, have been "spun off" and are now operating independently, with no further Federal financial support.

EVALUATION HIGHLIGHTS OF CONTRACTOR STUDY OF SOS

In 1970, an Office of Economic Opportunity Contractor, Kirschner Associates, Incorporated, completed an evaluation of SOS programs on a selective yet geographically wide basis. Among major findings of the contractor previously reported by the Office of Economic Opportunity were:

1. SOS is an effective means for identifying and meeting the needs of the elderly poor.
2. SOS programs have a low unit cost per beneficiary.
3. The elderly participate more actively in special programs designed for their own needs.

4. Opportunities in SOS projects have produced significant improvements in the sense of dignity and in the physical and emotional well-being of the elderly poor.

5. SOS projects are enthusiastically accepted by local governments and attract a more generous measure of community support than other types of programs for the elderly poor.*

OEO Multi-Generational Programs for Elderly Poor, 1971

The Office of Economic Opportunity survey of Community Action Agencies in 1971 was not only to gather and classify specific program characteristics of the 252 SOS programs now in operation nationwide, but to collect and analyze information, to the extent possible, concerning the wide range of CAA multi-generational activities and programs also reaching and serving the elderly poor.

In addition to the 800,000 elderly poor benefiting from SOS programs, results of the OEO national survey indicate that over 1,000,000 elderly poor are reached and served by Community Action Agency multi-generational programs. Survey data contained responses from *768 Community Action Agencies*, or approximately 85% of all Community Action Agencies currently in operation. Relevant findings of the survey are summarized below under appropriate headings.

PRIORITIES

Of 768 Community Action Agencies responding to OEO questionnaires, virtually 100% listed the elderly poor as a recognized priority. Half of the CAAs (375) reported the elderly poor as one of a series of ranked priorities; the other half included the elderly poor as a priority under such categorical needs as housing, health, and transportation.

TITLE I MAINSTREAM PROGRAMS

President Nixon in his Address to the White House Conference on the Aging on December 2, 1971, stated:

> "I have also ordered that our job programs for older persons with low incomes be doubled to $26 million. Under this program, projects such as Green Thumb and Senior Aides have demonstrated that older Americans can make valuable contributions in health, education, and community service projects, even as they earn additional income."

The Office of Economic Opportunity through its Community Action Agencies actively sponsors manpower programs of the type mentioned by the President, in conjunction with the Department of Labor, through OEO Title I delegated funds. In 1971, approximately 110 Community Action Agencies reported that they operate the following manpower programs at the local level:

Program:	*Number of CAA's*
1. Green Thumb	26
2. Green Light	13
3. Senior Aides	42
4. Other	28

CAA PROGRAM SERVICES FOR ELDERLY POOR 55 AND OVER

Of all Community Action Agencies surveyed, only 11% reported that they conduct no specific, identifiable services or programs for the elderly poor. In addition to the 228 Community Action Agencies that reported operating SOS programs, *453 other CAAs reported special Senior Citizens programs.*

On a percentage basis, Community Action Agencies reported that 13.7% of

*Dr. Glen Burch, Director of the University of California Extension Service, Davis, Calif., in 1970 summarized the potential impact of SOS programs as follows:

> "The OEO's Senior Opportunities and Services Program potentially constitutes the most powerful force now operating in our culture to bring about a needed restructuring of the educational and social services, both professional and volunteer, at the community level. Through innovative programing, enlistment of new personnel and involvement of the old people themselves in planning and carrying out programs, we can look forward to a greatly enlarged and improved approach to community planning for the aging."

their general program funds,*exclusive of SOS programs*, benefit the elderly poor aged 55 and over. Urban CAAs reported 11.6%; rural CAAs, 17.7%. In individual OEO program categories, CAA services to the elderly poor ranged from 25.4% for Emergency Food and Medical Services to 5.2% for general recreation programs.

Program title:	*Serving age 55 and above (Percent)*
1. Legal services	12.7
2. Comprehensive health	14.4
3. Emergency food and medical services	25.4
4. CAA administration	8.1
5. Neighborhood service systems	14.6
6. Employment programs	12.0
7. OICs	15.8
8. Adult education	9.7
9. Housing services	18.1
10. Housing development corporations	15.3
11. Community health	18.7
12. Consumer action	18.1
13. Cooperatives	13.5
14. Recreation	5.2
15. General social services	11.7
16. Other	14.8
Percent average of total	13.7
CAA Urban funds	11.6
CAA Rural funds	17.7

OEO Special Emphasis Programs for Elderly Poor, Offices of Legal Services & Health Affairs, 1971

OFFICE OF LEGAL SERVICES

The National Council of Senior Citizens has served as a grantee of the Office of Economic Opportunity since 1968. The current NCSC grant for $548,424 is a terminal grant scheduled to end on April 30, 1972. The objectives of the grant have been as follows:

1. To study the special legal and para-legal problems faced by elderly low-income citizens.
2. To examine the under-utilization of the OEO Office of Legal Services by the elderly poor.
3. To identify the body of law and administrative practices which adversely affect the lives of the elderly poor.
4. To change, or ameliorate, the effect of such laws and administrative practices.
5. To incorporate effective techniques designed by the grantee (Legal Research and Services for the Elderly—LRSE) into operating projects of the OEO Office of Legal Services.

As a demonstration or special emphasis project, LRSE is now in its final phase. The Office of Economic Opportunity will take the necessary steps (1) to integrate appropriate results of the experiment into the OEO Legal Services and Community Action Agency programs, and (2) to assure that the legal problems of the elderly poor receive the attention they warrant.

OFFICE OF HEALTH AFFAIRS

The OEO Office of Health Affairs administers five programs affecting the poor multi-generationally:

1. Comprehensive Health Services
2. Emergency Food Assistance
3. Family Planning
4. Alcoholism
5. Drug Addiction and Mental Health

Of these five special emphasis programs, Comprehensive Health Services and Emergency Food Assistance, in particular, reach and serve the elderly poor, although the main thrust of the Office of Health Affairs is to address health

issues as they relate to poverty in terms of service to an entire community. The goal is integrated, comprehensive, family-oriented services. Accordingly, a more categorical approach of defining a specific group within a total community has been avoided, in general.

The Office of Health Affairs estimates that in 1971 approximately 48,000 persons over the age of 55 were enrolled in Comprehensive Health Services programs, and approximately 65,000 persons in the same age category received Emergency Food Assistance. In urban areas, the elderly poor represented 15% of all registrants for Comprehensive Health Services; in rural areas, 20%. Approximately 25% of the beneficiaries of Emergency Food Assistance have been the elderly poor during the past year.

OEO R. & D. Programs Conducted for Elderly Poor, Office of Program Development 1971

The OEO Office of Program Development continues to plan its research and demonstration projects in order that the knowledge and experience gained can be applied not only to the OEO Community Action Agencies and to other Federal agencies and departments, but also to public, private, and volunteer organizations which, increasingly, are concerned with problems of the elderly poor. Among OEO R&D projects designed to benefit the elderly poor as well as other segments of the poverty population and continued during 1971 were the following:*

1. Rural Housing Repair projects for sub-standard homes for the elderly poor in four counties of eastern Kentucky.
2. Community Design projects involving the services of architects, city planners, and volunteers in low-income communities of Massachusetts, New York, and California.
3. Rural Community Development projects in nine States designed to help overcome the problems of service delivery systems in sparsely populated rural areas.
4. Consumer R&D projects in several urban, metropolitan areas.

Rural Housing Repair Projects

This program has been in existence since 1969. It is administered by the Eastern Kentucky Housing Development Corporation, a delegate agency of the Community Action Council in eastern Kentucky's Leslie, Knott, Letcher, and Perry Counties. The program trains the elderly poor as construction workers to repair homes owned by other elderly poor, including disabled and blind recipients of public assistance.

Approximately 2,000 homes have been repaired since the program was first started three years ago. Approximately 1,000 elderly poor have participated in the program, most of whom were 65 years of age or older. In 1971, the Office of Economic Opportunity provided the grantee with $489,000. The program also receives financial assistance from other Federal agencies as well as from State organizations.

COMMUNITY DESIGN PROJECTS

No new research and demonstration community design projects were undertaken during 1971. However, three earlier R&D programs of this type were continued in 1971: (1) Urban Planning Aid, Sommerville, Massachusetts; (2) Architects Renewal Committee, Harlem, New York (ARCH); and (3) Community Design Center, San Francisco, California.

The Urban Planning Aid project, first undertaken in 1969, tests the efficacy of providing the services of architects, planners, and volunteers to community organizations in order to assist the poor, including the elderly poor, in urban community planning. The housing needs of the elderly poor have been among the priorities charged to the grantee.

In 1971, the Urban Planning Aid grantee received $263,390 in OEO funds. In June, 1971, administration of the grant was transferred to the OEO Regional Office in Boston, in accordance with provisions of the FAR Program to decentralize government operations.

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*Project late start formerly conducted for OEO by NRTA/AARP was evaluated in 1971 by a Washington, D.C., firm.

The Architects Renewal Committee, Harlem (ARCH) project, first undertaken in 1967, has been held responsible to OEO for developing mechanisms to provide free architectural and planning services to the poor, including the elderly poor. Architects and planners assist the poor in expressing their needs and interests in housing, urban renewal, Model Cities, and other such programs.

In 1971, the grantee received $239,415 in OEO funds. In November, 1971, administration of the grant was transferred to the OEO Regional Office in New York, in accordance with provisions of the FAR Program.

The Community Design Center, San Francisco, project first undertaken in 1969, is responsible to OEO for conducting training programs among target poverty groups to develop indigenous skills in community development and city planning. The grantee utilizes students and volunteers to help meet community needs for specialized architectural and planning services. In 1971, the grantee worked to rehabilitate a neglected hotel in San Francisco, which is now used as a home for aged Orientals.

In 1971, the grantee received $204,826 in OEO funds. Administration of the grant has since been transferred to the OEO Regional Office in San Francisco, in accordance with provisions of the FAR Program.

RURAL COMMUNITY DEVELOPMENT PROJECTS

Nine OEO State-rural projects have been attempting to overcome complex problems of bringing improved services and new delivery systems to the rural poor in sparsely populated rural areas. The projects have been underway since 1969. Although not designed specifically for the elderly poor, they reach substantial numbers of the elderly poor age 55 and older. Statistics on low-income families in rural areas indicate that one out of every four heads of households is 65 years of age or older.

The projects are located in Massachusettes, Vermont, Maine, West Virginia, Maryland, Ohio, South Carolina, Arizona, and Colorado. Experimental programs have been conducted in leadership training, saturation use of outreach centers, development of small business enterprises, self-supporting transportation systems, and a communications system to increase awareness of opportunities and services available to the rural poor.

An estimated $0.3 million of OEO funds in 1971 was directed to these nine State-rural projects, in terms of effect on the elderly poor.

CONSUMER RESEARCH AND DEMONSTRATION PROJECTS

Among the major grantees responsible to OEO for consumer education programs affecting the elderly poor are:

1. Newark, New Jersey, Housing Complex and Consumer Affairs Project.
2. Newark, New Jersey, Personal Loan Program.
3. Freedom House Enterprise, Pittsburg, Pennsylvania.
4. Metropolitan Cooperation Service, Cleveland, Ohio.
5. Consumer Action Program, Bedford-Stuyvesant, New York.
6. Neighborhood Consumer Information Center (NCIC), Washington, D.C.
7. A small number (5) of credit units supported by R&D funds.

In 1971, an estimated $0.3 million in OEO funds was directed toward the elderly poor in these consumer research and demonstration projects.

PROJECT LATE START

The now concluded Project Late Start was independently evaluated in 1971 for the Office of Economic Opportunity by a Washington, D.C., Contractor, BLK Group, Incorporated. The project was initially a research and demonstration effort conducted for OEO by the National Retired Teachers Association (NRTA) and the American Association of Retired Persons (AARP). The project brought together target groups of the elderly poor in four cities for ten weeks of concentrated group-educational experience. The objectives of the project were: (1) to familiarize the target groups with available services and programs for the elderly poor; (2) to motivate the groups to use the services and programs; (3) to increase the community involvement and personal activities level of the groups; and (4) during the course of the training sessions, to provide hot meals, medical and health care, and small stipends as a means of improving the emotional and physical health of the participants.

The experimental emphasis of the project was on the use of a "concerted group experience" as a technique in ameliorating some of the problems of the elderly poor. The results of the evaluation of the project by BLK, Incorporated, indicated that Project Late Start had succeeded in meeting initial goals in education and information; medical and health services; nutritional supplements; stipends; involvement and socialization; and development of latent skills. The contractor concluded that the greatest changes in the lives of the participants, in terms of "before and after" the program, occurred in improved knowledge about social services available to the elderly, in increased friendships, and in increased social activities. In addition, it was found that Project Late Start had succeeded in attracting the attention of others in the communities where the intensive training sessions had been conducted for ten weeks. The communities involved made in-kind contributions to the participants.

OEO Cooperative Efforts With Other Federal Agencies in Programs For Elderly Poor, 1971

In 1971, the Director of the Office of Economic Opportunity and supporting staff participated in the activities of the Domestic Council Task Force on the Aging. In addition, OEO staff participation in many of the secretariats for sections of the 1971 White House Conference on the Aging afforded a strengthening of cooperative relationships with other Federal departments and agencies. Working relationships with the Administration on Aging also increased in 1971, both at the AoA Headquarters and Regional levels.

NUTRITION—SOCIAL SERVICES FOR THE ELDERLY

In June, 1971, the Office of Economic Opportunity and the Department of Health, Education, and Welfare entered into an Agreement to conduct a joint research and demonstration program to test delivery of coordinated social services to the elderly, with nutrition as the core service. The Office of Economic Opportunity agreed to provide $2.0 million for the project; HEW (Social and Rehabilitation Service), $400,000.

The project originated with testimony by the U.S. Commissioner on Aging, John B. Martin, before the House Committee on Education and Labor on September 24, 1970. At that time, Commissioner Martin stated:

"We need to test the operations of a social service network which includes nutrition service among the services which it delivers to older persons."

The Office of Economic Opportunity provides program and policy guidance to the project. OEO will also develop and undertake an evaluation of the project, in conjunction with the Social and Rehabilitation Service (SRS) of the Department of Health, Education, and Welfare. SRS, in turn, will be responsible for all administrative support, grants, and contracts. The program will be conducted throughout 1972 in Chicago, Illinois, and in three counties of Florida.

PROGRAM OBJECTIVES

The program objectives are twofold:

1. To provide demonstrations of meals and nutrition education programs for persons aged 60 and older, as integrated components of existing or developing systems of comprehensive social services.
2. To develop a "how to do it" handbook containing data and guidelines on standard costs for use by States and service areas within States, so that others may be able to initiate, organize, develop, and operate such programs.

CHICAGO PROJECT

The Chicago project is coordinated by the Division for Senior Citizens of the Chicago Department of Human Resources, which for the past three years has been operating the largest meals program funded by the Administration on Aging.

The Division for Senior Citizens will establish four to six core sites, at which comprehensive services will be made available to the elderly, including special transportation services. Emphasis is being placed upon the elderly poor. The Division will work with numerous Federal, State and local institutions.

FLORIDA PROJECT

The Florida project is coordinated by the Division of Family Services of the Florida Department of Health and Rehabilitation Services, which is a State agency responsible for operating the older Americans Act Title III Program and public assistance services programs.

The three counties are located in the southern part of the State: Palm Beach County, Pinellas County, and Dade County (Miami). The Florida project will emphasize strengthening or expanding existing resources rather than development of new resources. Among the services to be provided are: (1) transportation, (2) nutrition, (3) housing assistance, (4) day care, (5) homemaker, (6) health care, (7) health education, (8) legal services, and (9) services related to social isolation.

A strong research evaluation component has been built into both the Chicago and Florida projects.

OEO-HEW-AOA PROJECT

In addition to the Nutrition-Social Services Project, the Office of Economic Opportunity is also participating in a multi-agency effort in Wisconsin to develop a State-wide model for an information and referral system for the elderly poor. No OEO funds are involved.

OEO Support Contract With National Council of Aging, 1971

Since 1965, the Office of Economic Opportunity has entered into a series of annual contracts with the National Council on Aging. In 1971, the OEO contract with NCOA was renewed for $902,000.

In its contracts, the Office of Economic Opportunity stipulates that the contractor will provide training and technical assistance to Community Action Agencies, State Economic Opportunity Offices, OEO Regional Offices and OEO Headquarters on matters pertaining to the elderly.

In 1971, the contractor provided training and technical assistance to 200 Community Action Agencies. In addition, training programs were conducted for Indian organizations and other minority groups. For the 1971 western Indian Conference held in Phoenix, Arizona, the contractor provided the leadership training.

In connection with the White House Conference on the Aging, the contractor sponsored a series of "Regional Institutes" during 1971 to emphasize the problems, priorities, and needs of the elderly poor. Resolutions formulated by Indian participants in the contractor's Northwestern Regional Institute were instrumental in increasing the number of Indian representatives to the White House Conference on the Aging. The contractor also worked to increase Mexican-American participation in the White House Conference.

OEO Participation in White House Conference on Aging, 1971

Mr. Phillip V. Sanchez, Director of the Office of Economic Opportunity, encouraged active participation of the Agency in all phases of the White House Conference on the Aging by issuing directives to all OEO Regional Offices, State Economic Opportunity Offices, and the OEO Headquarters. In turn, approximately 1,000 Community Action Agencies were urged to participate in various planning programs at the State level related to the White House Conference.

OEO Headquarters staff served on the various secretariats of the White House Conference and were actively involved in planning several of the "Special Concerns" Sessions. In addition, all members of the OEO Older Persons Advisory Committee served as delegates to the Conference. The Committee prepared a "Manifesto for the Elderly Poor" distributed to Conference Delegates, which formed the basis of several recommendations to emerge from the Conference.

The OEO Older Persons Advisory Committee directed most of its efforts in 1971 to the White House Conference on the Aging. The Committee Chairman, Mr. Tony Kubek, wrote all governors to urge the appointment of the elderly poor to State Delegations to the Conference. A majority of the governors responded and indicated their intent to cooperate with the Advisory Committee.

Current members of the OEO Older Persons Advisory Committee are:

Tony Kubek, Wausau, Wisconsin, Chairman
Robert Blue, Eagle Grove, Iowa, Co-Chairman
Albert Abrams, Albany, New York

Cruz Alvarez, Mesilla, New Mexico
Chester Blubaugh, Lebanon, Indiana
Orin Crump, Sandy, Utah
Mrs. Mary Louise Johns, San Antonio, Texas
Dr. Donald Kent, University Park, Pennsylvania
Dr. Juanita Kreps, Durham, North Carolina
Mrs. Angela Little Beaver, Winnebago, Nebraska
Mother Bernadette de Lourdes, Trumbull, Connecticut
Mrs. Robert Morris, Denver, Colorado
Mrs. Ida May Petty, Baltimore, Maryland
John Pioda, Atlanta, Georgia
Mrs. Mary Powell, Akron, Ohio
Miss Ollie Randall, New York, New York
Bernard van Rensselaer, Washington, D.C.
Reverend Richard Waggy, Brighton, Colorado
Mrs. Minnie Wooden, Washington, D.C.
Mrs. Sally Wren, Edmonds, Washington

ITEM 14. OFFICE OF EDUCATION

DEPARTMENT OF EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., February 25, 1972.

DEAR MR. CHAIRMAN: Please accept my apology for the delay in responding to your letter of December 10 requesting reports on our activities in 1971 affecting the aging to be included in the report "Developments in Aging—1971."

I am enclosing statements of such activities under the following Office of Education programs:

Adult Education
Community Services and Continuing Education
Manpower Development and Training
Public Library Services

If I can be of further assistance, please let me know.

Sincerely,

S. P. MARLAND, Jr.
U.S. Commissioner of Education.

[Enclosures.]

ADULT EDUCATION

The adult education program authorized under the Adult Education Act of 1966, as amended, provides undereducated adults (persons 16 years of age and older) an opportunity to continue their education to at least the level of completion of secondary school and makes available the means to secure training that will enable them to become more employable, productive and responsible citizens.

The program is primarily a State Grant operation administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. States are allowed grants to pay the Federal share of the cost of establishing or expanding adult basic education programs and adult education programs in local educational agencies and private nonprofit agencies. The matching requirement for the State Grant program is 90 percent Federal funds and 10 percent State and/or local funds.

The Fiscal Year 1970 reports of age distribution in State Grant adult education activities indicate the approximate extent to which persons over 45 years of age participate in the program:

	Fiscal year—	
	1970 number of enrollees	1971 estimated enrollees
Age:		
45 to 54	70,940	78,780
55 to 64	35,275	42,420
65 and over	15,435	18,180

JULY 1971.

FACT SHEET—THE OE PROGRAM OF ADULT EDUCATION

LEGISLATION

Public Law 89–750, Title III.—The Adult Education Act of 1966, as amended, was further amended by Public Law 91–230, Title III. Cited in the law as the "Adult Education Act," this Act authorizes appropriations of Federal Funds for the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands. It also provides for discretionary grants to institutions of higher education, State or local educational agencies or other appropriate public or private agencies, or organizations.

Purpose.—The purpose of the Act is to establish and expand programs of Adult public education so that adults can continue their education through completion of secondary school and secure job training to help them become more employable, productive and responsible citizens.

FUNDING

Congress determines the appropriations annually, based on authorizations in the Act. Each State, in order to receive its allocation, must submit and obtain approval of a plan describing its present and future adult education needs and projected programs. Not less than 10 percent nor more than 20 percent of the total appropriation is reserved for special projects and teacher training projects; 2 percent of the remainder is reserved for outlying territories; a $150,000 basic grant goes to each State and the District of Columbia, and the remainder is allotted to the States on the basis of a statutory formula which takes into account the number of adults who do not have a certificate of graduation from a secondary school, or the equivalent, and who are not currently required to be enrolled in school. The matching requirement for the State grant program is 10% non-Federal and 90% Federal except for the Trust Territory of the Pacific Islands which is 100% Federal. Special projects also have a matching requirement of 10% of the cost of the project. There is no matching requirement for teacher training projects. Total appropriations for FY 1972: $61,300,000.

BASIC GRANTS

Grants are made to States to pay the Federal share of the cost of establishing or expanding adult education programs in local educational agencies and private nonprofit agencies. Federal appropriations for State grants totaled $51,134,000 in FY 1972.

SPECIAL ADULT EDUCATION PROGRAMS

FEDERAL APPROPRIATIONS AVAILABLE: FISCAL YEAR 1972

Special Project Grants: $7,000,000

Grants are made to local education agencies or other public or private nonprofit agencies, including ETV stations, for special projects which promote comprehensive or coordinated approaches to the problems of adults who have not achieved a high-school diploma or its equivalent.

Teacher Training Grants: $300,000

Grants are made to institutions of higher education, State or local educational agencies, or other public or private agencies or organizations to support training programs for adult education personnel and for persons preparing to work in adult education.

Year	Federal funds	Total expenditures (Federal, State and local funds)	State grant program	Special projects	Teacher training
Expenditures, State grants:					
1968	$29,461,428	$38,872,531			
1969	34,608,285	46,368,111			
1970[1]	38,063,155	50,523,983			
1971[1]	44,866,102	(2)			
Obligations, special projects:					
1968	6,550,000				
1969	6,999,707				
1970	7,899,838				
1971	6,639,003				
Obligations, teacher training:					
1968	1,500,000				
1969	2,000,000				
1970	1,980,637				
1971	3,360,016				
Enrollments:					
1968			455,730	39,300	2,075
1969			484,626	42,000	3,200
1970			535,613	48,000	1,727
1971			[1] 606,000	41,000	[1] 2,800

[1] Estimate figures subject to change pending acceptance of final reports.
[2] Not available.

Advisory Council

The Act requires the establishment of a National Advisory Council on Adult Education. The Council, consisting of 15 members appointed by the President, advises the Commissioner of Education, reviews the administration and effectiveness of the adult education programs, and reports annually to the President on its findings and recommendations. In FY 1972 $166,000 of the total appropriations was reserved for the Council.

For Further Information

Contact the Public Information Office, Bureau of Adult, Vocational, and Technical Education, U.S. Office of Education, Washington, D.C. 20202, or your nearest Department of Health, Education, and Welfare, Regional Office, Attention: Director of Adult, Vocational, and Technical Education.

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 1971 a total of 21,870 persons participated in 17 programs developed for older Americans in 15 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—

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;

Training programs for volunteers who counsel the aging and who supervise leisure time programs for the elderly in nursing homes and home for the elderly;

Job counseling, retirement, counseling, educational programs and discussion groups 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; Teaching older people the use of Medicare/Medicaid; and Compiling a directory of services to the elderly.

FACT SHEET: COMMUNITY SERVICE AND CONTINUING EDUCATION

LEGISLATION

Public Law 89-329, 79 Stat. 1219 Title I.—The Higher Education Act of 1965, as amended. This act authorized appropriations of Federal funds for the 50 States, the District of Columbia, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Virgin Islands.

MISSION

Development of a comprehensive, coordinated, and statewide system of community service programs designed to assist in the solution of community problems in rural, urban, or suburban areas with particular emphasis on urban and suburban problems, such as housing, poverty, Government recreation, employment, youth opportunities, transportation, health, and land use, by utilizing the resources of institutions of higher education.

OBJECTIVES

To apply the resources of institutions of higher education, both public and private, to the solution of community problems by enlarging and extending university extension and continuing education programs. To bring such programs within the economic and geographical reach of more persons, whether government employees or volunteers, professional or sub-professional, who are in a position to improve their communities.

FUNDING

Congress determines the appropriations annually. Of the sums appropriated for each fiscal year, the Commissioner allots $25,000 each to Guam, American Samoa, Puerto Rico, and the Virgin Islands and $100,000 to each of the other States, and distributes to each State an amount which bears the same ratio to the remainder of such sums as the population of the State bears to the population of all States. Each State submits and obtains approval of a plan to provide new, expanded, or improved community service programs. The matching requirement for the State grant program is two-thirds Federal funds and one-third State or local funds. Total appropriations for fiscal year 1971: $9,500,000 with $100,000 reserved for the National Advisory Council.

PROGRAM OPERATIONS

Conducted by the Title I State Agency as designated or created by the governor of each State and approved by the U.S. Office of Education. The State Agency in turn approves and funds community service programs proposed by institutions of higher education in the States.

ELIGIBILITY

Programs sponsored by institutions of higher education shall be directed to meet the unique educational needs of the adult population who have either completed or interrupted their formal training. Instructional methods include, but are not limited to, formal classes, lectures, demonstrations, counseling and correspondence, radio, television and other innovative programs of instruction and study organized at a time and geographic location enabling individuals to participate. Participation is voluntary and open to adults included in those community problem areas identified by the annual program plan of each State.

Advisory Council

The act established a National Advisory Council on Extension and Continuing Education. The Council advises the Commissioner, reviews the administration and effectiveness of all federally supported continuing education programs for adults, and reports annually to the President on its findings and recommendations.

For Further Information

Contact Community Service and Continuing Education Branch, Division of University Programs, Bureau of Higher Education, U.S. Office of Education, Washington, D.C. 20202. Phone (202) 963–7827.

MANPOWER DEVELOPMENT AND TRAINING PROGRAM

(Public Law 87–415, as amended)

Although occupational programs for persons over 45 have been available since the inception of the Manpower Development and Training Act of 1962, the 1966 amendments recognized the special requirements of the older worker in areas of training and employment.

In Fiscal Year 1971, participation of older workers in the MDTA program continued at about the same level as in previous years, with persons 45 years of age and older representing slightly below 9 percent of the enrollment among the total enrolled. Cumulatively (Fiscal Years 1963–71), the participation is slightly higher, at 10 percent of the total enrollment. Following is the report of participation for both institutional and on-the-job training for Fiscal Year 1971:

	Total	Institutional	OJT
Enrolled	227,300	155,600	71,700
45 years or older	19,898	13,226	7,672
Percent 45 years or older	8.8	8.5	10.7

PUBLIC LIBRARY SERVICES

The Bureau of Libraries and Educational Technology continued its support and participation in the White House Conference on the Aging. A high priority was given to Conference support—as a result the first comprehensive examination of the kinds of level and funding of public and institutional library service was sponsored by the Cleveland Public Library through a grant of funds from the Bureau under Title II–B of the Higher Education Act. As a portion of this study, a special interim summary brochure was prepared and distributed to all participants at the White House Conference. A copy of this brochure is attached. Two staff members were assigned to the Conference. At the Conference, public library services to the older adult were a matter of concern and study for the education task force and for the conferees resulting in these recommendations:

"Public libraries serve to support the cultural, informational and recreational aspirations of all residents at many community levels. Since older adults are increasingly advocating and participating in lifetime education, we recommend that the public library, because of its nearby neighborhood character, be strengthened and used as a primary community learning resource.

Adequate and specific funding for this purpose must be forthcoming from all levels of government and most importantly from private philanthropy.

"We recommend further that the Library Services and Construction Act be amended to include an additional title to provide library services to older persons."

The following recommendation originating with the Education Section's interest in strengthening library services was incorporated as a recommendation generally applying to all educational programs for older adults:

"Where matching funds are required for Federal education programs aimed to assist older persons, it is recommended that life-long contributions toward building this country by the now elderly be considered as suitable compensation in lieu of 'matching funds'." [1]

[1] 1971 White House Conference on Aging: Special Concerns Sessions.

Services and Program Developments for Older Adults

Federal funds from all sources in direct support of library services to the aging since 1961 have approximated $2.36 million for programs specifically designed for the older adult. The Federal share represents 59 percent of funds used for these purposes. Funds from the Library Services and Construction Act totalled $1.1 million in this period; 47 percent of all Federal sources. Eighty institutions at the State and local level have since 1967 received assistance funds from LSCA for developing or strengthening specific programs for older adults. In summary (1961–1971), Federal sources have supplied 59 percent of the dollar assistance; State Government, 10 percent; local government, 24 percent and private donors, 7 percent.

One conclusion of the survey noted above (Cleveland Public Library) is that while public libraries provide the largest share of programmed library services to older adults, there is no close correlation between the geographic concentration of older adults and the number of providers of services for this group among the States. Too, 57 percent of libraries identified offer services to older adults with only 33 percent of the aging population.

In general, that kind of public library activity most in demand as a service for older adults is the extension (or outreach) program in which the library through mobile or visiting services meets the older adult. Public libraries are the major provider of library services in institutions such as hospitals, nursing homes, and other institutions. Characteristic services provided by institutions are book cart services to patient wards and besides, distribution of talking books and large print publications and group services such as discussion groups.

Institutional library service still requires substantial development but significant firm beginnings have resulted from the opportunity to assist institutional library services recently afforded by the Library Services and Construction Act. Average annual expenditures for library services at Veterans Administration domiciliaries are $23.47 per resident while State institutions expend $7.81. Special extension library services to older adults have been computed at an annual cost of $30 per patron. The annual average cost per patron for general services in 1970 was $18.50.

Although outlays for specific service programs have fallen far short of the pro rata share to be anticipated for older persons and have failed to approximate the increasing percentage of older adults in our population, outstanding examples of library services to older adults point the way to improvement:

The Milwaukee (Wisconsin) Public Library operates a bookmobile (The Over-60 Service) with five paid community aides all over 65 as part of the staff. It is estimated that the service is made available to access to 15 percent of older adults in Milwaukee. The program is supported by local public funds.

Hospital and Shut-In Service is provided by the Cleveland Public Library through its Judd Fund to every municipal domiciliary and custodial institution. In terms of comprehensiveness, the service is unique.

Needham (Massachusetts) performs a direct mail solicitation of every person over 62 years of age in a program initiated by Library Services and Construction Act funds focusing on information on library materials.

The Boston Public Library which has received a grant of $30,000 from LSCA conducts a "Never too Late" group which sponsors programs at the Central Library and at 14 neighborhood libraries. A similar program, the "Live Long and Like It Library Club" of the Cleveland Public Library recently celebrated its 25th anniversary with a formal dinner attended by local community, civic and political leaders.

A program of instruction for older adults, principally low-income black women, is a program of the Wake County Library (Raleigh, North Carolina). Topics treated are: religion, citizenship, health care and nutrition, social security program participation and legal processes.

Future Expansion

Despite the exemplary programs and the comprehensive services cited as available through general library activities, library officials accord a low priority to the development of library services specifically designed for older adults. In the Cleveland Public Library Survey, about two-thirds of the public libraries and State library agencies assign their lowest priority to the future program development for the older adult compared to other age groups. Funds for specifically

designed library services to the aging constitute less than 1 percent of the budgets of State library agencies and public libraries. Less than 1 percent of Federal funds available for support of public libraries is allocated to services to the older adult. Whatever may be an equitable allocation, this seems disproportionally small. The adopted recommendations of the Education Special Concerns Group of the White House Conference are testimony to an interest by older adults themselves to their concern for this educational opportunity.

ITEM 15. POST OFFICE DEPARTMENT

OFFICE OF THE EXECUTIVE ASSISTANT
TO THE POSTMASTER GENERAL,
Washington, D.C., January 20, 1972.

DEAR MR. CHAIRMAN: In response to your request of December 9, 1971, we are pleased to submit the following information for consideration in preparing your report, "Developments in Aging—1971", in the belief that it may be of interest and aid to elderly consumers.

The Assistant Postmaster General—Inspection Service informs us that the oldest consumer protection law is enforced by his Department: section 1341, title 18, United States Code, otherwise known as the mail fraud statute. Enacted by the Congress in 1872, it provides a fine of $1,000 or 5 years' imprisonment, or both, for use of the mails in furtherance of a scheme to obtain money or property through fraudulent representations.

In collaboration with the Postal Service Law Department, the Inspection Service also utilizes two administrative and civil remedies: sections 3005 and 3007, title 39, United States Code. The first, known as the false representation statute, enables the Postal Service to cause the return to senders of mail addressed to any person who is engaged in a scheme for obtaining money or property through the mail by means of false representations, or is conducting a lottery. The second authorizes any District Judge to issue, upon showing of probable cause by the Postal Service, an order to detain mail incoming to a defendant (in a section 3005 case) pending conclusion of the statutory proceedings.

The mail is an indispensable artery of national commerce and communication. Fraudulent use of it harms honest merchants as well as consumers. Losses due to fraud are destructive of the public confidence and ultimately are borne by society as a whole—not just those who make purchases by mail. Offenses such as mail fraud, perpetrated without violence, are broadly characterized as "white collar crime". In practical terms, this has come to mean that the courts seldom impose penalties upon those convicted which are as severe as punishment for other crimes involving similar sums of money. This overlooks the fact that fraud is always premeditated and takes its victims totally unaware.

During fiscal year 1971 the Inspection Service processed 135,648 mail fraud complaints; 1,513 arrests were made. The 1,113 convictions represented a gain of 22%—the fourth successive year in which new records were set. A total of 5,626 questionable promotions were caused to be discontinued, and financial recoveries by fines and restitution amounted to $2,758,709.

Schemes promoted through the mails vary from crude operations, aimed at garnering as many dollars as possible from victims in a very short time, to extremely complex ones in which the true intent of the promoters may be clearly demonstrated only after lengthy investigations. In some schemes, the elderly are incidental victims; others are aimed primarily at them. Several types of mail fraud are described below.

Investments.—Frauds involving sale of stock, bonds, oil and gas leases and shares in savings and loan associations, and similar schemes comprise this group of investigations. In the past year, 108 cases were completed, with 70 convictions. Sentences imposed upon these offenders totaled 308 years, and fines amounted to $81,950. Illustrative of the special hazards to aging people is the case of John A. Pletcher, Peoria, Illinois. He devised a scheme to sell shares in a company titled Aulines, Inc., with an announced minimum fund of $177,000 to be raised, for use in providing dental care insurance. The money gathered was to be placed in an escrow account, and refunded if the goal were not reached. Thirty-four elderly investors turned over $140,000 to Pletcher, who failed to establish the insurance company or make refunds, and converted the money to his personal use. Follow-

ing indictment on eleven counts of mail fraud, Pletcher pleaded guilty to six counts; and he also entered a plea of guilty to two counts of an eight count income tax evasion indictment. On July 14, 1971, he was sentenced to serve 90 days in jail and placed on probation for three years. There was no fine, and no restitution was ordered or made.

Medical Frauds.—Wide varieties of medicines, reducing aids and orthopedic or surgical devices are advertised in the mails by means of false representations, often with special promises of benefit to those suffering debilities attributable to advanced age. Distribution of the advertising in some promotions indicates a preference for retired persons as prospective victims. Many such schemes have been thwarted by application of section 3005. Recently a compromise agreement was obtained halting promotion of "European Love Drops", which were claimed to restore sexual vigor in anyone who would drink a few drops in a cup of tea or coffee. The advertising suggested that age was no barrier to effectiveness of this product. Investigations brought about the discontinuance of 133 promotions in this general category in fiscal year 1971.

Faith Healer Solicitations.—The deep religious convictions held by many Americans deserve respect; unfortunately, however, swindlers have found ways to use those beliefs against their victims. Elderly persons in failing health are particularly susceptible to several types of alleged miraculous cures. Inspectors completed investigations of thirteen such promotions in the past fiscal year, of which eight were discontinued. Two convictions of mail fraud were obtained, resulting in a total of six years' imprisonment and $2,000 in fines. Investigations of these cases and the ones relating to worthless medicines help to prevent the raising of false hopes in the afflicted, and may aid in persuading them to seek competent medical advice.

Accident Claim Frauds.—The investigation of fraudulent automobile accident claims at Chicago, which was cited in our letter to you of January 8, 1971, is continuing on an expanded scale. Recently, indictments were returned against three attorneys and two doctors for mail fraud, and five policemen for perjury during testimony before an investigating Grand Jury. A doctor testifying for the government stated he had to keep his legitimate treatment records entirely separate from his reports in accident cases, the concocting of which was "just like writing fiction". A similar investigation is in its final stages in Louisiana, and a new one is underway in Florida. Payment of unjustified claims generated by these "rings" results in increased auto insurance premiums, a special hardship upon elderly persons trying to meet big city living costs on small annuities.

Business Opportunities.—Four separate, but related promotions fall within this category: distributorship, franchise, vending machine, and "other" job opportunity frauds, together constituting one of the most important areas in the fraud investigative program. Elderly and retired persons head the list of individuals who are preyed upon each year with promises of high returns for their investments, and guarantees of success which later prove worthless.

In one case of this type investigated by Postal Inspectors during 1971, Joe R. Perryman, who did business as Stuckey's Distributing Company in Dallas, Texas sold candy and nut vending machines to individuals at inflated prices and placed the machines in poor locations. The victims, who were assured that they would be established in a profitable business, were not given the assistance they were promised, and all requests for refunds were ignored by the operator. Perryman was arrested by Postal Inspectors, subsequently sentenced to 18 months probation and fined $1,000.

Magazine Subscription Frauds.—Probably no other type of scheme affects so many individuals, including the elderly, as that involving the deceit and misrepresentation practiced in the sale of magazine subscriptions. Many salesmen have tricked persons into signing contracts for magazines they did not want, and did not believe they had ordered.

In a recently concluded case of this type, five subsidiaries of Cowles Communications, Inc., in Des Moines, Iowa, entered pleas of no defense to ten counts of a mail fraud information. They paid a $50,000 fine and agreed to a permanent court injunction barring them from continuing the fraudulent practices.

In a concerted effort to further reduce such deceptive tactics, the Inspection Service has undertaken general investigation into operations of numerous magazine subscription agencies across the nation. This has already resulted in three criminal fraud indictments against similar enterprises.

Work-at-Home Schemes.—The Postal Inspection Service continues to receive complaints from housewives, shut-ins, retired persons and elderly widows, as well as others who can ill afford to lose even small investments, but have responded to advertisements on earning money by doing part-time work at home. The majority of these ventures claim that, by sewing baby shoes for re-sale to the promoter, clipping news items, addressing and stuffing envelopes, etc., home-workers can earn substantial profits. Our experience indicates little, if any, income can be derived from these operations. The one common denominator in all questionable work-at-home promotions is the requirement that the prospect buy something from the advertiser, whose primary interest is the sale of goods, literature, instructions, or services to the victim.

Chain Referral Schemes.—The elderly homeowner is particularly susceptible to a widespread scheme being promoted throughout the country known as "chain referral" selling. Almost without exception, promoters of these schemes grossly inflate the actual selling price of their particular product—which may be a sewing machine, television set, or central vacuum cleaning system. The promoter convinces the victim that the item will cost nothing, since commissions from sales to his referrals will more than pay for it. In a typical case, the population is soon exploited; later investors are unable to convince others to participate; and victims soon are being billed for the over-priced materials. In an effort to suppress this type of deception, extensive cooperation is given other agencies, including State and local authorities. Many State legislatures have declared chain referral violative of State Laws and others are giving the matter attention.

Public Education and Fraud Prevention Programs.—A new edition of the booklet, "Mail Fraud Laws—Protecting Consumers, Investors, Businessmen, Patients and Students", was published in fiscal year 1971 and it contains descriptions of nearly 40 types of schemes which are promoted through the mails. A large number of the new booklets already have been distributed, and adequate stocks are available to meet requests. More than 1,000 speaking appearances were made by Postal Inspectors before Law Enforcement, civic, educational and consumer groups. Close liaison is maintained by Inspectors with officers of other consumer protection agencies at all levels of government. In the field, this is enhanced by participation with numerous other organizations in the regional consumer protection coordinating committees sponsored by the Federal Trade Commission. Such exchanges insure that the Inspection Service, while giving its attention to frauds promoted by mail, will be in a position to refer other matters to proper agencies for investigation.

I hope that you and your committee will find this summary helpful. Please advise me if you find that the Postal Service can be of further assistance.

With kind regards,

Sincerely,

JOHN W. POWELL,
Congressional Liaison Officer.

ITEM 16. SOCIAL AND REHABILITATION SERVICE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
March 22, 1972.

DEAR MR. CHAIRMAN: In response to your letter of December 10, 1971, I am sending you the enclosed reports regarding developments on aging within the agencies of the Social and Rehabilitation Service during 1971.

This enclosure does not include a section on the Administration on Aging since it is my understanding that this has already been sent.

I hope that this information will be helpful.

Sincerely yours,

JOHN D. TWINAME, *Administrator.*

[Enclosure]

SOCIAL AND REHABILITATION SERVICE ACTIVITIES AFFECTING THE ELDERLY DURING 1971

As shown by this report, the Administration on Aging is not the only component of the Social and Rehabilitation Service which carries on activities

affecting older Americans. The old-age assistance program is one of the most important income maintenance mechanisms our society has been able to develop for the economically disadvantaged elderly. The Medicaid program supplements Medicare in meeting the health care needs of this segment of our population. SRS research and demonstration projects provide needed information and understanding regarding the elderly, as well as on other age groups. Rehabilitation services are provided the aged and others. SRS's Community Services Administration brings together under unified direction the provision of social services to individuals and families, including the aged. These various aspects of the work of SRS are discussed in this report.

Old-Age Assistance

In June 1971 SRS's assistance payments administration served 2,057,000 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 alltime high of 2,810,000 old-age assistance recipients in September 1950. The overall decline has occurred because a larger proportion of the increasing aged population have become eligible for old-age, survivors, and disability insurance cash benefits, and because such benefits have been rising in amount. An additional factor contributing to the decline of persons receiving old-age assistance money payments is the development of the program for providing care in intermediate care facilities for a large number of aged persons. In most instances, these aged do not receive money payments. In June 1971, payments to intermediate care facilities was provided for 139,000 recipients of old-age assistance. The average payment was $284.25.

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 1971 was $75.65.

According to the latest study available the median age of old-age assistance recipients is approximately 77 years of age. 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.

As a means of encouraging dependent elderly people to attain either partial or full self-support, 39 States now provide for a disregard of some portion of earned income in determining the amount of assistance payments. Additionally, 31 States allow for some disregard of income which is incurred from sources other than earnings.

Medical Assistance (Medicaid)

In 1971, all Federal matching funds for vendor payments for the medical care of the indigent aged and other groups were paid through State Medicaid programs. Forty-eight States—all States except Alaska and Arizona—and the District of Columbia, Guam, Puerto Rico, and the Virgin Islands were participating in Medicaid. All of these provided Medcaid to those over 65 who were eligible for public assistance payments, but 27 States provided it in addition to other aged persons who do not receive welfare grants, but whose income falls below the "medically needy" level. States also exercised their options in regard to services covered—46 offering prescribed drugs, 33 making eyeglasses available, 31 financing physical therapy, 35 paying for prosthetic devices, and many selecting other optional services.

The basic Medicaid package remained the same for the aged: Inpatient and outpatient hospital services, physician services, laboratory and X-ray services, transportation to medical care, and skilled nursing home services. By regulation, the States were required to offer home health services to those who otherwise were eligible for nursing home services. Many States continued to offer the special options for older persons—35 provided hospitalization in institutions for mental diseases; and 28 provided hospitalization in institutions for tuberculosis.

During fiscal 1971, the latest period for which statistics are available, 3.6 million persons over 65 received Medicaid services, an increase of more than 12 percent over 1970. Nearly 40 percent of the $6.25 billion budget for fiscal year 1971 was spent on services for the aged. Expenditures for skilled nursing home service—one heavily used by the aged—were $1.67 billion.

MSA acted to further refine the Medicaid program through the issuance of proposed and final regulations and other policy material. Final regulations issued that are of significance to the aged covered medical review of skilled nursing homes. Proposed regulations were issued on composition of the licensure board for nursing home administrators and certification and recertification of hospital stays. Revisions of regulations were underway regarding home health services; differential physician reimbursement for multi-patient visits; reimbursement for skilled nursing home services; and utilization review.

During 1971 the Medical Services Administration gave increasing attention to upgrading the care offered in Medicaid-financed skilled nursing homes. A preliminary study of State efforts to certify (i.e., approve for participation) skilled nursing homes led to a more extensive study of State programs which found most States seriously deficient in skilled nursing home certification. In November 1971, Secretary Richardson set deadlines for State fulfillment of Federal certification requirements. By February 1972, all States must reform certification procedures; by July 1972, they must inspect all nursing homes to be sure they comply with Federal standards. These deadlines implement President Nixon's eight-point program announced in August 1971.

The President's program highlighted:

1. Federally-financed training of an additional 2,000 State nursing home inspectors under present programs;

2. Congressional authorization for 100 percent Federal funding of State inspections;

3. Coordination in HEW of long-term care and enforcement of Federal standards—by year's end Assistant Secretary Merlin DuVal had been given over-all responsibility and had appointed Dr. Marie Callendar as his chief staff assistant. MSA established a Division of Long-Term Care.

4. Strengthened Federal presence in standards enforcement programs—at years end appropriations neared final passage for 150 new Federal positions to enforce standards, with most going to SRS regional offices.

5. Institution by HEW of short-term inservice courses for nursing home staff members.

6. Federal help in establishing State nursing home ombudsman units; as an interim measure, local Social Security offices assumed this role.

In the immediate future MSA planned to move beyond enforcement of State certification standards. It will also monitor State application of Federal standards for (1) medical review of the care of skilled nursing home patients, (2) utilization review, (3) quality of staff in nursing homes, (4) sanitation and environmental standards, and (5) fire safety. Among other activities that affected the care of the aging were these: Federal regulations affecting skilled nursing homes under Medicaid were collected and published under the title "Compilation of Federal Requirements for Skilled Nursing Homes Facilities", and distributed to Federal officials, State enforcement agencies, and nursing homes. Detailed guidelines for nursing services, medical review, and composition of State licensure boards for nursing home administrators were prepared as well. Finally, in December, President Nixon signed H.R. 10604, which made care in intermediate care facilities an optional Medicaid service under title XIX and ended the requirement that these facilities be separate institutions or distinct parts of skilled nursing homes. An intermediate care facility is an institution offering health-related care and services to individuals who do not require the care and treatment which a hospital or skilled nursing home provides, but do require institutional care above the level of room and board. Care in I.C.F.'s was formerly authorized by section 1121 of the Social Security Act, providing for funding by the various cash assistance programs (titles I, X, XIV, and XVI of the act).

Community Services Administration

The Community Services Administration continues to assist States to implement the adult service regulations. By the end of the calendar year 1971 all States and other areas but one were providing services to older adults at either 50 percent or 75 percent FFP. Eighty percent of the States extend services to former recipients and elderly who are eligible for the services but not the money payment. The Division of Services to the Aged and Handicapped, CSA, took leadership in helping States to increase their service activities to older adults in the program.

The number of older adults receiving services at any one time, nationwide, under the service program increased 50 percent over the previous year, with an increase in spending levels advancing as follows:

	Expenditures for fiscal year 1971	Estimated expenditures for fiscal year 1972
Federal	$104,000,000	$176,212,000
State	34,600,000	58,688,000
Total	138,600,000	234,900,000

Fiscal year 1972 expenditures for the adult services program were increased approximately $18 million over the fiscal year 1971 figure. Fiscal year 1973 expenditures are expected to be higher than fiscal year 1972 expenditures since the participating number of States will be larger and all States should, with regional office assistance, be expanding coverage and adding depth to their service activities. The principal service patterns have been and continue to show this sequence: the most frequent are (1) health support services, (2) protective services, (3) services to remain in own home, (4) services relating to self-care and (5) assistance in returning to own home from an institution.

In order to develop appropriate assistance to States, reflecting their expressed need for program and guide materials helpful to staff providing services to the aged, the Division of Services to the Aged, CSA, has used the demonstration route, utilizing section 1115 funding as well as contract funding.

This calendar year, the results of a 3-year section 1115 project on protective services to older adults, initiated in 1967, were published. The report showed the scope and volume of services provided to older aged, blind and disabled individuals in a metropolitan and in a rural setting. An evaluation of the results achieved in improved functioning on the part of those receiving such services were a particular highlight of this report. This publication was distributed at the recent White House Conference on Aging and to States providing protective services to aged clients of public assistance.

A second publication, "Social Services Related to Medicaid" is in final clearance. It provides valid data in the need for and current provision of social services to aged clients of public assistance in selected counties in three States.

A third study on case practice with APTD clients is in final draft stage and will be published early in 1972. This study reviewed staff efforts in two States to help suitable recipients of APTD to prepare for employment roles.

The findings and recommendations of these three studies should help States to improve their efforts to develop and expand service units providing protection to neglected, exploited and isolated elderly persons with serious impairment; improve both the number and quality of health support services necessary for the proper utilization of Medicaid and strengthen State practice in preparing APTD clients for suitable employment.

Though 51 States now provide homemaker services for the elderly this resource is not yet meeting all the need. An 1115 project in seven rural Mississippi counties for the purpose of demonstrating the usefulness of homemaker services has just been successfully concluded. The State agency will now assume this work and expand it statewide as soon as possible.

The above are only a few illustrations of methods that have recently been used to encourage greater recognition of the myriad service needs of our elderly poor and near poor by welfare agencies; at the same time providing models they can use to meet these needs. Welfare agencies are increasingly aware of and using an administratively integrated areawide approach to human services programs. This is a sound direction.

Throughout the calendar year the Community Services Administration was involved, in various ways, in planning for the White House Conference on Aging. The Division of Services to the Aged and Handicapped served as the focal point for CSA involvement. The administration furnished Federal resource staff to assist on various technical committees and sections of the Conference. Particularly, the conference section on facilities, programs and services. Continuing involvement in post-conference activities of the White House Conference is also planned.

The Community Services Administration, as the Department's focal point on social services is deeply involved in continued planning related to H.R. 1. Title XVI is the Adult Service title of H.R. 1. The title provides social services to individuals who are receiving benefits under title XX (to be administered by the Social Security Administration) as well as to other needy aged, blind or disabled who are 65 years of age or older. States may elect to provide services outlined in section 1605 of H.R. 1, such as information and referral, homemaker services, nutrition and protective services, under title XVI if they wish to earn 75 percent Federal matching. It is expected, with the passage of H.R. 1 that the number of aged receiving benefits will double thus increasing the number of aged needing social services.

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 vocational rehabilitation program.

The Rehabilitation Services Administration endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include evaluation and medical diagnosis to determine the nature and extent of the disability and to ascertain capacity for work, counseling to help in developing a good vocational plan, medical care to reduce or remove the disability, vocational training and placement into employment, and follow-up to ensure satisfactory placement.

As the Federal partner in the State-Federal program of vocational rehabilitation, the Rehabilitation Services Administration encourages State rehabilitation agencies to provide necessary services to physically or mentally disabled, aging people so that they may be restored to gainful employment. The problems faced by the older worker in securing suitable employment are, of course, intensified when he suffers from a handicapping disability; and it is estimated that more than 4 million disabled individuals, 40 years of age and over, are in need of vocational rehabilitation services.

In an effort to alleviate this situation, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and an increase in the number of these individuals served has resulted. For example, in 1960 a total of 88,275 disabled people were rehabilitated by the State rehabilitation agencies and of these 25,674 were aged 45 or older. In 1971, a total of 291,272 disabled persons were rehabilitated of whom 77,600 were 45 years of age and over and of this figure 4,600 were 65 years of age and over.

State rehabilitation agencies have utilized expansion grants and basic support resources to expand their services to the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the homebound which serves a large number of older disabled people. Also, the Ohio rehabilitation agency has participated in a public housing project designed for the handicapped and senior citizens.

South Carolina makes a special effort to meet the needs of the aging handicapped by providing rehabilitation services as well as participating in an advisory capacity to a special agency set up to administer services provided under the Older Americans Act.

In the District of Columbia, a pilot project is being conducted with the Davis Memorial Goodwill Industries for the development of sheltered workshop facilities, a part-time employment service, and an evaluation training program to serve older disabled clients.

The Rehabilitation Services Administration also uses its training grant authority to assist in program development for the aging. Long-term training grants in such fields as rehabilitation counseling, nursing, physical therapy, speech pathology and audiology, occupational therapy, and home economics yield benefits to the aging. For example, training in home economics includes home health care for the aging, home services for the aging in rural areas, and the preparation of specially designed clothing for the chronically disabled. Short-term training grants have also been used effectively by RSA in developing services for the aging. This resource was used, for example, to conduct a course on orthopedics and gerontology in cooperation with American College of Orthopedic Surgeons.

The purpose of this was to introduce young surgeons to surgical techniques particularly effective with the older orthopedic case.

In September 1971, through a short-term training grant, the Rehabilitation Services Administration co-sponsored with the Federation and Guidance Service of New York City a conference to prepare recommendations on rehabilitation to be presented to the 1971 White House Conference on Aging.

The Rehabilitation Services Administration and the Federation Employment and Guidance Service were assigned the responsibility of organizing and conducting the session on physical and vocational rehabilitation at the White House Conference on Aging. Delegates voted unanimously to adopt the recommendations and these became official recommendations on rehabilitation at the Conference.

The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month and other special projects and will continue to do so.

Research and Demonstrations

The demonstration projects program in public assistance under section 1115 of the Social Security Act provided grants for at least 16 different projects during the calendar year 1971 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.

Two projects are providing housing assistance to the aged. 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 1,000 aged, blind, and disabled and 100 AFDC families 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. A model cities project in Georgia is demonstrating the coordination of various types of housing aids and resources made available to local communities through HEW and HUD programs to improve the housing of aged recipients.

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 previously never been available. The services include transportation to medical facilities, arranging for fuel oil to be provided and delivered, and homemaker help.

Two projects in consumer affairs are currently in operation. A project in Georgia is providing educational materials and help to the elderly as well as other low income families and individuals. A project in Michigan is operating a Consumer Information Center which provides consumer education, training information and referral services for the elderly, and low income residents in a model city area.

Two projects are demonstrating the coordinated and comprehensive delivery of social services to aged, blind, disabled, and AFDC recipients. In Florida one stop information and referral centers are coordinating existing community services and developing new services while a project in New Jersey is operating a decentralized community organization in a suburban rural area to improve the delivery of such services as protective services, home management, housing, consumer education, et cetera.

Three neighborhood service projects serving elderly recipients are conducting experiments to determine which services are most wanted and needed at the neighborhood level.

A model city project in Washington is operating a Home Management Service Center to provide such services as money management, housekeeping skills, and family management for aged and other public assistance recipients. Other States demonstrating the value of providing homemaker services are enthusiastic about the results which include helping the elderly remain in their home or return to their homes following hospitalization. In all instances, the States experimenting with the provision of homemaker services have adopted the project activity into their ongoing program upon termination of the demonstration.

An initial step to test the delivery to older people of coordinated social services with nutrition as a core service has been undertaken. This $2.4 million research and demonstration program is located in Chicago, Ill., and in three counties in Florida—Palm Beach, Dade, and Pineallas.

Federal funding for the coordinated program is also coordinated, coming from three agencies—the Office of Economic Opportunity, the Social and Rehabilitation Service under section 1115 of the Social Security Act, and the Administration on Aging under title IV of the Older Americans Act.

The major objective of this program is to develop and test techniques for providing a permanent planning and service structure through which public and private agencies will work cooperatively to meet the needs which the elderly themselves feel most essential. In addition, the projects will include the recommendations of the 1971 White House Conference on Aging in program planning and problem identification.

ITEM 17. SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Washington, D.C., January 24, 1972.

DEAR MR. CHAIRMAN: I am enclosing the statement on the developments in Social Security and Medicare during 1971 for your "Developments in Aging—1971." As you requested, it has been written in essentially the same form as the reports sent last year.

I hope this report meets your needs.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure]

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration administers the Federal retirement, survivors, disability, and health insurance programs (titles II, VII, XI, and XVIII of the Social Security Act, as amended) and the "black-lung benefit" provisions of the Federal Coal Mine Health and Safety Act of 1969. Social Security coverage is the Nation's basic method of assuring income to the worker and his family when he retires, becomes disabled, or dies, and of assuring hospital and medical benefits to persons 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 IN 1971

Amendments to the Social Security Act passed March 17, 1971, and retroactive to January 1, 1971, authorized a 10-percent increase in Social Security monthly cash benefits for all beneficiaries except "special age-72" beneficiaries, who are to receive a 5-percent increase in their payments. These amendments also raised the maximum amount of a worker's earnings that is counted toward benefits and subject to contributions from $7,800 to $9,000 beginning January 1, 1972.

Other amendments to the Social Security Act, passed December 28, 1971, broadened the provisions for the payment of a lump-sum death benefit in cases where the body is not available for burial and extended a provision of the 1969 amendments under which all persons who were receiving both public assistance and Social Security benefits before January 1970 would be guaranteed a net increase in income of at least $4 or (if less) the actual amount of the increase in their Social Security benefits for months after February 1970.

About 93.7 million people contributed to Social Security in calendar year 1971. 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 July 1, 1971, had a face value of about $1,270 billion.

About 26.7 million men, women, and children were receiving monthly Social Security benefits as fiscal year 1971 ended. The beneficiaries include about 16.8 million retired workers and dependents of retired workers, 2.8 million disabled workers and their dependents, and 6.6 million survivors of deceased workers. About 0.5 million noninsured persons 72 years of age 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-one percent of those who were 65 or over at the beginning of 1971 were receiving benefits or would be eligible to receive benefits when they or their spouses retire. Of those who reached 65 in 1971, 93 percent were eligible for Social Security cash benefits. Projections to the year 2000 indicate that 97 percent of all aged persons will then be eligible for cash benefits under the program.

What the Program Did in Fiscal Year 1971

Beneficiaries and benefit amounts

During the fiscal year ended June 30, 1971, benefits paid under the old-age, survivors, and disability insurance program totaled $34,482 million—an increase of $5,437 million over the amount paid in the preceding fiscal year. Total benefit payments to disabled workers and their dependents were $3,381 million, 18 percent higher than in fiscal year 1970. Old-age and survivors insurance monthly benefits also rose 18 percent to $31,101 million. Lump-sum death payments amounted to $298 million, about $10 million higher than in the previous fiscal year.

The number of monthly benefits in current-payment status increased by 1.0 million to 26.7 million during the fiscal year, and the monthly rate rose $411 million (16.1 percent) to $3.0 billion.

At the end of December 1970, the average old-age benefit being paid to a retired worker who had no dependents also receiving benefits was $131 a month. When the worker and his wife were both receiving benefits, the average family benefit was $199. For families composed of a disabled worker and a wife with one or more entitled children in their care, the average was $270; and for families consisting of a widowed mother and two children, the average benefit was $291. The average monthly benefit for widows and widowers was $102.

During the fiscal year, a period of disability was established for about 381,100 workers, 46,000 more than in fiscal year 1970. The number of persons determined to have been disabled since childhood totaled 25,400.

The number of disabled workers receiving monthly benefits rose 9 percent in the fiscal year and totaled 1,561,100 at the end of June. Benefits were being paid to about 1,227,000 wives, husbands, and children of these beneficiaries. By the end of June 1971, child's benefits were being paid at a monthly rate of $22.5 million to 277,200 disabled persons 18 and over—dependent sons or daughters of deceased, disabled, or retired insured workers—whose disabilities began before they reached 18. About 26,600 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 52,500 at the end of June 1971.

In July 1971 black-lung benefits were paid to about 129,762 beneficiaries. Their average monthly benefit was $188.60.

ITEM 18. SPECIAL ASSISTANT TO THE PRESIDENT FOR CONSUMER AFFAIRS

Executive Office of the President,
Office of Consumer Affairs,
Washington, D.C., January 28, 1972.

Dear Senator Church: I am enclosing a report on the activities benefiting the aging that were undertaken by the Office of Consumer Affairs during 1971.

My Office has a special concern for the older consumer. Accordingly, it is a pleasure to be of assistance to you and the Special Committee on Aging in the preparation of "Developments in Aging—1971."

Sincerely,

Virginia H. Knauer,
Special Assistant to the President for Consumer Affairs.

[Enclosure]

REPORT OF THE ACTIVITIES OF THE OFFICE OF CONSUMER AFFAIRS DURING 1971 RELATING TO THE AGING

New Office of Consumer Affairs

On February 24, 1971, the President, by Executive Order 11583, established the Office of Consumer Affairs, which replaces the former President's Committee on Consumer Interests. Mrs. Virginia H. Knauer was named Director of the new office; she continued also to serve as the Special Assistant to the President for Consumer Affairs. This change reflects the increasingly broad scope of responsibilities assigned to the Special Assistant. OCA advises the Chief Executive on matters of consumer interest and also assumes primary responsibility for coordinating all Federal activity in the consumer field. Older consumers, with their special needs and problems related to the modern marketplace, stand to be greatly benefited by the efforts of the new organization.

Presidential Consumer Message

On the same date, the President presented his second Consumer Message to Congress which contained legislative and other proposals designed to advance the interests of the Nation's consumers. In the Message the President expressed a special concern to see justice for those who, in a sense, need it most and are least able to get it. He accordingly directed Mrs. Knauer to focus particular attention in her new office on the coordination of consumer programs aimed at assisting the elderly and others with special problems as consumers.

Consumer Legislation

Throughout the year the Special Assistant, as well as others in the Administration, worked actively on behalf of numerous consumer legislative proposals. Mrs. Knauer testified this year before the Congress in support of legislation which would give statutory underpinning to the Office of Consumer Affairs and would establish a Consumer Protection Agency having authority to act as an advocate of consumer interests in Federal agency proceedings and before the Federal courts. The agency would also be empowered to receive and act upon consumer complaints, to initiate and conduct programs of consumer information, and to study and disseminate information concerning the safety of consumer products.

Statistics show that about 30,000 persons are killed, 110,000 permanently disabled, and 585 hospitalized in household accidents each year. A disproportionate number of these persons are the elderly. The President is committed to reducing this tragic toll and has taken the initiative to assure the consumer that the products he uses are safe. The Administration is sponsoring legislation which would empower the Department of Health, Education, and Welfare to set mandatory safety standards for consumer products, ban from the market products which pose an imminent hazard to life and limb, and require supplies to notify purchasers of certain dangers and to meet repair and replacement obligations.

The President has also requested legislation which would provide a comprehensive health policy for the 70's, one of whose provisions removes the need for older people to pay Medicare premiums themselves. Other Administration health care legislation which could be of special importance to older Americans includes bills to assure the safety and effectiveness of medical devices and to require the identification coding of all prescription drug tablets, capsules and packaging. The proposal on medical devices authorizes mandatory safety standards and requires those devices whose malfunction could imperil life to undergo scientific review before marketing.

Other Administrative consumer legislative proposals of 1971:

—Require that warranties and guarantees relating to consumer products be meaningful and clearly expressed, and prohibit altogether the use of deceptive warranties and guarantees;

—Increase the effectiveness of the Federal Trade Commission in taking action against false and deceptive acts and practices;

—Prohibit a broad but clearly-defined range of practices which are unfair and deceptive to consumers (both this legislation and the legislation relating to the FTC's powers to act against fraud and deception are expected to provide needed increased protection for the elderly, since they are frequently the special targets of the unscrupulous) ;
—Provide for the development of consumer product test methods whereby accurate and relevant information about complex products can be generated.

White House Conference on Aging

On October 6, 1969, President Nixon issued a formal call for a second White House Conference on Aging to meet in Washington, D.C., in November 1971. He charged the participants to consider the many factors which have a special influence on the lives of the aging and to help develop national policies for older Americans.

Prior to the Conference Mrs. Knauer on August 2 wrote Dr. Arthur S. Flemming, Chairman of the Conference, on behalf of the Consumer Advisory Council, a body of experts from outside the Federal Government who advise her concerning the interests of consumers, to urge that there be a session at the White House Conference for the express purpose of discussing the special consumer concerns of the aged, and such a session was held. In response to a recommendation from this session the Office of Consumer Affairs has designated a staff member to serve as direct liaison between OCA and the elderly consumer.

Two CAC members participated in a special technical committee on facilities, programs, and services. In preparation for the Conference, this committee published a background and issues book. One entire section of the book deals with consumer and legal services for the elderly.

Because she has long been concerned about the problems of the elderly who invest their savings in "quick big profit" ventures, Mrs. Knauer chose the forum of the Conference as an appropriate one to announce jointly with the Securities and Exchange Commission that multi-level distributorships and pyramid sales plans would be required in the future to adhere to Federal securities laws.

National Voluntary Organizations, Ad Hoc Groups

The Office of Consumer Affairs continues to maintain very close liaison with associations concerned with the problems of the aging, in particular the American Association of Retired Persons/National Retired Teachers Association, the National Council of Senior Citizens, the National Association of Retired Federal Employees, and the National Committee on the Emeriti. OCA has encouraged them to develop information and education programs for the older consumer to inform him of his rights and of resources helpful to him, and has urged these associations to undertake special research relating to the needs and problems of their members as consumers.

OCA coordinated a meeting of 20 consumer leaders with President Nixon on September 21, 1971, and assured that the consumer concerns of the elderly were represented by including among those 20 leaders the President-elect of the American Association of Retired Persons, the President of the National Association of Retired Federal Employees, and a representative of the National Retired Teachers Association. And on November 12, 1971, Mrs. Knauer spoke on consumer affairs before 600 delegates attending a conference of the American Association of Retired Persons/National Retired Teachers Association in Washington, D.C.

During May and June 1971, the Office of Consumer Affairs sponsored five regional meetings for consumer leaders throughout the country. One of five simultaneous workshops at each of these meetings was directed to problems of the elderly and other consumers with special needs. In the discussions held, the consumer leaders almost universally expressed concern about the special consumer problems of the elderly, especially the need for much improved housing for those with low incomes and for consumer education.

Industry Relations

The Office of Consumer Affairs has always worked actively with industry to develop industry practices of benefit to the consumer. During 1971 OCA took steps of particular interest to older consumers to achieve: greater competition in prescription drug pricing: a continuation of voluntary efforts of unit pricing and open dating by food chains (over 75 major chains are currently engaged in

unit pricing and 59 chains have adopted or are experimenting with open dating); improved automobile service and repairs; greater consumer awareness of an appliance industry complaint resolution mechanism; greater juice content in diluted juice products; and more revealing packaging for sliced bacon.

Federal-State Relations

The Office of Consumer Affairs maintains liaison with and provides clearinghouse service and technical assistance to State and local officials in all 50 States. During the year OCA continued to work for strong State consumer protection laws and offices.

Mrs. Knauer coordinated the efforts of the State Attorneys General and various Federal agencies leading to the development of policy requiring those who offer investment opportunities in multi-level distributorships and pyramid sales plans to register such offers with the SEC. In 1971 Mrs. Knauer also made special appeals to State officials for prompt enactment of effective State auto no-fault insurance laws, laws which should be of material assistance to the elderly.

In another area of activity OCA helped Federal Executive Boards in 26 major U.S. cities develop consumer service programs as a priority project in 1971, placing special stress on making Federal services as accessible and as responsive as possible to the needs of the aged. As a result, a number of the FEB's have conducted informational programs, are preparing directories of local Federal services available at the local level, and have planned or are planning conferences with groups including those representing the aged.

Product Information

Under Executive Order 11566 entitled Consumer Product Information, the Office of Consumer Affairs provides continuing policy guidance relating to the activities of other Federal agencies in this area. During 1971 these activities included the publication of three editions of the *Consumer Product Information Index* which have been received by over 6 million consumers. This index includes much information of use to older consumers. These activities also included the completion on pilot study by the U.S. Army Natick Laboratories of methods for translating technical documents which the Federal Government uses in its purchasing programs into information useful to consumers. On another product information front, the General Services Administration, the largest non-military Governmental purchaser of consumer products, published a listing of the products which it buys that are the same as brand name consumer products.

Regulatory Proceedings by Federal Agencies

During 1971 on numerous occasions, Mrs. Knauer testified in person before—or sent formal written comments to—various Federal agencies in connection with regulatory proceedings then in progress before those agencies. As examples of issues of concern to elderly consumers upon which she expressed her views, she told the Federal Trade Commission that in the 20th Century marketplace the "holder-in-due-course" doctrine was a commercial anachronism and should be abolished.

In further actions she commented in favor of an FTC proposal to grant consumers a cooling off period of three business days in which to cancel door-to-door sales contracts, and to otherwise regulate such sales; and opposed labeling of goat meat for human consumption in a manner which would not clearly disclose its animal source.

Consumer Complaints

The Office of Consumer Affairs often receives as many as 4,000 complaints a month, and has a policy of sending individual replies to every writer. During 1971, the Office continued its practice of requesting from the manufacturer, trade association or retailer concerned an equitable resolution of the complaint in question.

Complaints received from elderly consumers during 1971 were primarily in the following major categories: cost of living/inflation; drugs (cost); food (cost, quality, packaging and labeling, additives); hearing aids; home repairs; insurance; mail orders; medical services (cost); mobile homes (inability to obtain repairs); television repairs; and taxes.

The principal areas of complaint from older consumers were the cost of food and drugs. Hearing aid costs and the inability to obtain repairs on mobile homes continued to be of major concern. Complaints relating to mail order businesses increased appreciably.

PUBLICATIONS

In the past year, the Office of Consumer Affairs has prepared several publications of benefit to the older consumer.

Consumer Education Bibliography.—The updated and revised *Bibliography* lists articles and other information specifically applicable to the elderly on such topics as frauds and consumer protection, health and safety, retirement planning, and budgeting for retired couples. The *Bibliography* has been distributed nationally to libraries and those concerned with education, and to delegates attending the White House Conference on the Aging.

Consumer News.—This twice monthly newsletter contains up-to-the-minute consumer news from the Federal government. Many of the articles have a direct bearing on the elderly.

Guide to Federal Consumer Services.—This booklet lists the consumer services in 34 major Federal departments and agencies and advises consumers on how to avail themselves of these services. It includes information on Social Security programs, the prevention of consumer fraud, and available recreation areas, three subjects of particular interest to older citizens.

Speak Up Series.—These three popular booklets have been translated into Spanish to assist elderly Spanish speaking consumers when buying a car, when signing a contract and when approached by door-to-door salesmen.

11 Ways to Reduce Energy Consumption and Increase Comfort in Household Cooling.—Published in conjunction with the National Bureau of Standards, this companion piece to *7 Ways to Reduce Fuel Consumption in Household Heating* tells consumers how to reduce their costs in keeping cool.

Consumer Education for Adults.—This publication now in preparation for adult educators and administrators will emphasize the consumer problems of the elderly. It is scheduled to be first available in the Spring of 1972.

Individuals may receive single copies without charge of any of the above publications in which they are interested by writing to the Office of Consumer Affairs. *Consumer News* is available on a subscription basis for $1.00 a year.

RADIO AND TV SCRIPTS

The Office of Consumer Affairs regularly provides radio and television stations around the country with scripts which offer viewers and listeners advice on how to shop and how to protect themselves against fraudulent tactics. Many of the scripts are based on actual case histories. These scripts are beneficial to all consumers, but particularly to older consumers on fixed or limited income. Radio and TV are excellent means to reach those elderly who are confined.

During 1971 the Office of Consumer Affairs was actively involved with the resolution of problems which the older consumer experiences vis-a-vis today's marketplace. OCA will continue to consider the special concerns of older consumers as it works in support of consumer programs to benefit all Americans.

ITEM 19. VETERANS ADMINISTRATION

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., January 17, 1972.

DEAR MR. CHAIRMAN: In response to your request of December 10, 1971, it is a pleasure to forward the enclosed report on Veterans Administration activities relating to developments in aging for the year 1971.

As I have indicated in past reports, the Veterans Administration is very much concerned with the problems of older Americans since almost two million of our veterans are 65 or older. By 1990 we estimate 25 percent of all veterans will have reached the older-age group. The effort by your committee in seeking ways to help older Americans is both highly commendable and of great interest to VA.

I hope the enclosed report will be useful to your committee.

Sincerely,

DONALD E. JOHNSON, *Administrator.*

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1971, DEPARTMENT OF MEDICINE AND SURGERY

1. VA HOSPITALIZATION

Despite the demands of the Vietnamese veteran population, the Department of Medicine and Surgery of the Veterans Administration continues to deliver a program of comprehensive health care for older veterans. Thus there were in VA hospitals a total of 20,247 patients aged 65 or more on October 14, 1970. This group totalled 23.7 percent of all the patients hospitalized on that date in Veterans Administration hospitals. Further during Fiscal Year 1971, 19.5 percent of all hospital discharges were made up of older veterans (65 years of age or more).

2. AMBULATORY CARE SERVICE

a. *Inpatients.*—Within the Department of Medicine and Surgery, the Ambulatory Care Service developed and has operated a system of facilities to care for the total spectrum of patient-care needs that are included within the concept of long-term care. While these facilities serve all veteran patients requiring such care, they are of particular importance for those who are 65 and over, who make up over one-half of the long-term group.

Specifically, the Ambulatory Care Service has included services in:

(1) Intermediate care, which provides hospital treatment for those who are chronically ill but still require physician's care and supervision on a more or less daily basis.

(2) Nursing home care, for those who no longer require close medical supervision, but whose disabilities are such that they require skilled nursing care.

(3) Domiciliary care, for veterans who are disabled by chronic medical or psychiatric disease, but are nevertheless capable of performing the activities of daily living.

(4) Restoration programs, for those who may be expected to return to community living after a period of rehabilitation.

(5) Hospital-based home care, for those who are bedridden but can be cared for at home with professional support by the hospital staff.

In Fiscal Year 1971, Ambulatory Care Service operated approximately 1,700 intermediate care beds, 6,000 nursing care beds, approximately 13,000 domiciliary beds and 759 restoration beds.

Paralleling the above programs are a number of veterans programs operated by the several states with particular emphasis on the aged. For example, in Fiscal Year 1971 state facilities had an average veteran census of 5,667 in domiciliaries, 3,117 in nursing home care units, and 1,065 in hospitals. During the same period, community nursing homes provided care for an average of 3,377 per day under contracts with the VA.

The aim of the Ambulatory Care Service, throughout all these facilities, has been to attempt to prevent further deterioration by encouraging the patient to make maximum use of his remaining facilities. By providing a spectrum of care, it was possible to provide care for a patient at the lowest level of institutional care consistent with his total needs, and thus neither overtreat nor undertreat.

b. *Outpatients.*—In Fiscal Year 1971, patients in the age group 65 and over made over 952,000 visits to staff and fee-basis physicians for outpatient treatment, representing about 11 percent of the total outpatient treatment load. The aging veterans thus continued to represent a significant percentage of the outpatient load, just as they did the inpatient load.

3. MEDICAL SERVICE

The delivery of optimal health care services to the elderly patient is one of the major responsibilities of Medical Service. This responsibility was enhanced during 1971 when some several thousand additional patients, many of them elderly and chonically ill, were assigned to Medical Service from Intermediate Care Services and Psychiatric Medically Infirmed Sections.

Medical Service recognizes that health care for the elderly must be highly individualized because of the multiplicity of illnesses encountered in this group and the frequent difficulties associated with application of routine diagnostic therapeutic measures to them. In addition, the high incidence among the aged of complicating social, psychological and economic factors requires a truly comprehensive approach.

4. PSYCHIATRY SERVICE

Even with the shortage of trained psychiatrists throughout the nation, the psychiatry services within the Veterans Administration provide a diversity of treatments, services, and consultations to the elderly veterans. Many of the elderly psychiatric patients, though also medically infirmed, receive continuing treatment for their disturbed emotions and thought processes. A special category of such mostly aged patients is designated as "Psychiatric Medically Infirmed" and this assures that they receive good psychiatric care.

Many special psychiatric treatment programs are especially designed for aged veteran patients. For instance, group psychotherapy is provided in many hospitals for such patients and designated "Group Therapy for Senior Veterans or Citizens" or "Positive Thinking for the Retired Person." Specific programs are taking place in Day Treatment Centers where the focus is on teaching elderly patients how to retire successfully. This involves the teaching of patients how to shop, develop hobbies, go to entertainment, and integrates them into community peer groups. At another psychiatric hospital, special classes, designed to improve the deficits in memory and orientation so common in the aged, are conducted on a daily basis. In addition, environmental guides are provided so that those disabled by age can get around in the psychiatric hospital environment. Research is being conducted with memory-enhancing drugs which may prove of great benefit in helping the aged veteran.

One of the most important but perhaps less dramatic indices of the psychiatric service helping the geriatric patient is the increased consultative services being provided to the VA nursing home units and intermediate care services. More attention is now being directed to the fact that for many of these patients the providing of mental and emotional stability and tranquility is as important as the provision of good physical care and increased psychiatric consultation is providing this essential service.

5. PSYCHOLOGY SERVICE

Increasing numbers of elderly veterans with chronic diseases and disabilities in VA hospitals, expansion of the VA nursing home care programs, and increasing professional involvement in the domiciliary program attest to the concern for the care and treatment of this significant group in the veteran population. Many of the diseases and disabilities associated with advancing age manifest themselves in psychological deficits, especially in the areas of emotional and intellectual functioning. However, the exact nature and extent of these deficits are unknown and research psychologists are attacking this problem. For instance, Dr. R. Hamlin, research psychologist at the VA Hospital in Danville, Illinois, recently received a special professional award for his finding that chronic, long-term patients suffering from schizophrenia show no deterioration in intelligence that can be attributed to the disease itself. Findings such as this are being used by VA psychologists to intensify their clinical treatment based upon ongoing research findings.

To augment this approach, the Psychology Laboratory for Research in Aging moved recently to the VA Center, Bay Pines, Florida, to maximize the opportunity for it to be an integral part of the Center's total effort in the delivery of services, education, training, and research related to older veterans. A high concentration of older patients and members from this VA center make it an ideal situation for collaboration between the clinical and research staff. The presence of all aspects of extended care facilities at this center enhances these efforts. Already specific plans are being formulated by the laboratory to study, from its inception, a new VA nursing home being built on the grounds at the center. Special attention will be given to the quality of life and psychosocial atmosphere of the nursing home as well as to the quality of its medical and nursing care.

While new knowledge is being sought and new program efforts are developed and evaluated in this kind of research-clinical environment, psychologists continue to increase their direct participation in hospitals and domiciliaries across

the country. Assistance is given to nursing home supervision in establishment of psychologically harmonious environments in VA nursing home units.

Principles derived from research on the learning process are being applied to assist aging veteran patients. Class-like sessions help them to learn and retain such things as the date, names of patients, and staff personnel with whom they associate, and other orienting facts. Such techniques have significantly reduced the development of confusion in many elderly patients and have helped aged veterans to strengthen and utilize again faculties which had been impaired. Reinforcement therapy techniques instituted by psychologists are assisting in the development of appropriate behaviors needed to allow the psychiatrically aged patients to maintain themselves in noninstitutional settings. Such things as neatness, eating habits, and control of body functions are especially helped by these treatment techniques.

In numerous hospitals, psychologists are working with the elderly veteran on specific conditions which are amenable to assistance by psychological means. For instance, in one hospital patients suffering from strokes meet with the psychologists in a group therapy support session with focus placed upon adjustment of these patients to their more restricted mode of living. At other VA installations the psychologist works with elderly patients who suffer from emphysema with specific focus being placed on establishing behavior patterns which assist them in their therapeutic program such as establishing breathing exercises and patterns. As treatment progresses, the patients are helped through applied psychological principles to discard behaviors such as smoking which are detrimental to their treatment and rehabilitation regimens. A special Conference on Aging was held at the Leavenworth, Kansas VA Hospital during 1971. The unique feature of this conference was its emphasis upon the psychological and social aspects of the aging process and the optimistic viewpoints regarding the possibilities of change and improvement in these often neglected areas of human adjustment that inevitably accompany aging.

In summary, psychology is deeply interested in, and substantially contributes to, the research, treatment, rehabilitation and social and vocational restoration of our senior veteran patients.

6. SOCIAL WORK SERVICE

It is the goal of Social Work Service to help each older person in the VA Health Care System live with dignity and self-respect, utilizing his strengths and abilities to the fullest extent possible and developing unrealized potentials. Every effort is made to prevent the development of a sick, dependent role which can result from disabling illnesses and lengthy hospitalization and to help achieve a healthier, more independent and self-sufficient role in a family and a community. Most often this means helping to create a place for the veteran within his own family group or developing a home-like situation in the community within which he can be a participating member.

Social Work Service is a full participant with the Ambulatory Care Service in the operation of the Hospital Based Home Care Program.

This program is an alternative to nursing home care and is particularly relevant for the older veteran. Under this program the whole range of health care and services as well as equipment, are being provided in the patient's own home. The outcome of this program is the patient returning to the warmth and devotion of his family where he has the incentive to live a fuller life.

For others, continued care in a facility is necessary to provide a level of health care that is not obtainable in a family setting. For these patients, VA is able to offer long-term nursing care in VA hospitals and nursing homes. Some ambulatory patients able to care for themselves are transferred to VA residential centers where rehabilitation services are available to assist in the restorative process. Others without families are assisted in finding a congenial personal care home where they can enjoy the full benefits of private family life. These homes are inspected by VA health care teams to insure that high standards of cleanliness, nutrition, as well as fire and safety standards, are met.

Social workers offer continuing supportive services to patients, families, personal care families, and institutional personnel to assist them in establishing and maintaining the kind of positive, mutually dependent relationship which will sustain them and help them achieve an optimum level of social functioning, satisfaction and personal dignity. To supplement their direct services to patients and their families in the community, VA social workers develop and supervise activi-

ties of volunteers who provide friendly visiting and recreational outlets for older patients with restricted mobility.

Social workers maintain a network of working relationships with other private and public health and welfare organizations at the local, state, and national level in identifying the needs of older persons and developing programs to meet their needs. For example, of particular concern has been the need to develop and train home health aides to provide medical support services in the home. Social Work Service is also participating with the Department of Health, Education and Welfare in the President's nursing home program to raise standards and improve the quality of life for those who must be cared for in nursing homes.

7. PHYSICAL MEDICINE AND REHABILITATION SERVICE

This Service is primarily a supportive service to all of the other patient treatment services in our hospitals and outpatient clinics. As such, it treats a large number of patients of all types in age groups from 18 to 80 and older.

In the face of modern drugs and medical technology, life span has been lengthened quite dramatically during the past several decades. The direct effect of this has seen our workload increase by ever growing numbers of long-term (chronic) aging patients.

Illnesses and disabilities common to the aging are, for the most part, degenerative processes. With good medical care and rehabilitation medicine, a great deal of temporary improvement is possible, so that many patients may again take an active part in society as productive wage-earning citizens. Should such a goal not be attainable, however, PM&R Service strives to bring these individuals the opportunity to live at the maximum mental and physical level attainable within the hospital community.

Because of the very nature of its component therapies, the Physical Medicine and Rehabilitation Service is in the most strategic position to provide a program of maintenance therapy to prevent the rapid deterioration of patients and members whose age or medical condition pose problems of self maintenance. Maintenance therapy is a program of minimal activity designed to maintain at the maximum feasible level the physical and mental condition of patients or members who have arrived at a stage where greatest benefit has been received from normal intensive medical treatment and there is poor prognosis for improvement. The objectives of the program are:

a. Continue self-help ability as long as possible.

b. Delay the necessity for maximum nursing care.

c. Improve morale of geriatric and chronic, long-term patients and members.

d. Fill a need for sustaining therapy by the development of specialized larger group techniques.

e. Screen geriatric, chronic long-term patients and members to determine those with the will and capacity to improve under more individualized therapy.

f. Provide recreational activities.

8. DIETETIC SERVICE

In the hospital

Food habits of the aged are firmly established. Therefore, menus are adapted to meet the nutritional requirements of older veterans and their special eating problems while catering to their food preferences. For example, in nursing home care units where a large percentage of patients are elderly, food is served at tables in a dining area within the unit. Food service in close proximity to these patients allows patients' preferences for certain foods and size of portions to be considered. This effort to respect the individuality of the aged motivates them to eat better, thus satisfying both their physical and psychosocial needs.

Edentulous patients and those wearing dentures require that special attention be given to size and texture of food pieces. Whenever possible, food is kept whole rather than ground or chopped to make the menu item more appetizing in appearance. Also, cooked fruits and vegetables are substituted for raw ones when necessary.

Physical limitations as paralysis, feebleness and poor eyesight frequently impede the aged from feeding themselves. Supplementary heat often is provided for dinner plates served to slow eaters in order to maintain the proper temperature of the food.

Dietitians participate in planning for patients' discharge. The geriatric veteran who lives alone is subject to serious nutritional problems. Many do not know how to prepare meals, and those who do know how are not motivated to cook for themselves. Hence, the aged veteran may suffer nutritional deficiencies from undereating or poor eating habits. Prior to discharge to his own home or to a community nursing home or family care residence, veterans are instructed on normal nutrition, simple food preparation, and food selection and budgeting. They are cautioned against food faddism, which frequently victimizes both the health and the pocketbook of the aged.

Metabolic studies have been conducted on patients with osteoporosis, a disease found among the elderly. Calcium, phosphorus, and fluoride balance, the effect of an anabolic agent on human metabolism, and the absorption and retention of calcium using milk as the principal source of calcium were among the various aspects of this research.

In the Community

As a member of the community placement team, the dietitian visited community nursing homes and other community homes such as family care residences and foster homes. The dietitians' responsibilities are to evaluate the adequacy of the veterans' nutritional care and to make recommendations for improvement when indicated.

Dietitians studied the intake of patients in these community homes and provided nutrition education for both patients and home sponsors. Dietitians reviewed the menus used by nursing home sponsors and suggested changes in selection of food, portion sizes, scheduling of meals, and preparation methods to assist patient in maintaining normal weight and to assure a nutritionally adequate intake.

Home sponsors attended classes at VA hospitals to help them learn how to make diet modifications prescribed by the veteran's physician and about other aspects of the patient's nutritional care.

9. VOLUNTARY SERVICE

We have found the senior citizen volunteer to be dependable and productive; accordingly, we encourage senior citizen participation in the VA Volunteer Service program. In this endeavor we are in contact with senior citizen groups such as the American Association of Retired Persons and National Retired Teachers Association. The Director of the Voluntary Service program participated as a staff resource for the President's 1971 Conference on Aging.

In this regard, we continue to expand older volunteer participation by developing assignments that match the older volunteer's ability with the need in veteran-patient care.

Effort is also being directed to utilizing the experience and maturity of the senior volunteer, who cannot for one reason or another serve in the VA hospital, in assisting in the community adjustment programs for hospitalized veterans returning to the community. The older volunteer's effort in the community programs can be most effective in inspiring former patients to once again become productive citizens.

There are at least three known senior citizen volunteers over age 90 in the VA Voluntary Service program actively performing volunteer service on a regularly scheduled basis.

The older volunteer in doing for others is discovering a new usefulness which not only enhances the morale and enthusiasm of the veteran-patients but also embues their own morale and enthusiasm.

10. NURSING SERVICE

Nursing Service has utilized the team approach to planning and providing individualized nursing care to each veteran patient. This concept permits the assessment of each veteran's nursing needs and is adaptable to goal directed therapeutic activity whether the patient is young or aged.

The written nursing care plans may include, particularly for the aged, not only measures for care during the illness but those for attainment of the maximum level of independent functioning, the maintenance of this level, and the maintenance of wellness. This plan is developed for the patient in all VA care settings. Collaboration and coordination with other disciplines in multidisciplinary patient planning conferences enables nursing—the Service which is present every

day, every hour—to effectively implement the total plan to meet the individual needs of the aged patient. This includes the preparation for discharge or other placement if this a realistic goal.

Within Nursing Service, there continues to be emphasis on reality orientation activities of daily living including bowel and bladder training, remotivation group, resocialization and recreational activities as part of the planned treatment program. However, a program is never completed; the expectation is that the learning is integrated into the daily activities of each and every patient in his specific setting.

Nursing Service in discharged planning, teaches the patient, his family or other health worker including non-VA nurses to care for the patient in the home or other setting. A nurse may visit the home or other setting to assure that it can be adequately adapted for this care. Nursing Service provides for follow-up visits through referral to community nursing agencies if this is considered desirable. Nurses participate in surveys of nursing homes and in visits to these homes to assure satisfactory adjustment of the individual veteran to the specific facility. The patient is an active participant in planning for his care in many settings. Family participation, too limited at this time, is a current objective.

Nursing Service strives in consonance with professional commitment to maintain the dignity and effective satisfactory functioning of the individual, not only in the ward unit and hospital setting but as a member of a family unit and as a member of his own community.

11. RESEARCH SERVICE

The VA sponsors basic and clinical research on aging in terms of there being an indistinguishable boundary between biologic processes that produce certain kinds of diseases and the phenomena that cause aging. A few examples of aging research sponsored by the VA follow.

Population studies have linked cholesterol levels as contributing to heart attacks and stroke. However, the question remained whether a reduction in cholesterol levels would actually forestall heart attacks. Now a study by investigators at the VA Center, Los Angeles, indicates that first-time heart attacks may be significantly reduced by lowering cholesterol levels. The study was begun in 1959 with 846 elderly domiciliary members participating. Within a few months participants on the experimental diet had an average cholesterol level that was 13 percent lower than the group on a conventional diet. The combined frequency of heart attacks and strokes in men on the experimental diet was two-thirds of that encountered in men on the regular diet. Death due to disease of the larger arteries and its complications were reduced by 30 percent among men on the experimental diet. The reduction was particularly impressive in the younger subjects, aged 55–65 at the start of the study. These results demonstrate that lowering of blood cholesterol by dietary means is capable of reducing the risk of heart attack and stroke even at a relatively advanced age.

The adhesiveness of one blood constituent, platelets, plays a critical role in causing the blocking of blood vessels by dislodged clots (thromboembolism) in patients given transfusions following surgery, a surgeon at the VA Hospital, Louisville, Kentucky, and university colleagues report. An increase in platelet adhesiveness was associated in patients who developed pulmonary embolism while in a similar group of patients given dextran intravenously, there was no pulmonary embolisms and platelet adhesiveness decreased. Since pulmonary embolism may be an extremely serious complication following surgery, this clinical study indicating the role of platelets in forming embolisms and showing how such formation may be prevented deserves serious consideration by the medical profession.

Investigators at the VA Hospital, Miami, Florida, have shown that the infusion of an agent directly into the pulmonary artery to dissolve blood clots is much more efficient in the treatment of pulmonary embolism and thrombosis than injecting that same agent via other routes.

A VA investigator and colleague at Miami, Florida, demonstrated that mice, rats, cats, and dogs survive for many hours in a fluorocarbon liquid. Fluorocarbon fluid dissolves about 60 volumes percent of oxygen or three times as much as whole blood derives from air. The fact that mammals can survive the breathing of an oxygenated organic fluid under normal atmospheric pressures opens the way to many new biological applications such as the preservation of isolated organs for transplantation, and has possible uses in decompression of divers. This

investigator also showed that six months were required in large mammals to restore the lungs to normal.

Based on the Miami work, a physician at the VA Hospital, Denver, Colorado, demonstrated that fluorocarbon breathing can be used to transport and deposit foreign materials on lung tissues. This development should have considerable impact on various aspects of lung research.

For example, in lung cancer research one of the great difficulties is placing cancer-causing materials on lung tissue of test animals because of the body's strong defense against contamination. Now such material can be simply, quickly, and directly placed in the lungs of laboratory animals. Similarly, the difficulty of placing into lungs in sufficient numbers different types of pneumonia-causing organisms can be easily managed by this method. Other possible applications in research would be the placement of allergy-causing agents and direct exposure of laboratory animal lungs to air pollution mixtures, dissolved gases, and the like.

A research trainee at the VA Hospital, Kansas City, Missouri, developed an experimental breathing chamber that provides a new and useful approach to asthma research. This chamber enables accurate measurement of small changes in the breathing of the guinea pig, an animal model that is unusually suitable for asthma research because its immune response is so similar to humans.

Dr. Harry Walter is conducting research on red blood cells which have been separated by special techniques as a function of elapsed time since their biosynthesis of certain soluble proteins. The thesis is that such separation would allow the differentiation of an older protein molecule from a younger one of the same species—and enable study of the nature of chemical and structural changes of large molecules as a function of their biological age. Evidence was obtained with hemoglobin (the oxygen-carrying protein of red blood cells) that certain of its biochemical characteristics (such as oxygen dissociation, its electrophoretic mobility and chromium-51 uptake) behave differently as a function of the biological age of this protein molecule. Utilizing this special separations technique, experimental study of a given type of cell also possibly could be applied to determine the molecular basis of biochemical events that lead to diminished enzyme activities in older red blood cells.

During the past, the *Normative Aging Study program, Boston Outpatient Clinic,* under the leadership of Dr. Benjamin Bell, was marked by an emphasis on data analysis, particularly interdisciplinary analysis. A population survey shows that attrition of subjects has been minimal (less than one percent a year). A number of guidelines have emerged which improve the coherence of the study. These may be summed up by the following dimensions: (1) the relationship between intrinsic and extrinsic factors in aging, (2) "time" aging effects as partialed out from secular effects through the application of a hybrid-cross-sectional-longitudinal design of the Normative Aging Study, (3) accounting for non-linear effects in aging change, (4) the juxtaposition of disease and aging through the concept of disease as an accelerated form of aging, (5) the "decremental" hypothesis (loss of speed, loss of cells, etc.), and (6) the "incremental" hypothesis (improvement in function through learning, use, etc.). Because of interdisciplinary emphasis, the investigators aim to discover similar effects across domains in accordance with the tenets of general system theory. Also, they attempt to discover convergences among the various guidelines, such as the relationship between decrement and increment.

The first full-length book, co-authored by Charles Rose and Benjamin Bell, from the Normative Aging Study was published in April 1971. The text identifies predictors of longevity for building in to the longitudinal design of the Normative Aging Study, reviews the status of research methodology in the prediction of longevity both from the literature and from Normative Aging Study data, and formulates a new research project in the prediction of longevity which will control for the secular effect. A finding of interest during the past year is the rather high incidence of hypertension and diabetes in the population. With the screening tests employed in a healthy population one would not have predicted the appearance of this amount of disease in the rather short period of time the subjects have been followed. Multidiscipline cross-domain analysis on these subjects will add an epidemiological aspect to the study. It is hoped that a suitable protocol for analyzing electrocardiograms for age changes will also be realized. The hearing levels of Normative Aging subjects have been correlated with a wide range of biochemical variables, age, and an index of anxiety. No relationships

were found with anxiety or with any of the biochemistry measures, such as serum cholesterol, but low blood sugar was found to relate to poorer hearing.

A critical review of the relationship between age and assessment of abilities was prepared by Drs. Fozard and Carr for vocational counselors and nonspecialists in gerontology. The review stressed the practical implications of laboratory research published in the last decade.

Department of Veterans' Benefits

1. GUARDIANSHIP PROGRAM

Guardianship program activities in 1971 centered on implementation of regulatory changes affecting the marginally functioning individual—the person on the borderline between competency and incompetency. The typical situation of many marginal VA beneficiaries is one in which there is little or no accumulated estate, and the only income is VA benefits and perhaps Social Security. Most, if not all, of the funds are necessary just to provide food, clothing, and shelter. When the beneficiary has some understanding of his financial situation and has a friend or relative who helps him, or his living arrangement is such that someone is around to see that he applies his benefits to his needs, a fiduciary may not be necessary. Yet, the beneficiary may not be sufficiently capable of handling his affairs to be rated competent by the VA's adjudicating activity.

Agency regulations previously required that benefit payments be made through a fiduciary when the beneficiary was rated incompetent. Under the revised regulations, payments may be made directly to the beneficiary provided he is not under court-adjudicated legal disability. When payment is made directly to an incompetent beneficiary, periodic personal contacts will be made to evaluate his status. If the beneficiary deteriorates to the point where a fiduciary is necessary, one will be obtained. On the other hand, if the beneficiary improves to the point where a competency rating seems to be in order, evidence will be submitted to the agency's adjudicating activity for that determination.

This arrangement, supervised direct payment, provides the degree of assistance the individual beneficiary requires and still leaves him a free and unencumbered member of society.

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 1,727,000 persons age 65 and older. This total is broken down to 888,484 veterans, 661,057 widows, 131,880 mothers, and 46,521 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 to 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. Approximately 500 persons over 65 years of age are enrolled in the education program under Chapter 35 of Title 38, United States Code.

ITEM 20. WHITE HOUSE CONFERENCE ON AGING

A REPORT ON THE SECOND WHITE HOUSE CONFERENCE ON AGING*

The Second White House Conference on Aging was held on November 28–December 2, 1971, in Washington, D.C. The Delegates invited to the Conference

*Prepared by the staff of the White House Conference on Aging at the request of the U.S. Senate Special Committee on Aging.

by the President numbered 3,574. In addition, approximately 600 persons were invited to be observers or guests of the Conference. Among the observers were 44 representatives of 23 foreign countries.

The Conference was authorized by a Joint Resolution (Public Law 90–256) of Congress which was signed into law by the President on September 28, 1968. A total of $1,900,000 was appropriated by Congress for the Conference, of which $650,000 was earmarked for travel and per diem expenses of Delegates to ensure that older persons themselves, particularly those with low incomes, would be included among the Delegates.

Responsibility for the Conference was assigned to the Department of Health, Education, and Welfare and Mr. John B. Martin, Commissioner on Aging, served as Director of the Conference. He was joined later in this task by Dr. Arthur Flemming, who served as the full-time Chairman of the Conference.

A Conference Planning Board was established to advise on the organization and conduct of the Conference. It included the White House Conference National Advisory Committee of 28 older citizens augmented by 67 other persons representing the Older American Advisory Committee of the Department of Health, Education, and Welfare, the membership organizations of older people, the National Association of State Units on Aging, youth, consultants on minority problems, and the chairman of the Conference Technical Committees.

The purpose of the Conference was stated in the President's Proclamation, issued on October 6, 1969, calling for the Conference to be held in November 1971. He asked that the Conference be directed to developing a more adequate national policy for older Americans with precise recommendations being addressed not only to the Federal Government but also to government at other levels and to the private and voluntary sectors as well.

CONFERENCE OBJECTIVES

In accordance with the wishes of the Congress and the President, three major objectives for the Conference were drawn up as follows:

—To initiate the development of specific, thoughtful guides and recommendations for policies and actions in aging at community, State, and national levels.

—To draw these guides and recommendations from cross-sections of older people, providers of services, specialists on aging, key decision makers, and youth in order that the recommendations may represent a broad and effective consensus.

—To achieve greater understanding—at community, State and national levels—of the needs of older people, and strengthen the willingness to act on the policy proposals that emerge from the White House Conference on Aging.

The intent of these objectives was to achieve (1) a broader public awareness of the circumstance of older Americans, (2) a realistic national policy for older people, (3) a greater commitment by government and the voluntary and private sectors serving the elderly, (4) clearer and stronger roles of advocacy and service for the elderly on the part of Federal, State, and community agencies responsible for planning and serving the older population, and (5) assumption by older people themselves of greater responsibility for meeting their own needs and contributing to community life.

INNOVATIONS

The Conference plan included several innovations of note. First, it was conceived as a process which would extend over three years. The *Pre-Conference Year* was when older people would be asked to speak out about their needs (and more than a half-million did in over 6,000 Older American Forums held at the community level throughout the Nation). The second year—the *Year of the Conferences*—would see White House Conferences on Aging held in hundreds of communities and in all States and Territories. These Conferences, to be complete by mid-summer, would generate the recommendations on national policies and programs which, when consolidated, would become the major agenda of the National Conference when it was convened late in the year. The third year, the *Year of Action*, would be devoted to following and monitoring the implementation of the White House Conference recommendations at all levels of government and by the private and voluntary sectors.

Other innovations included a major effort throughout all phases of the Conference to involve a relatively large proportion of the nation's older people (at

the National Conference 60 percent of the Delegates were aged 55 years or over, 9.3 percent over 75 years old). A substantial effort was also made to include representatives of the minorities in the planning and decision making aspects of the Conference as well as being Delegates to the National Conference. Another group included in the planning and as Delegates were youths between the ages of 17 to 25 years.

The setting up of National Organization Task Forces to have the same responsibility as the community and State conferences for developing recommendations for the National Conference insured that organizations already dedicated to serving the elderly would be included in the planning of the Conference. And perhaps most important of all in determining that the Conference would reflect the needs, wants, and preferences of older people, was the initiation of national policy recommendations at the community conferences which included, as participants, at least 45 percent older citizens. These first formulations of recommendations were refined by the more than 37,000 participants at State Conferences. The National Conference Delegates thus received for their consideration a set of recommendations that had been generated at the grassroots level, largely by older people themselves.

ORGANIZATION OF THE CONFERENCE

The 1971 Conference was organized around 14 Subject Matter Areas. Nine of these—Education, Employment and Retirement, Physical and Mental Health, Housing, Nutrition, Retirement Roles and Activities, Spiritual Well-Being, and Transportation—represented *Needs Areas*. The other five—Facilities, Programs, and Services; Government-Nongovernment Organization; Planning; Research and Demonstration; and Training—were *Needs Meeting Areas* representing the means through which action can be brought about to satisfy the needs of older persons.

A Technical Committee, made up of specialists in the subject matter, representatives of minority groups, and older people who served in the role of "consumers," was appointed for each of the 14 Subject Areas. The functions assigned these committees included (1) review of background papers, (2) identification of the major issues needing resolution as a basis for formulating a national policy for feasible action, and (3) consolidation of the recommendations made by the State conferences and national organization Task Forces for the use of the Delegates at the National Conference. The Technical Committees were assisted in their tasks by Secretaries made up of Government personnel.

In addition to the 14 Subject Areas, the Conference plan included a set of 17 Special Concerns Sessions. These sessions were developed in response to requests from groups or organizations having a concern for a particular population among the elderly or for specific problems which they felt should be studied in depth.

The titles of each of the Special Concerns Sessions were as follows:

Long Term Care of Older People
Mental Health Care Strategies
Homemaker-Home Health Aide Services
Aging and Blindness
Physical and Vocational Rehabilitation
Rural Older People
The Poor Elderly
Aging and Aged Blacks
Asian American Elderly
Spanish Speaking Elderly
The Elderly Indian
The Older Family
The Religious Community and the Aged
The Elderly Consumer
Legal Aid and Urban Aged
Volunteer Roles for Old People
Youth and Age

Each Concerns Session was planned and conducted entirely by representatives of the Organizations sponsoring the Session. The recommendations formulated and adopted by the Sessions are included as a part of the official proceedings of the Conference.

EDUCATIONAL ASPECTS OF THE CONFERENCE

It was recognized that the 1971 Conference plan was very complex. It involved thousands of communities, hundreds of national organizations, every State and Territory, and finally the 3,500 Delegates to the National Conference. In all, it is estimated that approximately 1,000,000 persons were involved in one or more aspects of the Conference during the first two of the three projected years.

In order to permit the many individuals and the many groups to address themselves to the same Conference objectives and tasks in an orderly, focused way, it

became necessary to have common information and guidelines. The Conference Staff, therefore, prepared various materials on all phases of the Conference for distribution to the planners and the participants.

Chief among these were the *Background and Issues papers* for each of the 14 Subject Areas[1] and a *Technical Guide for Community and State White House Conferences* which provided information on the overall plans for the Conference as well as instructions for organizing and holding the community and State conferences. This guide was adapted for the use of National Organizations. A third and most important item was a *Leadership Training Guide in Policy Formulation* which included an accompanying film on the Policy Proposal. This training guide was used by State Agencies on Aging in training leaders of Community and State White House Conferences on Aging in the difficult task of formulating clear and concise recommendations for national policy. This training effort, plus the experience gained in formulating policy statements at the local and State White House Conferences on Aging, resulted in a National Conference Delegate body well-equipped for its task.

THE NATIONAL CONFERENCE

The Second White House Conference on Aging opened at 7:30 P.M., November 28, 1971, in the International Ballroom of the Washington Hilton Hotel, Washington, D.C.

The program

Three general sessions and a series of Conference luncheons were scheduled; otherwise, the four days of the Conference were spent in Section and Subsection meetings and in a 4-hour Special Concerns Session.

The opening session, the first general session, was devoted to welcoming the Delegates and to addresses by the Conference Director, Mr. John B. Martin, and the Conference Chairman, Dr. Arthur S. Flemming. A Multi-media presentation, designed to show the problems of being old in a young society, was the closing feature of the session.

The second general session was an Open Forum held on Monday evening to give any Delegate who wished to present ideas related to aging an opportunity to address the Conference. More than 60 persons spoke and summaries of the remarks of 57 persons will appear in the final proceedings of the Conference.[2]

The Conference luncheon meetings were arranged for groups of Sections in order that Delegates might hear first hand the views of major Federal officials and members of Congress on current problems of older people and pending legislative thrusts in their behalf.

The closing general session was held from 9:00 A.M. to 12:00 Noon on December 2. The Delegates were addressed by the President of the United States who outlined the plans of the Federal Government for carrying forward and expanding its efforts on behalf of America's older people.

Among the highlights of the President's remarks were those directed toward improving the income status of older people by enactment of H.R. 1 which, among other things, would increase, extend, and make inflation-proof social security benefits; establish an income floor for all older Americans; modify the retirement income test so that older people could earn more money from their work; and modify the Medicare program to reduce health costs to the elderly, including elimination of the monthly supplementary premium fee. The President also pointed out the eight point program he proposes for upgrading nursing homes, the establishment of information centers on Federal programs for the elderly in all Social Security District and Branch offices, the requirement that all Federal grants that provide services also provide transportation so that older people can take advantage of them, increases in funding of programs which provide older people opportunity to work or offer volunteer service, and increased services designed to assist older people to live decent lives in their own homes. To help achieve these goals, the President announced that he had named a Cabinet level Committee on Aging of the Domestic Council, appointing Mr. Arthur S. Flemming

[1] Copies of the Background and Issues paper for each of the Sections can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

[2] The 2-volume proceedings will be on sale by mid-summer by the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

as his Special Advisor on Aging, and increased the current fiscal budget of the Administration on Aging to the $100,000,000 level in order to implement immediately many of the recommendations made by the Delegates at the White House Conference on Aging.

The Conference Chairman spoke to the Conference of the challenge of implementing the Conference recommendations in the immediate future. An interim report containing all recommendations adopted by the 14 Conference Sections and the 17 Special Concerns Sessions was distributed to the Delegates at this Session.

The 14 Sections each held two plenary sessions. The first was held on Monday, November 28, to orient and instruct the Section participants in the process of formulating recommendations which would come before them for discussion and vote at the final plenary sessions of the Sections on Wednesday, December 1. Each Section was divided into Subsections of 35 to 40 Delegates each. There were 95 Subsections in all. They met on Monday and Tuesday from 10:00 A.M. to 5:00 P.M. to develop their recommendations. The recommendations of the Subsections were then consolidated on Wednesday morning by the Section Policy Coordinating Committee and presented for action at the Wednesday afternoon Section meeting.

The Special Concerns Sessions were scheduled to meet simultaneously on December 1, from 8:00 A.M. until 12:00 Noon, during which time they adopted the resolutions which became their report for the Conference proceedings.

Who were the Delegates

The Delegates to the White House Conference were representative of all segments of American society. All but 148 of the 3,574 Delegates filled out pre-Conference registration forms which included questions designed to provide information about the characteristics of the Delegate body charged with developing a National Policy on Aging. Not every Delegate answered all the questions, but with the exception of the questions concerning income level on which 2,900 Delegates gave information, more than 3,000 persons answered each of the questions.

The data show that 60 percent of the Delegates were aged 55 years and over; only 20 percent were younger than middle age (45 years). Men outnumbered women nearly 2 to 1. Just over 50 percent of the Delegates came from nine States and the District of Columbia. These same jurisdictions also contain just over half the nation's older population. A quarter (24.4 percent) of the Delegates came from communities with populations under 25,000, approximately a third (31.2 percent) came from cities of 500,000 and over.

Approximately two-thirds (67 percent) of the Delegates reported that they are employed currently in either full or part-time jobs. Twenty-four percent indicated that they had retired from their regular occupations but many of these people added that they continue to work either part-time or as volunteers. The two occupational categories which showed the highest proportion of employed Delegates were Education (15.5 percent) and Social Services (14.7 percent). Only 28 percent of the Delegates indicated that they were employed 50 percent or more of their time in some aspect of aging. In other words, the professionals made up a far smaller proportion of the Delegate body than did older people themselves.

Income data was available for 2,902 Delegates (exclusive of the youth group, most of whom were still in school). A fourth, 23.7 percent, of the Delegates aged 65 and over who lived as a one-person household reported annual incomes under $2500; 7.4 percent receive less than $1500 income per year, and 53.5 percent have less than $5000. Of the older Delegates living in households of two or more persons, only 3.5 percent reported annual incomes under $2500 and only .7 percent have less than $1500. A fifth have less than $5000. Fifty percent of those living as members of families have incomes of $10.000 or more, but only 18 percent of those living alone fall in this relatively high income bracket.

When Congress provided funds to assist Delegates to attend the Conference, it became possible for the States to name as their Delegates many persons who would not otherwise have been financially able to take part. These were the very persons best able to communicate the realities of aging and the special needs of those who are old and poor.

A special effort was made to include a significant number of elderly Delegates from among the minority groups because they, in large part, are disadvantaged not only by age and considerable poverty but also by a lifetime of so-

cietal neglect. The Delegate body included 10.3 percent Blacks, 5.4 percent Spanish Speaking, 2.7 percent American Indians, and 1.2 percent Asian-Americans.

Output of the National Conference

The Delegates to the National Conference were aware of the importance of their work and came to their task with enthusiasm and dedication. From the beginning to the end, it was a working Conference and the recommendations developed were relevant to the contemporary problems of the decade. They included recommendations for both policy and programs.

Inspired by the call of the Conference chairman for "Action Now," the Delegates confined themselves largely to those proposals which they perceived as feasible in their own communities and States, given the continuing leadership and involvement of government and other sectors of society.

The recommendations were reported as the interim Conference report at the Closing Session on Thursday morning, December 2. Thus, they became immediately available to the various Federal Departments, to the States, and localities, and interested groups, both public and private. The momentum of the Conference was therefore carried forward in a way that would not have been otherwise possible.

The U.S. Senate Special Committee on Aging reproduced the interim report so that it could be made available to a much wider audience.

In order to obtain a systematic, coherent organization of the recommendations from the Sections and Special Concerns Sessions, the Conference staff collated and arranged all the recommendations according to specific topics within the 14 subject-areas. This organization of the recommendations made it possible to learn quickly, and in one place, what the various Sections and Sessions recommended regarding such specific questions as, for example, what was regarded by various Sections of the Conference as adequate income levels for older couples and individuals.[3]

The proceedings of the Conference were issued in parts at intervals during the spring. A report was prepared for each Subject Area Section which includes the recommendations of the Section together with the related recommendations from other Sections and Special Concerns Sessions. In addition separate reports were issued for each of the 17 Special Concerns Sessions.[4]

The final report of the Conference Recommendations has already been filed with the President. The report of the Conference proceedings, which will provide a chronicle of the development and work of the Conference, will be issued soon.

THE YEAR OF ACTION

It is still too early to evaluate the success of the 1971 Conference in terms of the implementation of the recommendations. But any fair assessment of activities during the four months since the Conference reveals new commitments and plans to bring forth a national program in aging and to initiate action that will benefit all of America's older people, while, at the same time, giving special attention to those who are particularly disadvantaged.

Examples of the action taken to date include a special message on aging from the President to the Congress in which he announced some new, far-reaching programs designed to bring more and higher quality services to the older population. The Cabinet level Committee on Aging of the Domestic Council has received reports from all Federal Departments on the initiatives they are taking to implement the Conference recommendations. Several of the Departments are reorganizing to give a higher order of priority to the needs of older people. The Regional Federal Councils are taking leadership in developing the plans outlined by the President and by their Departments.

The National Organizations, in cooperation with the Administration on Aging and the Center for Voluntary Action, have organized to promote a "Plan for Action" to develop alternatives to institutionalization for older people.

The Congress has taken action to increase the appropriation of funds to the Administration on Aging for this fiscal year and has authorized a $100,000,000

[3] Copies of these *Topical Collation for Sections* can be obtained for the various Sections from the White House Conference on Aging, Washington, D.C.

[4] Copies of Section and Special Concerns Sessions reports may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

nutrition program which uniquely attempts to satisfy both the social and nutritional needs of the elderly. Under consideration are bills to increase Social Security benefits, reduce the cost of Medicare to the older person, renew the Older Americans Act, establish a National Institute of Gerontology as an independent unit of the National Institute of Health, and fund the construction of multipurpose senior centers and provide for their inclusion in housing built for the elderly.

The White House Conference on Aging Post-Conference Board will oversee and evaluate the implementation efforts. It will hold its first meeting in mid-May at which time it will receive reports of action taken by the Government, the States, and the national organizations.

The State Units on Aging, which bore such heavy responsibility for the preparation at local and State levels for the National Conference, are carrying forward their post-Conference efforts with the same energy and dedication. No systematic information is yet available, but it is known that most States are planning to devote their annual State Conference on Aging (generally held in May) to planning for the implementation of the White House Conference on Aging recommendations at the State and local levels.

The urgency for action is reflected in the hundreds of letters received by the White House Conference on Aging from America's older citizens. For them, credibility of the Conference will be established only when they can see concrete results which improve their lives.

Appendix 2

[House Document 92-268, 92d Cong., 2d Sess.]

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

RECOMMENDATIONS FOR ACTION ON BEHALF OF OLDER AMERICANS

MARCH 23, 1972.—Referred to the Committee of the Whole House on the State of the Union and ordered to be printed

To the Congress of the United States:

When I addressed the White House Conference on Aging last December, I pledged that I would do all I could to make 1972 a year of action on behalf of older Americans. This message to the Congress represents an important step in fulfilling that promise.

Many of the actions which are outlined in this message have grown out of concerns expressed at the White House Conference and at related meetings across the country. The message also discusses a number of steps that have already been taken or that were announced at an earlier date. All of these actions are part of our comprehensive strategy for helping older Americans.

The momentum which has been generated by all these steps—old and new—will move us toward the great national objectives which the White House Conference set forth. I pledge that this momentum will be sustained as we follow through on these initiatives and as we keep other recommendations of the White House Conference at the top of our agenda, under continuing review.

This message, then, does not represent the last word I will have to say on this important subject. It does, however, identify those administrative steps which we are taking immediately to help older Americans, along with a number of legislative initiatives which should be of highest priority on this year's Congressional agenda.

We often hear these days about the "impatience of youth." But if we stop to think about the matter, it is the elderly who have the best

reason to be impatient. As so many older Americans have candidly told me, "We simply do not have time to wait while the Government procrastinates. For us, the future is now." I believe this same sense of urgency should characterize the Government's response to the concerns of the elderly. I hope and trust that the Congress will join me in moving forward in that spirit.

A COMPREHENSIVE STRATEGY FOR MEETING COMPLEX PROBLEMS

The role of older people in American life has changed dramatically in recent decades. For one thing, the number of Americans 65 and over is more than six times as great today as it was in 1900—compared to less than a 3-fold increase in the population under 65. In 1900, one out of every 25 Americans was 65 or over; today one in ten has reached his 65th birthday.

While the number of older Americans has been growing so rapidly, their traditional pattern of living has been severely disrupted. In an earlier era, the typical American family was multigenerational—grandparents and even greatgrandparents lived in the same household with their children and grandchildren, or at least lived nearby. In recent years, however, the ties of family and of place have been loosened—with the result that more and more of our older citizens must live apart or alone. The rapid increase in mandatory retirement provisions has compounded this trend toward isolation. Under such conditions, other problems of older persons such as ill health and low income have become even more burdensome. And all of these difficulties are intensified, of course, for members of minority groups and for those who are blind or deaf or otherwise handicapped.

The sense of separation which has characterized the lives of many older Americans represents a great tragedy for our country. In the first place, it denies many older citizens the sense of fulfillment and satisfaction they deserve for the contributions they have made throughout their lifetimes. Secondly, it denies the country the full value of the skills and insights and moral force which the older generation is uniquely capable of offering.

The major challenge which confronts us, then, as we address the problems of older Americans is the new generation gap which has emerged in this country in recent decades between those who are over 65 and those who are younger. The way to bridge this gap, in my judgment, is to stop treating older Americans as a burden and to start treating them as a resource. We must fight the many forces which can cause older persons to feel dependent or isolated and provide instead continuing opportunities for them to be self-reliant and involved.

If we can accomplish this goal, our entire Nation will reap immense benefits. As I put it in my speech to the White House Conference on Aging, ". . . any action which enhances the dignity of older Americans enhances the dignity of all Americans, for unless the American dream comes true for our older generation, it cannot be complete for any generation."

From its very beginnings, this Administration has worked diligently to achieve this central objective. To assist me in this effort, I established a special task force on aging in 1969. In that same year, I elevated the Commissioner on Aging, John Martin, to the position of Special Assistant to the President on Aging, the first such position in history. Later,

I created a new Cabinet-level Committee on Aging, under the leadership of the Secretary of Health, Education, and Welfare, to ensure that the concerns of the aging were regularly and thoroughly considered by this Administration and that our policies to help older persons were effectively carried out. To provide greater opportunity for older Americans to express their own concerns and to recommend new policies, I convened the White House Conference on Aging—which met last December and which was proceeded and followed by many other meetings at the grassroots level. I asked the Cabinet-level Committee on Aging to place the recommendations of the Conference at the top of its agenda. And I also asked the Chairman of the Conference, Arthur Flemming, to stay on as the first Special Consultant to the President on Aging, so that the voice of older Americans would continue to be heard at the very highest levels of the Government.

One dimension of our efforts over the last three years is evident when we look at the Federal budget. If our budget proposals are accepted, overall Federal spending for the elderly in fiscal year 1973 will be $50 billion, nearly 150 percent of what it was when this Administration took office. One particularly important example of increased concern for the elderly is the fact that overall Federal spending under the Older Americans Act alone has grown from $32 million in fiscal year 1969 to a proposed $257 million in fiscal year 1973—an eight-fold increase. This figure includes the $157 million I originally requested in my 1973 budget, plus an additional $100 million which I am requesting in this message for nutrition and related services.

How much money we spend on aging programs is only one part of the story, however. *How* we spend it is an equally important question. It is my conviction that the complex, interwoven problems of older Americans demand, above all else, a *comprehensive* response, one which attacks on a variety of fronts and meets a variety of problems.

This message outlines the comprehensive strategy which this Administration had developed for bridging the new generation gap and enhancing the dignity and independence of older Americans. That strategy has five major elements:

1. Protecting the income position of the elderly;
2. Upgrading the quality of nursing home care;
3. Helping older persons live dignified, independent lives in their own homes or residences—by expanding and reforming service programs;
4. Expanding opportunities for older people to continue their involvement in the life of the country; and
5. Reorganizing the Federal Government to better meet the changing needs of older Americans.

A SUMMARY OF MAJOR INITIATIVES

In addition to discussing important actions which have been taken in the past or are now underway, this message focuses attention on the following major items of new and pending business.

1. *To protect the income position of older Americans—*

The Congress should:

—enact H.R. 1 as soon as possible, thus providing older Americans with $5½ billion of additional annual income. H.R. 1 would in-

crease social security benefits by 5 percent, make social security inflation-proof, increase widow, widower and delayed retirement benefits, liberalize earnings tests, and establish a floor under the income of older Americans for the first time;

—repeal the requirement that participants in part B of Medicare must pay a monthly premium which is scheduled to reach $5.80 this July. This step would make available to older persons an additional $1.5 billion—the equivalent of roughly another 4 percent increase in social security benefits for persons 65 and over;

—strengthen the role played by private pension plans by providing tax deductions to encourage their expansion, requiring the vesting of pensions, and protecting the investments which have been made in these funds;

—enact revenue sharing proposals designed to provide the opportunity for significant property tax relief; and

—enact my proposed consumer protection legislation which deals with problems which are especially acute for older citizens.

The Administration will:

—continue its investigation of alternative methods for financing public education in such a manner as to relieve the present heavy reliance on property taxes;

—propose major improvements in the military retirement system, including a one-time recomputation of retired pay;

—continue the battle against price inflation, with special emphasis in the health care field;

—develop a program to foster greater awareness among older citizens of their legal rights under the Interstate Land Sales Full Disclosure Act; and

—develop a program designed to help each State create consumer education programs for older citizens.

2. *To upgrade the quality of nursing home care—*

The Congress should:

—make it possible for the Federal Government to assume the entire cost of State inspection of homes receiving payments under the Medicaid program; and

—approve my request for additional funds for training nursing home personnel.

The Administration will:

—continue to strengthen and expedite other portions of my 8-point program for upgrading nursing homes, including my commitment to withdraw Federal funds from those homes that refuse to meet standards and to make adequate alternative arrangements for those who are displaced from substandard homes; and

—develop proposals for protecting older persons in the purchase of nursing home services.

3. *To help older persons live dignified, independent lives in their own homes or residences—*

The Congress should:

—appropriate the $100 million I requested for the Administration on Aging in my 1973 budget;

—appropriate an additional $100 million for nutritional and related purposes;

—appropriate $57 million for other programs under the Older Americans Act, bringing total spending under this act to $257 million—an eight-fold increase over fiscal year 1969;

—renew and strengthen the Older Americans Act, which so many older persons rightly regard as landmark legislation in the field of aging—extending it for an indefinite period rather than for a specified period of years;

—create a new, coordinated system for service delivery under this act, so that the Administration on Aging can help develop goals for such services, while State and area agencies create specific plans for achieving these goals; and

—allow States and localities to use some of the funds now in the Highway Trust Fund to finance their mass transit programs, including special programs to help the elderly.

The Administration will:

—ensure that Departments and agencies involved in the field of aging identify the portion of their total resources that are available for older persons and ensure that use of these resources is effectively coordinated all across the Government;

—strengthen the role already played by local officials of the Social Security Administration and other agencies in providing information about Federal services to older persons and in receiving their complaints;

—launch this summer a new Project FIND—a program which will enlist the services of Government workers at the grassroots level in an outreach effort to locate older persons who are not involved in Federal nutrition programs and who should be;

—step up efforts to meet the special transportation needs of older Americans, giving priority to community requests for capital grants that aid the elderly from the Urban Mass Transportation Fund;

—provide more and better housing for older Americans by issuing new guidelines for two HUD programs to make them more readily applicable to the elderly, by extending the mortgage maturity for the FHA-insured nursing home program, by drawing upon research of the Law Enforcement Assistance Administration to reduce crime, by encouraging the provisions of more space for senior centers within housing projects for the elderly, and by developing training programs in the management of housing for older persons.

4. *To expand opportunities for older persons to continue their involvement in the life of our country—*

The Congress should:

—appropriate the funds I have requested for such action programs as Retired Senior Volunteers and Foster Grandparents;

—authorize the ACTION agency to expand person-to-person volunteer service programs, helping more older Americans to work both with children and with older persons who need their help; and

—broaden the Age Discrimination in Employment Act of 1967 to include State and local governments.

The Administration will:

—work with 130 national voluntary groups across the country in a special program to stimulate volunteer action; and

—develop a national program to expand employment opportunities for persons over 65, through programs such as Senior Aides and Green Thumb, by urging State and local governments to make job opportunities available under the Emergency Employment Act of 1971, by working through the public employment offices to open part-time job opportunities in both the public and private sector, and by reaffirming Federal policy against age discrimination in appointment to Federal jobs.

5. *To improve Federal organization for future efforts—*
The Administration will:

—strengthen the Secretary of Health, Education, and Welfare's Advisory Committee on Older Americans—providing it with permanent staff capability to support its increased responsibilities;

—arrange for the Commissioner of Aging, in his capacity as Chairman of the Advisory Committee on Aging, to report directly to the Secretary of Health, Education, and Welfare;

—create a Technical Advisory Committee on Aging Research in the Office of the Secretary of Health, Education, and Welfare to develop a comprehensive plan for economic, social, psychological, health and education research on aging.

PROTECTING THE INCOME POSITION OF OLDER AMERICANS

Perhaps the most striking change in the lives of most Americans when they turn 65 is the sudden loss of earned income which comes with retirement. The most important thing we can do to enhance the independence and self-reliance of older Americans is to help them protect their income position. I have long been convinced that the *best* way to help people in need is not by having Government provide them with a vast array of bureaucratic services but by giving them money so that they can secure needed services for themselves. This understanding is fundamental to my approach to the problems of the aging.

The success of this income-oriented strategy depends in turn on giving effective attention to two factors: first, where older Americans' money comes from and second, what it is used for.

Where the Money Comes From: Reforming and Expanding Government Income Programs

The most important income source for most older Americans is social security. Accordingly, improvements in social seccurity have been the centerpiece of this Administration's efforts to assist the elderly. Today, approximately 85 percent of all Americans over 65 receive regular cash benefits from social security, while 93 percent of those now reaching age 65 are eligible to receive such benefits when they or their spouses retire.

Since 1969, social security cash benefits have been increased twice—a fifteen percent increase in January of 1970 and another ten percent increase one year later. These increases represent a $10 billion annual increase in cash income for social security beneficiaries. As I suggested, however, in my 1969 message to the Congress concerning social security

reform, *bringing* benefit payments up to date alone is not enough. We must also make sure that benefit payments *stay* up to date and that all recipients are treated fairly.

My specific proposals for achieving these ends are presently contained in the bill known as H.R. 1—legislation which is of overwhelming importance for older Americans. This bill passed the House of Representatives in the first session of the 92nd Congress and is presently pending before the Senate Finance Committee. I continue to believe firmly that H.R. 1 is the single most significant piece of social legislation to come before the Congress in many decades.

Let us consider the several ways in which this legislation would help the elderly:

1. *An additional increase in social security.*—Under H.R. 1, social security benefits would be increased by an additional 5 percent effective in June of 1972. This increase would provide $2.1 billion in additional income for older Americans during the first full year that it is effective. It would mean that social security benefits would be one-third higher after this June than they were just 2½ years ago. *This represents the most rapid rate of increase in the history of the social security program.*

2. *Making social security "inflation proof."*—Under H.R. 1, social security payments would, for the first time, be automatically protected against inflation. Whenever the Consumer Price Index increased by 3 percent or more, benefits would be increased by an equal amount. Payments that keep pace with the cost of living would thus become a guaranteed right for older Americans—and not something for which they have to battle again and again, year after year.

3. *Increased widows' benefits.*—About 58 percent of the population age 65 and over are women, most of whom depend primarily on social security benefits earned by their husbands. Under the present law, however, widows are eligible for only 82½ percent of the retirement benefits which would be paid to their late husbands if they were still alive. H.R. 1 would correct this situation by increasing widows' benefits to 100 percent of the benefits payable to their late husbands. It would similarly expand the eligibility of a widower for benefits payable to his late wife. Altogether, this provision would mean that about 3.4 million widows and widowers would receive increased benefits totaling almost three quarters of a billion dollars in the first full year.

4. *Increased benefits for delayed retirement.*—Under present law, those who choose *not* to retire at age 65 forfeit their social security benefits for the period between the time they are 65 and the time they finally retire. H.R. 1 would allow retirees to make up a portion of these lost benefits through higher payments after retirement. Benefits would increase by one percent for each year that a person had worked between the ages of 65 and 72.

5. *Liberalized earnings tests.*—Like the increased benefit for delayed retirement, the liberalized earnings tests contained in H.R. 1 would encourage more of our older citizens to remain active in the economic life of our country. This is a step which I promised to take in the 1968 campaign and for which I have been working ever since.

It is high time this step was taken. Those who *can* work and *want* to work should *not* be discouraged from working—as they often are under the present law. By reducing the barriers to work, we can

increase the sense of participation among older citizens and at the same time tap their energies and experience more effectively.

Under H.R. 1, the amount that a beneficiary could earn without losing any social security would be increased from $1,680 a year to $2,000 a year. That ceiling, in turn, would be automatically increased each time there was a cost of living benefit increase in social security. In addition, for those who earn in excess of $2,000, the potential reduction in social security payments would also be lessened. Under the present law, benefits are reduced by $1 for each $2 of extra earnings, but this rate applies only to the first $1,200 earned above the exempt amount. Additional earnings beyond that level now cause benefits to be reduced on a $1 for $1 basis. Under H.R. 1, benefits would be reduced on a $1 for $2 basis for all earnings above $2,000—no matter how much more a person earned.

6. *Adult assistance reform.*—One of the most important elements of H.R. 1—and one of the most under-publicized—is its provision to place a national floor under the income of every older American. H.R. 1 would replace the present Old Age Assistance program with a single, federally-financed program which would provide a monthly income of $150 for an individual and $200 for a couple when fully effective.

This program would assist 4.5 million elderly persons instead of the 2.1 million currently reached. It would also eliminate the practice of placing liens on homes as a condition of eligibility. Eligibility for assistance would be determined on the basis of need without regard to the income or assets of relatives. Relative-responsibility rules would not be a part of this new program.

I believe this reform is particularly important since it channels massive resources—some $2.8 billion in additional annual benefits—to those whose needs are greatest.

7. *Special minimum benefits.*—H.R. 1 would also provide special minimum benefits for people who have worked for 15 years or more under social security. The guaranteed minimum benefit would range from $75 a month for a person who had worked 15 years under social security to $150 a month for a person with 30 years of such work experience. At maturity, this provision would increase overall benefit payments to $600 million.

H.R. 1: The Need for Prompt Action

In addition to all of these benefits for older people, H.R. 1 would have enormous benefits for many younger Americans as well. Clearly the passage of this bill is a matter of the very highest priority. I have made that statement repeatedly since I first proposed this far-reaching program in 1969. As I make that statement again today, I do so with the conviction that further delay is absolutely inexcusable. To delay these reforms by even one more year would mean a loss for older Americans alone of more than $5 billion.

It is my profound hope that the Senate will now carry forward the momentum which has been generated by the passage of H.R. 1 in the House of Representatives, thus seizing an historic opportunity—and meeting an historic obligation.

Where the Money Comes From: Military, Veterans and Federal Employee Benefits

We are also making significant progress toward improving the retirement income of career military personnel, veterans and Federal employees.

1. *To improve military benefits*, I will soon submit legislation to the Congress for recomputing retirement pay on the basis of January 1, 1971 pay scales, thus liberalizing annuities for current retirees. I will also submit legislation to provide—for the first time—full annuities for retired reservists at an earlier age, and to revise benefit payments so that retirees receive their full annuities when they are most needed, at the conventional age of full retirement. I hope these proposals will receive favorable consideration.

In addition, I support legislation to provide military retirees with a less expensive survivor annuity plan—one which is similar to that now provided to retired civil servants.

2. *Benefits for veterans* are also improving. Our efforts to improve both the quality of care and the number of patients treated in Veterans' Administration hospitals will have a major impact on older veterans, since more than one-fourth of all VA patients are over 65. The staff to patient ratio at VA hospitals will be increased to 1.5 to 1, an all-time high, if our budget proposals are accepted.

The fiscal year 1973 budget also provides for further increases in nursing home care with the result that the authorized number of VA-operated nursing beds will have doubled since 1969 and the number of community contract beds and State home beds built and operated with VA subsidies will have increased by one-third over the same period.

In addition, I have signed into law significant improvements in pensions for elderly veterans which relate benefits more closely to need and protect recipients from income loss because of increases in the cost of living. In January of 1971, pensions were increased by an average of 9.6 percent. One year later, they went up an additional 6.5 percent and a new formula was adopted relating benefits more closely to need for the first time.

3. *Federal Employee Benefits* are also up. Retirement benefits for Federal employees have been liberalized in several instances, and—under a more generous formula for determining cost of living increases—annuities have gone up nearly 16 percent in the last 2½ years. In addition, the Government's contribution to Federal health benefit premiums of current and retired employees has been substantially increased.

Where the Money Comes From: Reforming the Private Pension System

Only 21 percent of couples now on our social security rolls and only 8 percent of non-married beneficiaries are also receiving private pensions. While this picture will improve somewhat as workers who are now younger reach retirement, nevertheless—despite the best efforts of labor and management—only half the work force is presently covered by private pension plans. As the White House Conference on Aging pointed out, the long-range answer to adequate income for the

elderly does not lie in Government programs alone; it also requires expansion and reform of our private pension system.

Late last year, I submitted to the Congress a five-point program to achieve this goal. It includes the following items:

1. *Tax deductions to encourage independent savings toward retirement.*—Individual contributions to group or individual pension plans should be made tax deductible up to the level of $1500 per year or 20 percent of earned income, whichever is less. Individuals should also be able to defer taxation of investment earnings on these contributions.

2. *More generous tax deductions for pension contributions by self-employed persons.*—The annual limit for deductible contributions to pension plans by the self-employed—on their own behalf and for those who work for them—should be raised from $2,500 or 10 percent of earned income, whichever is less, to the lesser of $7,500 or 15 percent of earned income.

3. *Requiring the vesting of pensions.*—Persons who have worked for an employer for a significant period should be able to retain their pension rights even if they leave or lose their jobs before retirement. Unfortunately, many workers do not now have this assurance—their pensions are not vested. To change this situation, I have proposed a new law under which all pensions would become vested as an employee's age and seniority increased. Under this law, the share of participants in private pension plans with vested pensions would rise from 31 percent to 47 percent and the overall number of employees with vested rights would increase by 3.6 million. Most importantly, among participants age 45 and older, the percentage with vested pensions would rise from 60 percent to 92 percent.

4. *The Employee Benefits Protection Act.*—This legislation was first proposed to the Congress in March of 1970; it was strengthened and resubmitted in 1971. It would require that pension funds be administered under strict fiduciary standards and would provide certain Federal remedies when they are not. It would also require that plans provide full information to employees and beneficiaries concerning their rights and benefits.

5. *A study of pension plan terminations.*—In my December message, I also directed the Departments of Labor and the Treasury to undertake a one-year study concerning the extent of benefit losses which result from the termination of private pension plans. This study will provide the information we need in order to make solid recommendations in this field, providing needed protection without reducing benefits because of increased costs.

Where the Money Goes: The Burden of Health Costs

Growing old often means both declining income and declining health. And declining health, in turn, means rising expenditures for health care. Per capita health expenditures in fiscal year 1971 were $861 for persons 65 and older, but only $250 for persons under 65. In short, older Americans often find that they must pay their *highest* medical bills at the very time in their lives when they are *least* able to afford them.

Medicare, of course, is now providing significant assistance in meeting this problem for most older Americans. In fiscal year 1971, this program accounted for 62 percent of their expenditures for hospital and physicians services and 42 percent of their total health payments.

In addition, an estimated 40 percent of Medicaid expenditures go to support the health costs of the elderly, while other programs provide significant additional assistance.

But serious problems still remain. Accordingly, this Administration has been working in a number of ways to provide even more help for the elderly in the health-care field. One of our most important proposals is now pending before the Congress. I refer to the recommendation I made more than a year ago that the Congress combine part B of Medicare—the supplementary medical insurance program, with part A—the hospital insurance program, thus eliminating the special monthly premium which older persons must pay to participate in part B—a premium which will reach $5.80 per month by July. I have reaffirmed my commitment to this important initiative on other occasions and today I affirm it once again. Elimination of the premium payment alone would augment the annual income of the elderly by approximately $1.5 billion, the equivalent, on the average, of almost a 4 percent increase in social security for persons 65 and over. I hope the Congress will delay no longer in approving this important proposal.

Our concern with health costs for older Americans provides additional reasons for the prompt approval of H.R. 1. Under that bill:

—Provision is made for extending Medicare to many of the disabled (about 60 percent of whom are age 55 and over) who are drawing social security benefits and who have had to give up work before reaching regular retirement age;

—Medicare beneficiaries would have the opportunity to enroll in Health Maintenance Organizations—organizations which I strongly endorsed in my special message on health policy because of my conviction that they help to prevent serious illness and also help to make the delivery of health care more efficient;

—Provision is made for removing the uncertainties relative to coverage under Medicare when a person needs to use extended care facilities after hospitalization.

In my recent message to Congress on health policy, I indicated a number of other measures which will help reduce the cost of health care. I spoke, for example, of the special attention we have been giving under Phase II of our New Economic Policy to the problem of skyrocketing health costs, through the special Health Services Industry Committee of the Cost of Living Council. I indicated that a number of cost control features would be introduced into the Medicare and Medicaid reimbursement processes—with the overall effect of reducing health costs. I have also called for new research efforts in fields such as heart disease, cancer, and accident prevention—initiatives which also promise to reduce health problems—and health bills—for older persons.

Where the Money Goes: Inflation

Inadequate retirement incomes are strained even further when inflation forces older persons to stretch them to meet rising costs. Because older persons are uniquely dependent on relatively fixed incomes, they are uniquely victimized by the ravages of inflation. While my proposals for making social security benefits inflation-proof will provide significant help in defending the elderly against this menace, it is also important that we take on this enemy directly—that we curb inflationary pressures.

This goal has been a central one of this Administration. When I came to office this country was suffering from a massive wave of price inflation—one which had resulted in large measure from the methods chosen to finance the Vietnam War. The problem of reversing this wave by conventional methods was a more stubborn problem, frankly, than I expected it to be when I took office. By the summer of 1971, it became clear that additional tools were needed if inflation was to be quickly and responsibly controlled. Accordingly, I announced last August a New Economic Policy—one which has received the strong support of the Congress and the American people.

I have been especially gratified that older Americans—whose stake in the battle against inflation is so high—have rallied to support this new economic program. With their continued support—and that of all the American people—we can carry this battle forward and win a decisive victory.

One key element in that battle, of course, is to be sure that Government spending programs, including those which help the elderly, are responsibly financed. If they are not, then inflation will merely be reignited and Government policy will merely be robbing older Americans with one hand of the aid it gives them with the other.

Where the Money Goes: Property Taxes

Two-thirds of all older citizens—and 78 percent of older married couples—own their own homes. For these Americans—and for many younger Americans as well—the heavy and growing burden of property taxes constitutes one of the most serious of all income-related problems. Even those who rent their homes often bear an unfair burden since property tax increases are frequently passed along in the form of higher rents. The reason these burdens are so onerous, of course, is that the income from which property taxes must be paid by the elderly is usually going *down* at the very time the taxes are going *up*.

Property taxes in the United States have more than doubled in the last ten years. The problems which this fact implies are felt by Americans of all ages. But elderly Americans have a special stake in their solution.

I am committed to doing all I can to relieve the crushing burden of property taxes. I have been proceeding toward this end in two ways. First, I am continuing to push for passage of our General and Special Revenue-Sharing proposals, legislation which would channel some $17 billion into State and local budgets and thus provide a significant opportunity for property tax relief. At the same time, as I indicated in my recent State of the Union Address, I am also moving to change the system through which we finance public education. In developing a new approach, I will draw on the recommendations of the President's Commission on School Finance, the Advisory Commission on Intergovernmental Relations, and other analyses such as those which are being performed under the direction of the Secretaries of the Treasury, and of Health, Education, and Welfare. The purpose of this intensive investigation is to develop ways of putting this Nation's educational system on a sounder financial footing while helping to relieve the enormous burden of school property taxes.

Reducing Income Tax Burdens

Recently approved and pending changes in the income tax laws also provide special help to older persons. Under these provisions, a single person age 65 or over would be able to receive up to $5,100 of income

without paying any Federal income taxes, while a married couple with both husband and wife 65 or over would be able to receive up to $8,000 of such tax-free income.

Where the Money Goes: Protecting Elderly Consumers

The quality of life for older Americans depends to a large extent upon the responsiveness of the marketplace to their special needs. It is estimated that elderly persons now spend over $60 billion for goods and services every year—and they will be able to spend billions more if my proposals for increasing their income are enacted. Our economy should be responsive to the needs of older Americans; they have a high stake in advancing consumer protection.

Through organizational changes, administrative actions and legislative recommendations, this Administration has been working to provide needed protection for the American consumer in general—and for the older consumer in particular. The several pieces of consumer legislation which I have submitted to the Congress are designed to reduce dangers which are especially acute for older consumers—and I again urge their enactment.

In addition, I am asking my Special Assistant for Consumer Affairs, in cooperation with the Secretary of Housing and Urban Development, to develop a program for helping to enforce the Interstate Land Sales Full Disclosure Act by fostering greater awareness among older citizens of their legal rights under this legislation.

Recognizing that the complexity of today's marketplace demands great sophistication by the individual consumer, our primary and secondary schools have stepped up their programs for consumer education. Unfortunately, many older Americans have never had the opportunity to benefit from such programs. The Office of Consumer Affairs is therefore developing guidelines for adult consumer education programs with particular emphasis on the needs of the elderly. To carry out these guidelines, I am asking my Special Assistant for Consumer Affairs, working in cooperation with the Secretary of Health, Education, and Welfare, to develop a program of technical assistance to help the States create consumer education programs specifically designed for older citizens.

A Comprehensive Effort for Improving Income

The key characteristic of my strategy for protecting the income position of older Americans is its *comprehensiveness.* For it would help to augment and protect the income older persons derive from social security, adult assistance, Federal military, veterans and civilian benefits, and private pensions, while at the same time curbing the cruel drain on those incomes from rising health costs, inflation, taxes and unwise consumer spending. I hope now that the Congress will respond promptly and favorably to these proposals. If it does, then the purchasing power of the elderly can be enhanced by billions of dollars a year—an achievement which could do more than anything else to transform the quality of life for Americans over 65.

UPGRADING THE QUALITY OF NURSING HOME CARE

Income related measures can help more older Americans to help themselves; they build on the strong desire for independence and self-reliance which characterizes the older generation. We must recognize,

however, that some older Americans—approximately five percent by recent estimates—cannot be primarily self-reliant. These older men and women require the assistance provided by skilled nursing homes and other long-term care facilities. For them, a dignified existence depends upon the care and concern which are afforded them in such settings.

In June of 1971, at a regional convention of the National Retired Teachers Association and the American Association of Retired Persons, I pledged to meet the challenge of upgrading nursing home care in America. I expressed my determination that nursing homes, for those who need them, should be shining symbols of comfort and concern. I noted that many such facilities provide high quality care, but that many others fall woefully short of this standard. I observed that those who must live in such facilities are virtual prisoners in an atmosphere of neglect and degradation.

Following that speech, I directed the development of an action plan to improve nursing home care and I announced that 8-point plan in August of 1971. I am pleased to be able to report that we have made significant progress in carrying out that plan. We have delivered on all of the eight promises implied in that program. Let us look at each of them:

1. *Training State nursing home inspectors.*—Through February of 1972, almost 450 surveyors had been trained in federally-sponsored programs at three universities. Contract negotiations are underway to continue ongoing programs and to establish new ones at two university training centers.

2. *Complete Federal support of State inspections under Medicaid.*—Legislation to raise the level of financial participation by the Federal Government in this activity to 100 percent was submitted to the Congress on October 7, 1971, as an amendment to H.R. 1. This proposal is awaiting Congressional action.

3. *Consolidation of enforcement activities.*—A new Office of Nursing Home Affairs has been established in the Office of the Secretary of Health, Education, and Welfare. This unit is directly responsible for coordinating all efforts to meet our July 1, 1972, deadline for inspections of skilled nursing homes and for certification of these facilities in accordance with proper procedures.

4. *Strengthening Federal enforcement.*—142 new positions have been allocated to the Medical Services Administration to enforce Medicaid standards and regulations. Added emphasis is being placed on the audit process as a tool for enforcement; 34 additional positions are being added in HEW's Audit Agency to perform audits of nursing home operations.

5. *Short-term training for professional and paraprofessional nursing home personnel.*—This program is currently funded at the $2.4 million level and is scheduled to train 20,000 persons. The fiscal year 1973 budget which I submitted to the Congress contains $3 million to train an additional 21,000 persons.

6. *Assistance for State investigative units.*—A program to develop and test investigative-ombudsman units to respond to individual complaints and to other problems in the nursing home area has also been initiated. As an interim mechanism, nearly 900 social security district

and branch offices have been designated as listening posts to receive and investigate complaints and suggestions about nursing home conditions.

7. *Comprehensive review of long-term care.*—The Office of Nursing Home Affairs is now carrying out a comprehensive analysis of issues related to long-term care.

8. *Cracking down on substandard nursing homes.*—Progress is also being made on this important front. Last December I signed legislation which, among other things, authorizes Federal quality standards for intermediate care facilities, thus giving us additional authority to guarantee a decent environment for those who live in long-term care facilities.

Every State providing nursing home care under the Medicare and Medicaid programs has now installed systems for surveying and certifying nursing somes. In the area of fire-safety and other safety guidelines, a coordinated set of standards for homes providing care under these programs is being put into effect.

Medicaid compliance activities have also been stepped up. Onsite Federal reviews of State Medicaid certification procedures have been carried out. Deficiencies in those procedures were found in 39 States. These deficiencies were publicly announced by the Secretary of Health, Education, and Welfare on November 30, 1971, along with a timetable for correcting them. Since that time, 38 of the 39 States have made the necessary corrections. We have determined that every facility receiving Medicaid funds must have been inspected and correctly certified by July 1, 1972.

While we prefer to upgrade substandard homes rather than shut them down, we will not hesitate to cut off money when that is necessary. As of February 11, 1972, in fact, 13 extended care facilities had been decertified for participation in Medicare. In such cases, as I have often pledged before, we are firmly committed to seeing that adequate alternative arrangements are made for those who are displaced.

In fiscal year 1971, the Federal Government contributed $1.2 billion to the cost of nursing home care. We should also remember, however, that more than 40 percent of the annual expenditure for nursing homes is borne by private sources. In addition to seeing that Federal tax dollars are properly spent in this area, it is also important that private individuals are protected when they purchase nursing home services. I have asked the Secretary of Health, Education, and Welfare to develop proposals to deal with this dimension of the nursing home challenge.

SPECIAL SERVICES TO FOSTER INDEPENDENCE

Improving the income position of older Americans and upgrading nursing homes—these are two concerns which have been of highest priority for this Administration in the past and which will continue to be central in the future. As we work to develop a truly comprehensive strategy, however, other agenda items have also been emerging as areas of special emphasis, particularly those involving public and private services which can help older persons live dignified, independent lives in their own homes for as long as possible.

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Increased Resources for the Administration on Aging

Since the passage of the Older Americans Act in 1965, the Administration on Aging has had the lead Federal role in developing and coordinating such services. While that office has accomplished many significant things, the importance and urgency of its mission have outstripped its financial resources.

It was to help remedy this situation that I announced at the White House Conference on Aging last December that I would call for a five-fold increase in the budget of theAdministration on Aging—from $21 million to $100 million. As I will discuss below in greater detail, I am now requesting an additional $100 million for nutritional and related purposes, money which would also be spent through the Administration on Aging.

With this substantial increase in funds, we would be able to step up significantly our efforts to develop and coordinate a wide range of social and nutritional services for older Americans. Our central aim in all of these activities will be to prevent unnecessary institutionalization—and to lessen the isolation of the elderly wherever possible.

Extending the Older Americans Act

Since its passage in 1965, the Older Americans Act has served as an important charter for Federal service programs for the elderly. Unless the act is promptly extended, however, the grant programs it authorizes will expire on June 30th. This must not happen. I therefore urge that this landmark legislation be extended—and that the extension be indefinite, rather than limited to a specific period of time.

Strengthening the Planning and Delivery of Services

In addition, I am asking that the Older Americans Act be amended to strengthen our planning and delivery systems for services to the elderly. Too often in the past, these "systems" have really been "non-systems," badly fragmented, poorly planned and insufficiently coordinated. My proposed amendments are designed to remedy these deficiencies.

We should begin by helping to develop and strengthen the planning capacities of the State agencies on aging and of new area agencies on aging which would be established within each State. Up to 75 percent of the administrative costs of these new area planning agencies would be funded by the Administration on Aging, which would also establish general goals to which activities at the State and local levels would be directed. One of the major priorities would be to enhance and maintain the independence of older citizens.

The State and area planning agencies would plan for the mobilization and coordination of a wide range of resources—public and private—to meet such goals. The Administration on Aging would be authorized to fund up to 90 percent of the cost of social and nutritional services provided under plans developed by the area planning agencies. In fiscal year 1973, $160 million would be allocated in formula grants for nutritional and social services. An additional $40 million would be allocated in special project assistance to develop new and innovative approaches and to strengthen particularly promising area plans.

By establishing overall objectives and by providing both money and mechanisms for a stronger planning and coordination effort, we can ensure that resources and energies which are now widely scattered and fragmented can be pulled together in ways which will notably increase their impact.

Coordinating Federal Efforts

Even as we strengthen coordination at grassroots levels, so we must do a better job of coordinating Federal programs. As this message makes clear, efforts are being made all across our Government to help older citizens. But if there was one clear message at the White House Conference on Aging, it was that this wide range of Federal resources must be better coordinated. To help achieve this important objective, I have directed my Special Consultant on Aging to work with all these agencies in an intense new effort to develop coordinated services.

As the first step in this effort, I have directed those agencies whose programs have a major impact on the lives of older persons to provide the Cabinet-level Committee on Aging, within sixty days, with the amounts they identify as serving the needs of the elderly. In addition, I am directing that each agency identify, within the total amount it expects to spend for its aging programs, a sum that will be available to the States and localities for purposes related to the Older Americans Act. The Administration on Aging will then provide this information to the States so that it can be utilized in the State and local planning process. State aging agencies will also be able to transmit their views on proposed Federal programs, thereby furthering the interchange of information and strengthening overall coordination.

Under these procedures, we can ensure that all resources for helping the elderly are fully marshalled and coordinated, in a way which is responsive to the special needs of every State and locality in our land.

Establishing Information and Complaint Centers

We must also work to improve communications between the Federal Government and older Americans and to alert the Government to areas of special need. Because older persons often have some difficulty moving about conveniently, and because services are often fragmented and channeled through complex bureaucratic mechanisms, it is especially important that the elderly have one place to turn where they can obtain needed information and let their views be heard.

As I have already noted, we have been moving in this direction under my program to upgrade the quality of nursing home care. Following the directive which I announced at the White House Conference on Aging, Social Security offices have also been expanding their information and referral services for the elderly. District and branch offices are now handling more than 200,000 such inquires each month—and that number is expected to increase. A task force is now at work within the Social Security Administration to examine ways of improving this service.

As another step in this direction, I have directed the Cabinet-level Committee on Aging to examine ways in which we can use other Government offices—such as the General Services Administration's Federal Information Centers and the Agricultural Extension Service's local offices—in further expanding and improving our information and complaint services.

Fighting Hunger and Malnutrition

In addition to our overall funding and coordination proposals concerning Federal services, we are also moving ahead in a variety of specific service areas. One of the most important is the fight against hunger and malnutrition among the elderly.

The thought that any older citizens—after a lifetime of service to their communities and country—may suffer from hunger or malnutrition is intolerable. Happily, since I submitted my message on hunger and nutrition to the Congress in May of 1969, we have made significant strides toward eliminating this problem among all age groups in America. Our efforts to increase incomes have been central to this endeavor, of course. But our special food assistance programs have also been substantially augmented.

If my budget proposals for fiscal year 1973 are accepted, overall spending for food stamps will have increased ninefold since 1969. In the coming fiscal year, an estimated 2 million elderly participants in the Food Stamp Program will receive benefits of $343.5 million, compared with only $45.8 million in fiscal year 1969. Virtually every county in the Nation now offers either the Food Stamp or the Food Distribution Program; in early 1969, nearly 500 counties offered neither. In all, 2.5 million older Americans benefit from at least one of these programs.

Food assistance is important to the elderly. They benefit not only from nutritious food but also from the activity of preparing meals and sharing mealtimes with others. To maximize these benefits, the Department of Agriculture in January revised its regulations to improve the nutrition program and expand participation.

But more needs to be done. Many older persons who are entitled to food stamps or to surplus commodities are still not receiving them. Why is this the case? In many instances, older Americans do not realize they are eligible for participation. The agencies which provide assistance are often unaware of older persons who need their services. Some older persons choose not to participate—out of pride or out of fear that accepting food assistance may subject them to the arbitrary treatment they associate with the present welfare system. In some cases, older persons want to participate but find that necessary transportation is unavailable.

To overcome the barriers which keep older Americans from full participation in food assistance programs, we are launching this year a major outreach campaign called Project FIND. This campaign will be conducted through a senior citizen awareness network made up of federally operated or funded field offices and outreach workers. It is my hope that Federally-supported personnel will be augmented in this effort by volunteers from State local government offices and from the private sector. For ninety days, all these workers will go out across our country to find those who should be participating in nutrition programs but who are not yet involved.

Last night, I signed into law S. 1163, a new national nutrition program for the elderly. This program will provide prepared meals in a group setting and delivered meals for those who are confined to their homes. I welcome this effort. Because of my strong feeling that this area should be one of priority action, I will submit to the Congress—as I suggested above—an amendment to my 1973 budget to

provide an additional $100 million for nutritional and related services. My proposed amendments to the Older Americans Act would further strengthen this effort by ensuring that the Food Stamp Program is planned as part of a more comprehensive service effort.

Other steps will also be taken in this area. In some areas, for example, space at federally-assisted housing projects will be utilized for feeding older persons. The support of State and local governments, of civic and religious organizations and of the food services industry will also be solicited. Maximum use will be made of existing technical resources, including skilled personnel who have worked with the school lunch program and other special programs of the Department of Agriculture. The time has come for marshalling all of our resources in a comprehensive campaign to meet the nutrition needs of older Americans.

Providing Better Transportation for the Elderly

For many older Americans, lack of mobility means poor access to friends and relatives, to government services and to meaningful participation in the community. Unless we meet the challenge of providing better transportation for older persons, our efforts in other fields will not be as effective as they should be. This is why I told the delegates to the White House Conference on Aging that I would, by administrative action, require that Federal grants which provide services for older persons also ensure that the transportation needed to take advantage of these services is available.

In addition, the Department of Transportation is significantly increasing its program for developing new ways to meet the public transportation needs of older persons. The approaches which are being tested include special new transportation services to take elderly citizens from housing projects and other residential areas to hospitals, senior citizen centers, social service agencies, employment opportunities and the like; and demand-responsive services whereby the elderly are picked up at their doorsteps and taken to specific desired destinations.

Once new ways have been developed for meeting the transportation needs of the elderly, we must also make them generally available. One proposal which could help significantly in this effort is the recommendation recently submitted to the Congress by the Secretary of Transportation under which some of the funds now in the Highway Trust Fund could be used by States and localities to augment resources in the mass transportation area.

I hope the Congress will give prompt approval to this important plan. The flexibility it provides would allow State and local officials—who know best the transportation needs of the elderly within their own jurisdictions—to give special consideration to meeting those needs. I am asking the Secretary of Transportation to develop specific suggestions for assisting the States and localities in these undertakings.

In addition, the Department of Transportation is ready to give priority attention to community requests for helping older Americans through capital grants from the Urban Mass Transportation Fund and is willing to commit significant resources to this end. I urge the States and localities to move immediately to take advantage of these resources.

Meeting the Housing Needs of Older Citizens

This Administration has also worked hard to respond to the very special housing needs of older Americans. It is expected, for example, that an all-time record in producing subsidized and insured housing and nursing homes for the elderly will be achieved this year by the Department of Housing and Urban Development. In the current fiscal year, nearly 66,000 units of subsidized housing for the elderly will be funded under HUD's housing assistance programs—a figure which should rise to over 82,000 in fiscal year 1973. In addition, accommodations for over 14,000 people, mostly elderly, will be provided this fiscal year under HUD's nursing and intermediate care facility programs—and nearly 18,000 such accommodations will be provided next year. Finally, a large number of elderly citizens will benefit from other housing funded by this year's record number of nearly 600,000 subsidized housing unit reservations. Clearly, we are making substantial progress in this important area.

A number of other administrative steps have also been taken to ensure that this new housing is responsive to the special needs of the elderly. For example, Secretary Romney recently announced new guidelines for the Section 236 subsidized rental program for lower income elderly tenants. These guidelines will help ensure greater variety in building types, including highrise structures, and more flexibility in their locations. As a result of these guidelines, older persons will find such housing arrangements even better suited to their particular needs.

The Department of Housing and Urban Development has also issued initial guidelines for the new Section 106(a) program which will provide technical assistance to non-profit sponsors of low and moderate income housing—including housing which is specially designed for the elderly.

In addition, the Department will extend the mortgage maturity for its Federal Housing Administration insured nursing home program up to a maximum of 40 years. This decision will not only reduce monthly occupancy charges to patients, but it will also enable sponsors of residential housing to "package" residential and nursing home complexes more easily. The proximity of these facilities will permit elderly persons temporarily to vacate their residential units for short term nursing care—and at the same time remain close to family, friends, and the environment to which they are accustomed.

I have also directed the Secretary of Housing and Urban Development to work with the Administration on Aging in developing training programs dealing with the management of housing for the elderly.

The Law Enforcement Assistant Administration has undertaken an intensive research effort to determine factors which encourage or inhibit crime in residential settings and to develop total security systems to reduce crime in housing projects. The Department of Housing and Urban Development plans to use the results of this effort in its housing programs. I have also made grant funds available through the Law Enforcement Assistance Administration for reducing crime in areas housing older persons. Already, in two cities, funds have been granted specifically for this purpose.

Crime is an especially serious problem for our older citizens. Through these and other measures, we will continue our strong effort to meet this challenge.

Two years ago my task force on aging observed that "older persons would make greater use of many of the services society intends them to receive if these services were made more accessible to them. One reason that the number of senior centers has increased so fast is because centers facilitate the packaging, marketing, and delivery of services." The task force also noted that, "although the number of senior centers has rapidly grown in recent years, centers are still too limited in number to reach more than a fraction of the older population." In my judgment, a natural location for a senior center is a housing facility occupied primarily by older persons.

The Department of Housing and Urban Development administers two housing programs under which such facilities can be made available to older persons living in the project and in the surrounding neighborhood: the Section 236 Program and the Public Housing Program. Both of these programs provide specially designed housing for lower income older persons. The law under which these programs are administered contains language which allows the financing of facilities designed primarily for use by older persons including "cafeteria or dining halls, community rooms, workshops, infirmaries, . . . and other essential service facilities."

To increase the supply of well located senior centers, I have instructed the Department of Housing and Urban Development to encourage greater provision of community space for senior centers within subsidized housing projects for the elderly. The Department will consider the community's overall need for these centers in determining the appropriate scale of centers within such housing projects.

On other fronts, the Farmers Home Administration in the Department of Agriculture is taking steps to meet the housing needs of elderly persons who live in rural areas. Under the Section 502 program, for example, thousands of elderly families have received millions of dollars in loans for home ownership and repair. The Section 515 program, which provides favorable interest loans with repayment periods of up to 50 years to stimulate the development of rental housing in rural areas, has also moved forward. Rental units financed under this program have tripled from 1969 to 1973.

EXPANDING OPPORTUNITIES FOR INVOLVEMENT

It is important that we give sufficient attention to the things our Nation should be doing for older Americans. But it is just as important that we remember how much older Americans can do for their Nation. For above all else, what our older citizens want from their country is a chance to be a part of it, a chance to be involved, a chance to contribute.

I am determined that they will have that chance. For as I told the White House Conference, "we cannot be at our best if we keep our most experienced players on the bench." This Administration is deeply

committed to involving older citizens as actively as possible in the life of our Nation—by enhancing their opportunities both for voluntary service and for regular employment.

Improving Voluntary Service Programs

Voluntary social action has long been recognized as one of the great distinguishing characteristics of America, a force which has helped to unite and focus our diverse people in the pursuit of common goals. And even as the voluntary spirit has helped our country move forward more effectively, it has also provided those who have volunteered for service with a greater sense of fulfillment.

The voluntary spirit is particularly relevant to the lives of older Americans. The White House Conference on Aging, for example, called attention to "ways in which older Americans could fulfill themselves by giving service to one another and to their communities." Delegates to the Conference called for "a national policy . . . to encourage older adults to volunteer," and urged "that existing national older adult voluntary programs should be expanded and funded at adequate levels in order to serve extensive numbers of volunteers." They urged a mobilization of public and private organizations to strengthen the volunteer movement.

I agree completely with these judgments. That is why, at the time of the White House Conference, I pledged to move successful voluntary programs from demonstration status to full operation on the national level, an expansion effort that is rapidly moving forward.

I requested, for example, that the Foster Grandparent program be doubled to $25 million, providing for 11,500 foster grandparents to serve 23,000 children each day—50,000 children in all each year—in some 450 child care institutions throughout the country. I also asked that ACTION's Retired Senior Volunteer Program (RSVP) be tripled to $15 million so that as many as 75,000 senior volunteers could be involved in community services.

When the RSVP program has developed to the full extent permitted by the new appropriations, as many as 11,000 volunteers will be serving older persons in nursing homes and other extended care facilities, bringing companionship and personal assistance to some 45,000 residents who might otherwise be lonely and isolated. At the same time, as many as 13,000 part-time RSVP volunteers will be serving as homemaker and health aids, enabling thousands of older persons to continue to live in their own homes. By using senior volunteers in a variety of programs, we can foster that human contact which brightens the lives both of those who are served and those who volunteer.

But other new steps are also needed in this area.

As one such step, the Congress should enact legislation which would enable the ACTION agency to expand person-to-person volunteer service programs for older Americans. These efforts would build on the successful experience of the Foster Grandparent program. One important characteristic of such programs is that so much good can be accomplished, so many people helped, for a relatively small dollar investment. It would indeed be tragic if we did not capitalize on this opportunity.

Measures are also needed to improve coordination among the many Federal and non-Federal volunteer activities which affect the aging.

As one important step in this direction, the Administration on Aging and the National Center for Voluntary Action have enlisted the cooperation of 130 national voluntary organizations in a program to help older men and women in 300 communities live dignified lives in the familiar settings of their own homes. Too often, older Americans are displaced from such settings simply because small problems such as simple home repairs, shopping and trips to obtain health care have become too difficult. And yet, with only minimal assistance from volunteers, these problems could easily be met.

I have directed the ACTION agency to work in every possible way to help provide such assistance. Already, the RSVP program is moving forward in this area. I am confident that other ACTION program volunteers can also make a major impact in this field. It is my hope, too, that communities will consider the elderly residents of federally assisted housing projects as a source of volunteer manpower for serving other older persons.

As we move ahead with this entire program, we should take encouragement from successes of the past. One which is particularly noteworthy is the program in Mount Vernon and Edmonds, Washington, where local citizens have designed a unique bridge across the generation gap called STEP—Service To Elderly Persons. Under this program, volunteers from the local high schools have undertaken, on a regular basis, to assist elderly persons in performing small tasks, while at the same time providing them with companionship and renewed hope. Everyone gains from a program of this sort. If leaders at every level are alert to such possibilities, our progress can be enormous.

Often in quiet ways, the people of the United States have been responding to the challenges of our society with compassion and resourcefulness. Now it is for those of us who have the responsibility for national leadership to provide the Federal assistance which can help such voluntary efforts go even further and accomplish even more.

Employment Opportunities for Older Citizens

Discrimination based on age—what some people call "age-ism"—can be as great an evil in our society as discrimination based on race or religion or any other characteristic which ignores a person's unique status as an individual and treats him or her as a member of some arbitrarily-defined group. Especially in the employment field, discrimination based on age is cruel and self-defeating; it destroys the spirit of those who want to work and it denies the Nation the contribution they could make if they were working.

We are responding to this problem in a number of ways. The Department of Labor, for example, has filed over 80 suits under the Age Discrimination in Employment Act of 1967—30 of which have been successfully concluded. I will soon propose to the Congress that this act be broadened to include what is perhaps the fastest growing area of employment in our economy—the State and local governments. I will also send a directive to the heads of all Federal departments and agencies reaffirming and emphasizing our policy that age shall be no bar to a Federal job which an individual is otherwise qualified to perform.

The Age Discrimination in Employment Act relates to persons between the ages of 45 and 65. I recognize that persons falling within this age group are confronted with special problems in the employment area and that we should do everything we can to resolve these problems. It is also important, however, that we help open employment opportunities for persons over 65. To this end, I have requested the Secretary of Labor to urge the States and local communities to include older persons in the opportunities provided by the Emergency Employment Act of 1971, and to work with our public employment offices so that they will be in a position to help open job opportunities for the over 65 group, including opportunities for part-time employment in both the public and private sectors.

I also asked last fall that funds be doubled for special Operation Mainstream projects for low-income older workers—such as Green Thumb and Senior Aides. This measure can mean that as many as 10,000 older persons will be employed in activities that provide useful community service.

ORGANIZING FOR FUTURE ACTION

One of the important concerns of the White House Conference on Aging was the way in which the Government is organized to deal with the problems of older Americans. It was because I share this concern that I established my original task force on aging, appointed the first Special Assistant to the President on Aging and the first Special Consultant to the President on Aging, set up a new Cabinet-level Committee on Aging and called the White House Conference.

In a similar manner, the Secretary of Health, Education, and Welfare has taken steps to ensure that the voice of older Americans speaks loud and clear within that Department. He has informed me that he will strengthen the Department's Advisory Committee on Older Americans and provide it with staff capability to support its increased responsibilities. The Commissioner of Aging, in his capacity as Chairman of the Advisory Committee, will report directly to the Secretary.

Another important organizational concern involves Government research activities which concern the process and problems of aging. It is important that the same scientific resources which have helped more people live longer lives now be applied to the challenge of making those lives full and rewarding for more Americans. Only through a wise investment in research now, can we be sure that our medical triumphs of the past will not lead to social tragedies in the future.

What we need is a comprehensive, coordinated research program, one which includes disciplines ranging from biomedical research to transportation systems analysis, from psychology and sociology to management science and economics. To coordinate the development of such a program, a new Technical Advisory Committee for Aging Research will be created in the office of the Secretary of Health, Education, and Welfare.

A GENERATION NO LONGER FORGOTTEN

We all grow old; the younger generation today will be the older generation tomorrow. As we address the needs of older Americans,

therefore, we are truly acting in the best interest of all Americans. The actions and proposals which have been outlined in this message are designed to address those needs and meet those interests.

When I spoke about the problems of the elderly back in 1968, I described our older citizens as "an entire generation of forgotten Americans." But since that time, as this message clearly demonstrates, that situation has sharply changed. Today, it can truly be said that at all levels of Government and in all parts of the country, "the aging have come of age." Much work still remains, to be sure, but we can conclude with assurance that the aging are forgotten no longer.

Just before the First World War, one of the brilliant young writers of that day penned a line which has since become a hallmark of the period: "It is the glory of the present age," he wrote, "that in it one can be young."

Since that time, the generation of which he wrote has come through a troubled and challenging time—through two World Wars and a Great Depression, through the difficult experiences of Korea and Vietnam. The members of that same generation have led this country through a time of social and economic change unparalleled in world history. And they have come through all of these challenges "with colors flying." Because of their success, we now have the opportunity to complete their quest for peace and justice at home and around the world.

At such a moment, one obligation should be very high on our list of priorities: our obligation to this older generation. Let us work to make ours a time of which it can be said, "the glory of the present age is that in it men and women can grow *old*"—and can do so with grace and pride and dignity, honored and useful citizens of the land they did so much to build.

RICHARD NIXON.

THE WHITE HOUSE, *March 23, 1972.*

Appendix 3

STATEMENT OF HON. ELLIOT L. RICHARDSON, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

I. Introduction

It is a pleasure to appear before this Subcommittee* to discuss the extension of the Older Americans Act which will expire on June thirtieth of this year. I shall direct my remarks essentially to the Administration's proposal S. 3391. We look forward to working closely with the Subcommittee to produce the best possible bill to achieve the objective which I believe we both share: Improving and expanding services to older Americans.

The Older Americans Act is a major segment of the Administration's comprehensive strategy to improve the lives of our older citizens by enabling them to live independent and meaningful lives and to live with dignity in a home environment. That comprehensive strategy has included the following:

—A 26 % increase in Social Security benefits since 1969;
—Proposals in H.R. 1 for far-reaching improvement and reform of Social Security and adult assistance programs:
  —an additional 5% across-the-board increase in Social Security benefits;
  —provision for automatic cost-of-living adjustments in social security benefits—to make them inflation proof;
  —increased widows (and widowers) benefits;
  —increased benefits for delayed retirement and a liberalized earnings test;
  —provision for a floor of protection under the income of every older person.
—A proposal to reduce the burden of health costs by eliminating the supplementary medical insurance premium—a saving of 1.4 billion dollars annually for older persons;
—Proposed legislation to strengthen and reform the private pension system—to provide increased income security above and beyond that provided through the social security system;
—Administrative initiatives to improve the health standards and safety of nursing homes—for the 5% of the elderly who are institutionalized; and
—A New Economic Policy to control inflation—a particularly cruel drain on the relatively fixed income of older persons.

We believe that our proposed amendments to the Older Americans Act are an important complement to these other initiatives.

*Statement before the Subcommittee on Aging, Senate Labor and Public Welfare Committee, Mar. 23, 1972.

The Older Americans Act has been an important Federal vehicle for the development and coordination of social services for older Americans. Our experience in the last seven years, however, indicates that its objectives could be better achieved if the Act were refocussed.

The part of the Older Americans Act which has had the greatest impact is Title III. I shall direct most of my remarks to the programs under that Title.

Title III has supported the establishment of State Agencies on Aging in every U.S. jurisdiction except Samoa. The State executives on aging who head these aging agencies have been hard-working, dedicated people, who, with limited funds and generally small staffs, have administered a wide range of programs and activities for the elderly persons in their States.

These programs have had significant impact on the lives of thousands of older Americans. But, although there is much good to say about the Title III programs, we have reached the moment in the history of the Older Americans Act when we must determine how to improve Title III in order to ensure that services for older Americans are developed and administered effectively.

II. Principal Deficiencies in the Present Title III Program

Based upon almost seven years of experience, we believe that the current program needs reform and strengthening in two major areas:

(1) *We must improve State and sub-State planning capability.*

At the State level, aging agencies are still in the early stages of development—with limited funding and limited staff capability. At the sub-State level, planning capability generally does not exist at all.

(2) *We must treat problems more comprehensively, and make optimal use of scarce resources, to achieve better development and coordination of services for the elderly.*

Too often, objectives have not been clearly specified, Federal resources have not been targeted in areas of greatest need, other public and private resources have been underutilized and ill-coordinated—and the catalytic effect which might have been achieved has not been.

III. The Administration Strategy for Overcoming Deficiencies in Title III

The Administration's bill would remedy these problems.

IMPROVING STATE AND SUB-STATE PLANNING CAPABILITY

In order to improve State and sub-State planning capability:

—We propose to strengthen existing State agencies on aging. Up to 8% of a State's total allotment will be available to enable State Agencies to plan for and administer the much broadened Title III program proposals which we are presenting today.

—We propose to create new sub-State agencies on aging. Up to 8% of a State's total allotment will be available to support administrative costs of these agencies.

—We propose to require the new sub-State agencies to develop comprehensive area plans on aging.

ACHIEVING OPTIMAL DEVELOPMENT OF COMPREHENSIVE SERVICES

In order to achieve optimal development of comprehensive services:

—We propose to bring a sense of purpose to the disparate components of the service delivery system by setting appropriate national objectives for this program. We would require State and local agencies to develop coordinated programs which would:

"(1) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services . . .", and

"(2) remove individual and social barriers to economic and personal independence for older persons (who are) capable of self-support."

—We propose to encourage the targeting of Federal resources on areas of greatest need by requiring that Governors designate priority sub-State planning areas for a concerted effort on behalf of the elderly.

—We propose to stimulate service development—with a multiplier effect insofar as possible—by: (a) providing resources to planning agencies for the initiation of services through purchase-of-service authority, and (b) emphasizing commitments from a broad range of public and private providers of service. These commitments are necessary to ensure that an appropriate range of services will be made available to older persons on a sound, continuing financial basis.

—We propose to encourage the development of integrated service delivery systems—in order to facilitate access to the full range of services which older persons may require.

—We propose to help ensure that the complex problems of older persons are addressed with the comprehensiveness necessary for their resolution by authorizing the purchase of a broad spectrum of services—including nutrition, transportation, health, continuing education, recreation, housing assistance, counseling, information and referral.

—We propose, in particular, that the assistance for nutrition services authorized by S. 1163 and signed by the President yesterday be provided through a well-planned, comprehensive services approach. We intend to seek additional appropriations in the amount of $100 million to carry out this program. Such an approach is especially important in the case of malnutrition which, as the framers of S. 1163 clearly recognized, usually arises from a combination of problems: income, education, transportation, and mental health. Because of the special importance we attach to nutritional services for the elderly, we have proposed in our Older Americans bill to require that each State spend between 35 percent of its allotment under Title III for nutrition. And because of the importance we attach to planning for comprehensiveness, our proposal would link the planning and administration of nutritional services with the planning and administration of other services to the elderly. This approach would be most efficient administratively; but even more important, it would ensure that older persons receive the range of services necessary to solve their prob-

lems—and that they receive those services with a minimum of bureaucratic hindrance.

—We propose to help ensure that all available Federal resources are planned for and utilized by State agencies in addressing the needs of older persons. We would accomplish this by: (a) identifying in advance the resources in each Federal Agency available to meet the needs of the elderly, (b) providing information about these resources—through the Administration on Aging—to State aging agencies, and (c) requiring State agencies to utilize this information in the development of their plans. Dr. Flemming is available to elaborate upon this concept, as you may wish.

We believe, Mr. Chairman, that the approach which I have just outlined is the most effective means to promote the coordination and comprehensiveness which we both desire in the delivery of services to older persons.

IV. Strengthening Federal Organization on Behalf of the Elderly

We are all aware that the aged have become an increasingly large proportion of our society. And the Federal response to the needs of the elderly has become increasingly diverse and complex. Yet the degree of representation of the interests of the aged in the policy councils of the Federal government—and the degree of coordination of Federal resources on behalf of the aged—have only recently begun to keep pace with the numerical growth of older persons and the resources allocated to them.

The Older Americans Act of 1965 meant to address this issue. But when this Administration came to office in 1969, we found an unsatisfactory situation. There was no effective institutional mechanism to coordinate policy and programs across the Federal government on behalf of the elderly. And older people had no high-level spokesman—certainly not one at the White House.

This Administration has taken a number of strong, positive steps to meet more adequately the needs of Older Americans for Federal coordination and representation. Soon after his inauguration, the President appointed John Martin, the Commissioner on Aging, as his Special Assistant on Aging, thus giving older persons a direct line of communication to the White House. The White House focus for advocacy and coordination has recently been strengthened further by the appointment of Dr. Arthur Flemming as Special Consultant to the President on Aging. And the President has, as you know, created the Domestic Council Cabinet Committee on Aging, which I chair, to coordinate across the government policy development as it affects older persons.

I am pleased to announce that we are taking another important step to heighten our responsiveness to the concerns of the elderly. I am expanding the role and increasing the capacity of the Advisory Committee on Older Americans, which prior to this has not been fully utilized. The Commissioner on Aging will continue to serve as Chairman of the Committee—and will report directly to me in that capacity. And I have asked Miss Bertha Adkins, former Under Secretary of

HEW, to serve as Vice-Chairman. Miss Adkins has a distinguished record of public service as well as a deep understanding of the needs of the aged.

The Committee will advise me directly on ways in which the vast resources of this Department may be marshaled and coordinated to deal more effectively with the problems of the elderly.

I am also pleased to announce the establishment of a Technical Advisory Committee on Aging Research, reporting to the Chairman and Vice-Chairman of the Advisory Committee. Its location in the Office of the Secretary will be a particularly appropriate one from which to develop a comprehensive plan for the vast range of social, psychological, health, education, and economic research activities conducted by HEW and affecting the aged.

Both Committees will have coordination as their exclusive concern; and both will be supported by permanent, full-time staff. With these initiatives, Mr. Chairman, and those already taken by the President, we believe that the interests of older persons will be properly represented in the Executive branch.

With your permission, Mr. Chairman, I would like to submit for the record two charts which highlight the organizational changes which we have effected since 1969.

V. Conclusion

In sum, I suggest that these organizational changes are an appropriate complement to our proposed amendments to Title III of the Older Americans Act. Through these amendments and our administrative initiatives we would provide at the Federal, State, and local level the mechanisms and the resources necessary to serve effectively the objectives which we share. I thrust that we will be able to work out any differences we have to the benefit of today's 20 million older Americans and for the good of the generations of older persons who will follow. As we begin that work together on the legislation before us today, let us be guided by the conviction which the President expressed in his address to the delegates at the White House Conference on Aging:

> "Any action which enhances the dignity of older Americans, enhances the dignity of all Americans. For unless the American dream comes true for our older generation it cannot be complete for any generation."

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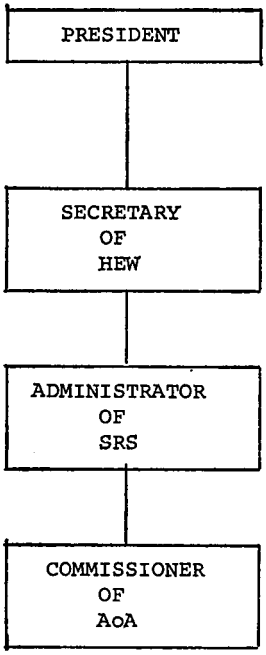
FEDERAL ORGANIZATION RELATED TO AGING PRIOR TO JANUARY 1, 1969



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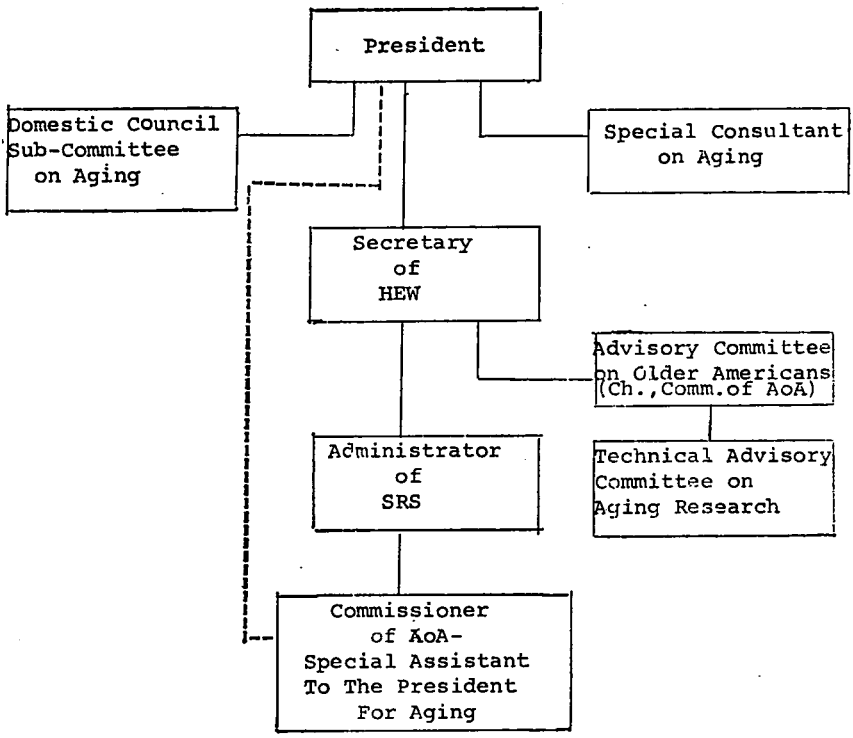

Appendix 4

TEXTS OF SENATE ADDRESSES BY MEMBERS OF THE SPECIAL COMMITTEE ON AGING

THE STATE OF THE AGING

Mr. CHURCH. Mr. President, recently I told the White House Conference on Aging that our Nation seems to be falling behind, rather than advancing, in terms of achieving genuine security and well-being for older Americans. Nevertheless, my message was not one of pessimism. Instead, it was one of challenge.

That challenge, very briefly stated, is that the 1970's can be either a period of triumph or one of despair for older Americans. We can seize this historic opportunity to translate the recommendations of the 1971 White House Conference on Aging into action—immediate and long range. Or we can fumble and fritter away our opportunity, with the result that the elderly will taste more disappointment and despair.

Quite bluntly, older Americans of today have already waited too long for too little. They will not be willing—nor will their successors—to wait until the White House Conference of 1981 for action to begin.

For these reasons, I have requested time to make the leadoff address today—the first in what might be called a state of the aging message—to be delivered by members of the Committee on Aging. Our purpose is to press home certain facts to the Congress and the administration about the issues now facing the elderly, the significance of the recently concluded White House Conference on Aging, the immediate and long-range opportunities for legislative action, and some thoughts about the future of aging Americans.

And my own personal goal is to help generate impetus for bipartisan congressional and administrative efforts to make the 1970's a memorable decade of achievement. To begin, I would like to make a few comments on comparative costs. What are we talking about when we ask for reforms that would help older Americans?

Well, we could abolish poverty among the elderly for what it costs to run the war in Southeast Asia for just 3 months. We could broaden Medicare coverage to include out-of-hospital prescription drugs for what we now spend for an aircraft carrier. We could establish a comprehensive manpower program for older workers for the cost of one submarine.

Given such incongruities in our present spending patterns, it is easy to understand why the 1970's could become a decade of despair for older Americans. They see a nation which boasts a gross national

product of more than $1 trillion, but in which nearly 5 million older Americans subsist below the poverty line. They see a nation where the median family income is almost $10,000, but in which nearly one-fourth of all aged couples have incomes below $3,000. They see a nation in which $70 million is requested for military aid for Spain, but in which only $30 million is appropriated for service programs to enable elderly Americans to live independently.

But they also see a nation where there is new reason for hope. Through the voices raised at the White House Conference on Aging, all of us have heard a stirring declaration for action. And that call has already produced momentum on two key fronts.

Throughout 1971, the Congress struggled with a reluctant administration for more adequate funding for the Older Americans Act. And rightly so. A budget assigning the Administration on Aging approximately the same amount of money that was allocated to the Pentagon for publicity purposes was not worthy of a great nation.

We questioned the administration on these spending priorities. And finally, we won some limited victories, including a $15 million increase in appropriations.

But it took a White House Conference to turn around an administration that was first willing to settle for $29.5 million for the Older Americans Act, about $1.45 for each senior citizen. It took a White House Conference to demonstrate that the elderly were deeply dissatisfied. And it took a White House Conference to provide the necessary impetus to secure a $100 million appropriation for the Older Americans Act, the highest in its history.

There is also no doubt in my mind that the Conference helped to marshal support for establishing a national hot meals program. For nearly 2 years, the administration had opposed this measure. During the week of the Conference, though, the Senate rejected this advice and approved the Nutrition Program for the Elderly Act, S. 1163, by a vote of 89 to 0. This measure, which was sponsored by the Senator from Massachusetts, is now before the House of Representatives. And I understand that the House is scheduled to take action today on this proposal.

And behind it all, there is a firm bipartisan attitude in Congress when it comes to issues affecting older Americans. Nowhere is this better demonstrated than in the Committee on Aging, on which I serve as chairman. We may have 11 Democrats and nine Republicans on our committee. But in our treatment of the issues affecting the elderly, we try to conduct our business in a bipartisan manner.

What is now necessary is a joint effort by Congress and a willing administration to construct a sound and coherent program for the aging.

How Real Is the Administration's "Game Plan"?

Before discussing what form this action program should take, an examination of the administration's "game plan" is essential. This is not done in a partisan vein because no administration to date, whether it be Democratic or Republican, has really come to grips with the predicament of the elderly.

Despite the crying need, the administration, until recently, exhibited a narrow, negative attitude. Not only did it fail to propose new

programs of its own, but it resisted, opposed, and even blocked several congressional initiatives.

Until last week, the administration opposed the enactment of the Nutrition Program for the Elderly Act. Yet, 8 million older Americans have diets insufficient for good health. And the administration's own White House Conference on Food, Nutrition, and Health strongly supported this type of legislation.

The administration has opposed legislation to create a midcareer development services program for older workers. But today, nearly 1.1 million persons 45 and older are unemployed. They account for less than 4 percent of all enrollees in our Nation's work and training programs, although they represent 21 percent of the total unemployment in the United States and 37 percent of all joblessness for 27 weeks or longer.

The administration has argued against the establishment of a National senior service corps, although 4 million older persons may want to participate in this program. And many pilot programs under Mainstream—such as Green Thumb and Senior Aides—have shown beyond any doubt that community service employment is good for the elderly as well as the localities being assisted.

The administration opposed establishment of a National Institute of Gerontology and an Aging Research Commission. Yet our Nation probably spends no more than 8 cents per person for biomedical aging research. And the low priority assigned to aging research continues to be one of the major problems in the field of gerontology.

The administration has presided over the continued decline of the Administration on Aging. Today, AoA is no longer the strong Federal focal point which Congress intended. Instead, it is a crippled agency with no real clout in the Federal bureaucracy.

To make matters worse, the administration now proposes sharp cutbacks in the scope of coverage under Medicare and Medicaid. Medicare protection has already eroded to the point that the elderly, as a group, are paying almost as much in out-of-pocket payments for health care as the year before this historic law went into effect.

But the fundamental weakness in the administration's game plan is the failure to develop real income strategy to provide security in retirement. Its policy of adding a few dollars every 2 years to monthly Social Security checks is just not going to get the job done.

Cost-of-living adjustments will also provide little protection if the administration continues to insist that this escalator should be pegged to an inadequate base. All this will do is perpetuate deprivation for persons who now receive low benefits.

We in the Congress have long supported automatic adjustments to protect the elderly from inflation. However, there is one crucial difference: The Congress wants to raise Social Security benefits to a more realistic level before employing this escalator mechanism. Only in this manner will older Americans have any meaningful protection from rising prices.

The retirement income crisis which now affects millions of older Americans is much too deep for the administration's shallow treatment. It cries out for much more far-reaching action on several key fronts. And it deserves no less than a national commitment to eliminate poverty for the elderly and to allow them to share in the economic abundance which they have worked most of their lives to create.

Yet the administration's income stratgey has been pursued, to a large degree, in a halfhearted manner with no realistic goals.

In 1970, for example, the administration was first willing to settle for a 7-percent increase in Social Security benefits. Later it upped the ante to 10 percent when an avalanche of criticism forced reassessment. But the significant point is that neither of these proposals would even have kept pace with the rise in prices since the last Social Security increase.

Only because of bipartisan congressional insistence did the elderly win a 15-percent raise. And then the administration threatened to veto this measure because of its "inflationary" impact. But fortunately the measure was tacked onto a tax proposal which the President could not veto.

Again last year, the Congress and the administration had another go-around on Social Security. This time high-level administration spokesmen urged the Congress not to rock the boat by approving a raise in excess of 5 percent. Later the request was eased up to 6 percent. But, once again, this increase would have been wiped out by the time the elderly received their first checks. And once again, a bipartisan Congress ignored the advice of the Administration and approved a stop-gap 10-percent raise.

The net impact of this action is that social security recipients are now receiving about $4 billion more in benefits than they would have received, if the administration had prevailed. Equally significant, we would now have thousands more on the poverty rolls if the Congress had accepted the Nixon recommendations.

Now I turn to the President's address to the delegates at the White House Conference. In some respects, his remarks represented a step forward, particularly his proposal for increased funding for the Older Americans Act. However, his statement fell far short of prescribing what is really needed to come to grips with the basic problems confronting the elderly—relating to income, health, and housing. And once again, this was symptomatic of the administration's failure to establish realistic goals.

The President, for example, recommended that H.R. 1 be approved "without delay." At the outset, I wish to express my support for early action on H.R. 1. In terms of numbers of persons affected, this could quite possibly be the most significant domestic legislation considered during this session. But many important changes are still needed to improve this bill and to eliminate some of its undesirable provisions. And I, along with other members of the committee, will have more to say about that later.

If the Congress were to accept H.R. 1, without any modifications, the elderly will find themselves on the same old economic treadmill. The 5-percent increase in Social Security benefits would not become effective until this June. Even more significant, this raise may not be sufficient to keep the elderly even in their desperate race with inflation. By June, the jump in the cost of living since the 1971 Social Security increase, which became effective last January, may well be in excess of 5 percent.

Additionally, the proposed $1,560 income floor for a single aged person is nearly $300 below the existing poverty line. By the time this income standard becomes effective, it will fall substantially below the poverty index.

There are also very crucial omissions of fact in the President's address. He did not, for instance, inform the delegates that his administration made no request for a Social Security increase for 1972. The 5-percent raise was principally the result of bipartisan efforts; in the House of Representatives. Nor did he tell the delegates that his administration was first considering a $65 income standard for its welfare reform proposal for the aged. With such a low threshold, this was tantamount to no welfare reform at all. Now that standard has been doubled, but once again largely because of bipartisan congressional efforts.

During the last 3 years, our unemployment rate has jumped from 3.4 to 6 percent, adding nearly 2.5 million persons to the jobless rolls. Today more than 5.2 million individuals are looking for work. More than 1.1 million have been searching unsuccessfully for 15 weeks or more.

All age groups have felt the crunch of these economic policies—whether in the form of massive layoffs, shorter workweeks, smaller paychecks, rising prices, high interest rates, or just slow business. But older persons and their families have been especially hard-hit.

Many have discovered that they have lost more than jobs. Thousands have also lost their pension coverage as well—even though they may have worked most of their lives for this little "nest egg."

And the elderly—perhaps more so than any other age group—have been especially hard pressed by inflation. As prices go up, their limited purchasing power goes down.

Reasons For Optimism

Yet, despite my earlier skepticism about administration policies, I still find many hopeful signs for 1972 to be a year of decisive legislative victories for older Americans.

First, White House Conference Chairman, Arthur Flemming, has repeatedly emphasized the need for early action to implement the policy recommendations of the 3,400 conferees. Second, the President's White House Conference speech has provided a possible signal that the administration may look more favorably upon categorical programs for the elderly.

Third, issues related to aging now enjoy strong bipartisan support in Congress. This has been demonstrated time and time again. It may be revealed when Congress stands up and demands that Social Security benefits be raised to a much more realistic level. Or it may be demonstrated when bipartisan efforts turn an inadequate request for the Older Americans Act into a $70.5 million victory for the elderly. Fourth, I believe that the Congress is ready, willing, and able to act on several major proposals during this session. Important momentum was generated during the week of the White House Conference, and I look for this impetus to continue during the months ahead.

The Challenge

Our Nation is now being challenged—as it never has been before—to develop and implement a national policy on aging. This will, of course, require a full fledged action campaign in several areas if the later years are to be a time for dignity and self respect.

Nowhere is this more evident than in the area of economic security. Today more than 4.7 million older individuals 65 and older fall below the poverty line, nearly 100,000 more than in 1968. And for the first time since poverty statistics have been tabulated, their impoverished numbers have increased, instead of decreased.

Today older Americans are more than twice as likely to be poor as younger Americans. One out of every four persons 65 and older—in contrast to one in nine for younger individuals—lives in poverty. And the threshold, I might add, is a "rockbottom" standard. According to the Census Bureau, it is $1,852 for a single person and $2,328 for an aged couple.

Perhaps one of the most economically disadvantaged groups in our society now is the aged widow. Approximately 50 percent live in poverty. And as they grow older, they seem to grow poorer.

Equally alarming is the high incidence of poverty among elderly minority groups. Their likelihood of being poor is nearly twice as great as for the white aged population, and four times as great as for our total population. Approximately 48 percent are victims of poverty, compared with 23 percent for elderly whites. Especially disadvantaged is the aged Negro woman who lives alone or with nonrelatives. More than 88 percent—or nearly 9 out of every 10—are considered poor or marginally poor. And there is strong evidence to suggest that they suffer from greater extremes of impoverishment. More than 59 percent, for instance, have annual incomes below $1,500.

Another area of retrogression, in many respects, is in the field of health care. Today, less than 7 years after the passage of Medicare, the threat of costly illness is still too real for many older Americans.

Medicare now only covers about 43 percent of their health care expenditures. And that coverage is being eroded further with proposed cutbacks and rising medical costs.

The sad truth is that serious illness strikes with much greater frequency and severity at a time in life when incomes are most limited. Persons 65 and older have health bills averaging almost $800 a year, nearly six times that for youngsters and three times that for individuals 19- to 64-age category.

If our Nation is to assure true economic security in retirement, we must resolve the serious medical cost problems which pose an intolerable drain upon their limited incomes.

Our Nation has also made little progress in terms of maximizing employment and service opportunities for older persons. Many older workers are now being eased out of the work force. Only about 17 percent of all persons in the 65-plus age category have jobs, usually part-time and in lower paying employment.

Many persons now in their 40's or 50's are also discovering that advancing age may become a problem long before traditional retirement. It may occur when age may make it difficult to locate new employment, although we now have a law prohibiting such discriminatory practices. In large part, this is rooted in other fundamental problems which work to the disadvantage of middle-aged and older persons: Inflexibility in adjusting employment patterns during the latter working years; false stereotypes about the undesirability or feasibility of employing older workers; and the lack of training opportunities to prepare older workers for new and gainful employment.

Little improvement has also been made in developing a comprehensive and coordinated system for the delivery of vitally needed social services. According to a recent report by the Gerontological Society, no community in the United States has developed a comprehensive network of services to meet the varied and changing needs of the aging. And that message should be of major concern for all Americans, because an effective social service system can enable the elderly to live independently, instead of being institutionalized at a much higher public cost.

An effective income strategy must be complemented by social service delivery systems which are far superior to those that now exist. Adequate income will be of little consolation to aged persons who are unable to go to the doctor, the supermarket, or visit friends because suitable transportation is unavailable or inaccessible.

Much of this lack of progress or retrogression, in some respects, is reflected in the elderly's living environment. Less than one-quarter of a century ago, our Nation announced a goal for a decent home and suitable living environment for all Americans. But this objective is far beyond the means of too many older Americans. Nearly 6 million are estimated to live in dilapidated, deteriorating or substandard housing.

Yet, our housing programs have lagged behind their demonstrated needs. Only about 350,000 units have been constructed for seniors under Federal programs during the past 10 years. This is only about the equivalent of the net gain in their population during any one year.

Large numbers of aged homeowners are also finding themselves in a "no-man's land" for housing. Rapidly rising property taxes and maintenance costs are driving them from their homes. And alternative quarters at prices they can afford are simply not available.

Complicating everything else is the fact that the elderly are among the chief victims of our Nation's most pressing problems: such as the decline in our cities, the migration from rural areas, the disintegration of our public transportation system, and the sheer wastefulness of a Nation which overspends for military hardware while tightening its fiscal belt for human investment expenditures.

What Now Must Be Done

But even these problems can be solved if we insist on an appropriate national commitment and a soundly conceived strategy. And this session of Congress provides a splendid opportunity to launch a comprehensive action program to implement the goals of the White House Conference on Aging.

First and foremost, early action is needed to make H.R. 1 as strong as possible in terms of ending poverty for the elderly. Several features adopted by the administration—such as full Social Security benefits for widows, a liberalization of the retirement test, an age-62 computation point for men, and cost-of-living adjustments—provide a solid basis for genuine reform of our Social Security program.

However, essential finishing touches are necessary to perfect this measure. Heading the list, in my judgment, is the need for more substantial increases in Social Security benefits. And this raise should be retroactive to January 1, instead of taking effect in June.

The 5-percent increase proposed in the House-passed bill, though welcome, is simply not enough.

For these reasons, I am urging—as I have previously in my omnibus Social Security-Welfare Reform proposal—across-the-board increases in Social Security benefits which would average about 12 percent. This raise would also be weighted to provide larger percentage increases for persons who now receive low Social Security payments. Under my proposal, persons with very low benefits would receive benefit increases averaging about 21 percent.

My bill also would abolish Old Age Assistance and would replace it with a new income supplement program to be administered by the Social Security Administration. For persons who now receive Social Security benefits and Old Age Assistance—about 2 million older Americans—this would provide an efficient, single step service. Another advantage is that the Social Security Office has the trust and respect of most aged persons; it does not have the same negative connotations associated with the local welfare office.

Particularly significant, my proposal would establish an income standard which would be sufficient for abolishing poverty among all older Americans. In contrast, H.R. 1 fixes the income floor for single persons only at $1,560 per year. This is certainly a step forward. But the income standard in H.R. 1 would still leave millions of elderly persons in poverty. For these reasons, I urge the Senate to raise the threshold in H.R. 1 to an amount which would wipe out poverty once and for all. Moreover, I recommend that there be cost-of-living adjustments to make this standard inflation-proof for low-income older Americans in the future.

Important as a realistic income strategy is, we must not overlook the need for further improvements in Medicare through H.R. 1. For many older Americans, the single greatest threat to their economic security is the high cost of illness. Gaps still exist in Medicare, causing a further drain upon their limited pocketbooks.

Two vital reforms, in my judgment, are needed: (1) the elimination of the premium charge for doctor's insurance, and (2) coverage of out-of-hospital prescription drugs under Medicare. These measures were strongly supported by the 1971 Social Security Advisory Council, as well as the delegates at the White House Conference on Aging. Now, I believe, is the time to extend this essential protection to the elderly.

Other changes are also necessary to improve the health care provisions in H.R. 1. Since other members of the committee will focus on these measures, I shall concentrate on two provisions which may seriously cut back the availability of health care to the elderly:

The increase in the deductible for doctor's insurance from $50 to $60; and

The $7.50 copayment charge for Medicare patients for each day in the hospital from the 31st to the 60th day.

The copayment charge, alone, could add $225 to the hospital bill of an older American. Ironically, this provision is likely to fall most heavily upon the very person Medicare is supposed to help the most—the individual who may be exposed to costly health care expenditures because of a prolonged period in the hospital.

These increased levies, I believe, should either be striken or substantially reduced by the Senate.

Another area for early action during this session is the establishment of a strong Federal spokesman to represent the elderly in the highest councils of Government. Recent reorganization moves during the past 5 years have raised very serious questions about the capability of the Administration on Aging to serve as an effective advocate for older Americans. Today, AoA is a weak agency with very little authority. Its program responsibility has been reduced by two-thirds during the past 2 years.

In short, we need a new, strong, and coordinated apparatus to serve as a cornerstone for a cohesive and comprehensive Federal approach on aging.

Within a few days, I shall introduce legislation to implement this objective. Basically, the bill will be patterned after the recommendations of the Committee's Advisory Council on the AoA or a successor. Their proposal—later adopted at the White House Conference on Aging—called for:

Establishment of an independent office on aging at the White House level to formulate policy and monitor programs on aging;

Creation of an advisory council to assist this office and to prepare an annual report on the progress made in resolving the problems of older Americans; and

Elevation of the AoA by placing it under the direction of an Assistant Secretary on Aging in HEW.

Enactment of this measure, I believe, can provide the operating governmetal framework for developing coordinated policies on behalf of aging Americans. And early action on this proposal becomes imperative, because June 30 is the deadline for extending the Older Americans Act.

Equally important, Congress should act promptly to enchance employment and service opportunities for aging Americans. With unemployment continuing to mount, mature workers are finding that they are among the first to be fired, but the last to be hired. Many now stand in need of a flexible manpower program which is responsive to their needs. Large numbers are jobless because their skills have been outdistanced by technology or because they are seeking the work of a bygone era.

For these reasons, I urge the administration to reassess its opposition to the Middle-Aged and Older Workers Employment Act. For thousands of unemployed or underemployed workers 45 and over, this measure could provide the training, counseling and other supportive services to enable them to move back onto the payrolls or to more productive work. It also authorizes placement and recruitment services in communities where there is large scale joblessness because of a plant shutdown or other permanent reduction in the work force.

Another area meriting early attention is broadened service opportunities for older persons. Several Mainstream pilot projects have amply demonstrated that there are thousands of older Americans who are ready and able to serve in their communities. We do not need any more proof that these programs will work. What is needed now is a genuine national commitment to build upon the solid achievements of these projects. And enactment of the Older American Community Service Employment Act, S. 555, can provide a basis for converting these projects into permanent, ongoing national programs.

Housing

Far-reaching action in the housing field is also essential if we are to assure a full and satisfying life for the elderly. We must begin at once to eliminate the conditions which force many older Americans to live in inferior and unsuitable homes simply because thye cannot find or afford better housing. The Chairman of the Subcommittee on Housing for the Elderly (Mr. Williams), will discuss in greater detail the committee's recommendations for improving housing programs for the aged; and my remarks will be brief.

Basically, I have two points to make. First, legislation should be considered during this Congress to make home repair services available for elderly homeowners who would otherwise have difficulty paying for these costs. Many urban and rural neighborhoods are deteriorating because essential home repairs must be delayed for several reasons—limited income, failing health, or the lack of necessary skills to perform the fix-up work. But these blighted neighborhoods can be renovated with the establishment of a national home repairs program, utilizing the skills of older persons to assist aged homeowners.

Second, the administration should, I believe, spell out more clearly its housing goals for older Americans. This should be done early to enable appropriate congressional units to act on administration proposals during this session. In this fashion, a comprehensive housing package—combining the best features of congressional and administration initiatives—could be developed.

Concluding my list of suggestions for early action is a proposal that legislation should be enacted early this year to authorize mini-White House Conferences on Aging every 2 years. These periodic conferences would permit more intensive review, one at a time, of specific issues raised at the 1971 Conference—such as retirement income, health, housing, and others. Equally significant, this would establish a continuing mechanism for developing and implementing the policy recommendations of the 1971 Conference. It would also provide vital followup work to assure that the proposals outlined by the 3,400 delegates lead to concrete action, instead of more words. This concept, I am pleased to say, has been enthusiastically endorsed in the report of the 1971 White House Conference. In the very near future, I shall introduce legislation to implement this proposal.

What More Must Be Done: The Long Run

My earlier remarks have been directed essentially at action that can and should be taken now to meet immediate challenges. But the development and implementation of a national policy on aging would be incomplete without also establishing long-range goals and direction.

As chairman of the Senate Committee on Aging, I believe that the committee can play an important role in focusing on crucial issues with far-reaching and long-term implications for the aged of today and tomorrow. For example, the allocation of work and income is still a major unresolved problem in our country today. Instead of the "all or nothing" principle—100 percent full-time employment during the adult years and then complete inactivity during the retirement years—new work lifetime patterns must be considered. Greater ex-

perimentation, for instance, with phased retirement, trial retirement and sabbaticals will be essential, particularly if the trends toward shorter workweeks and longer periods of leisure time continue.

The resolution of this crucial problem has a far-reaching impact for all age groups. This point cannot be understated because more than seven out of every 10 children born today can expect to reach age 65. And they can expect to spend longer periods in retirement—perhaps a third of their entire lives.

But how will these retirees make use of their new free time? Will it lead to fulfillment and enjoyment, or just boredom and frustration? All age groups, now and in the future, have a very deep interest in these fundamental issues.

Another major question requiring immediate attention is the crushing burden of the property tax upon the aged homeowner. Many now find themselves financially paralyzed because their property taxes have doubled, or even tripled, during the past 10 years. In 1970, property taxes hit an all-time high of $37.5 billion, nearly 35 percent higher than in 1967. This tax, moreover, frequently takes a much greater chunk out of an elderly homeowner's limited budget because it is regressive in the extreme. Renters also feel the pinch since landlords usually shift this burden to the tenant.

Several potentially helpful measures—such as the proposal sponsored by the Senator from Missouri (Mr. Eagleton) to provide a credit for low- and moderate-income homeowners and renters who are 65 and older—have been introduced during this Congress, and can provide welcome relief. But in view of recent State supreme court decisions, other alternatives may have to be considered for the financing of our elementary and secondary schools. For these reasons, the Committee on Aging will focus on several issues of vital concern to aged property owners and tenants, such as:

> If a substitute for the property tax is developed, what type of an impact will it have on the aged? Will it provide substantial relief for the elderly homeowner or tenant? Will it protect them from extraordinary burdens?
>
> If the property tax is still retained, what would be the most effective method for providing relief for aged homeowners and tenants? Should it take the form of a Federal tax credit or rebate for individuals confronted with extraordinary burdens? Should Federal assistance be made available to States which provide such relief? Or, should other alternatives be developed?

Additionally, the committee will work with senior citizen organizations, educators, and others in the development of an effective system for the delivery of social and health services. The necessity for coordinating social and health services is now widely talked about, but it is still rarely practiced. But the much-sought goal—to assist aged persons to live independently, instead of being institutionalized—will not really be resolved until that principle is widely applied.

Another key concern is to find ways to involve the elderly more in programs meant to serve them. They must have a role, a voice, and an input in the decisionmaking process. One possibility is that our national policy should encourage the development of what might be called Community Councils of Older Americans. Elderly council

members could work with governmental and private agencies to make programs more responsive to the special needs of the elderly. Eventually, as in the case of the Council of Elders in Boston, these units could incorporate and become contracting agents for such programs.

Establishment of these community councils can also enable the elderly more and more, to manage the programs which are now meant to serve them. There are many experts and professionals in the field of aging. But there is really no expert like the elderly person who has lived and experienced the very problems we are attempting to resolve.

Need for Early and Bipartisan Action

1972, it seems to me, can be a year in which we break away from false, fixed notions about aged and aging Americans. It can be a year in which we take advantage of the momentum of the White House Conference to make certain that its goals are implemented.

As we move toward these goals, we must also remember that the field of aging will be the big loser if the politics of expediency is practiced for narrow, partisan advantage. The elderly need the cooperation of Republicans, Democrats, and Independents alike. The administration and Congress must also work together if we really intend to solve their problems, rather than debate them.

Today, there are more than 20 million Americans who are 65 or older, about 1 out of every 10 Americans. The elderly's combined numbers are nearly equivalent to the total population in 20 of our States.

Equally important, each year 1.4 million Americans have their 65th birthday. And by the year 2000, approximately 45 million individuals will have become newcomers to this age group.

Today our Nation has a unique opportunity to make advancing age a time of fulfillment, instead of neglect and despair. Perhaps even more significant there is already broad agreement on many crucial policy goals and the course of action our Nation should take now and in the future. In many respects the report of the White House Conference is a ringing reaffirmation of recommendations advanced by the Committee on Aging and its advisory councils. With this broad base for support, our Nation can begin to develop, for the first time in its history, a comprehensive, workable national policy for the elderly American.

AGING IN AMERICA—9 WEEKS AFTER WHITE HOUSE CONFERENCE

Mr. Fong. It is now 9 weeks since completion of deliberation at the 1971 White House Conference on Aging called by President Nixon.

Nine weeks is a very short period, but it is appropriate that the Senate take a look now at where we stand and make a preliminary evaluation of what may be expected to follow the Nixon Conference on Aging.

Such assessment must be made on the basis of rather clear priorities which were reaffirmed by more than 3,500 delegates who came from all over the Nation to make recommendations for a sound national policy for older Americans.

Despite great diversity of experience and interests among the more than 20 million older Americans it is perfectly clear that our obliga-

tion to all of them demands that we respond effectively to their primary needs for economic and social independence, that we expand opportunities for involvement in community and national life, and that we change society's attitudes which now so often isolate them from America's mainstream.

Minimum Goals for Older Americans

In practical terms this calls for minimum national commitments which will:

1. Assure all older Americans of an income sufficient to avoid the deprivation and degradation of poverty;
2. Protect the income of older persons from the ravages of unbridled inflation;
3. Remove ceilings on their share of America's great bounty, including that which they may earn during their later years.
4. Guarantee all Americans that their own efforts to achieve adequate and decent retirement incomes through private pension plans, and similar savings programs, shall be protected throughout their lives and that there be no denial of earned benefits through caprice or change in employment.
5. Expand opportunities for older men and women to make continuing contributions to America either through employment or volunteer service activities.
6. Assure older Americans of safety of person as fully as possible—through development and implementation of more effective police protection, better safety standards in institutions where the elderly may be housed, and vigorous efforts against any and all threats to their safety.
7. Increase availability of necessary services—at costs within reach of retirees—including (a) comprehensive health care, (b) decent housing, (c) adequate nutritional services, (d) readily accessible transportation, and (e) worthwhile recreational and educational programs to broaden personal horizons, combat loneliness, and enrich the quality of life.

President Nixon recognizes the necessity of meeting these commitments. Certainly all members of the Senate Special Committee on Aging will do what they can to support the President in efforts he has already begun or will initiate in the future toward their achievement. Such support may be expected whether steps taken are through presidential executive action or require additional legislation.

The magnitude of the task before us—and the task is a big one—should not deter us from addressing it as quickly and fully as possible.

No realist questions that our goals, and those of the White House Conference, will take time. No one expects this massive job to be done over-night or even this year.

My contacts with older persons persuade me that older Americans understand this. But they have already been patient a long time. They should not be expected to continue acceptance of what for too many years was too often a counterfeit concern for their needs—counterfeit concern which paid lipservice, which raised unreasonable hopes, and which then dashed them to the ground because the promises were not capable of delivery.

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Action in Weeks Ahead

An end to counterfeit concern, and a beginning of valid responses to the plea of older Americans is, in my judgment, at hand. In truth, I believe that such a beginning is well underway through actions taken during the past 2 or 3 years and additional progress which may be instituted within weeks.

This is reinforced by testimony by Presidential Consultant on Aging Arthur Flemming and Commissioner on Aging John Martin at our committee hearing last Thursday which related to White House Conference follow-up.

Within weeks, the President will deliver a message on aging. It will at least address itself to the most pressing needs of older persons.

Within weeks final passage of H.R. 1, the Social Security amendments now before the Finance Committee, should bring realization of several earlier major recommendations by President Nixon on behalf of older persons.

Key 1972 Social Security Improvements

Noteworthy in this bill is provision for automatic cost-of-living adjustments in Social Security benefits. I take pride in the fact that the proposal originally introduced by Senator Jack Miller was first given serious support by Republican members of the Senate Special Committee on Aging and by President Nixon. We are pleased with the bipartisan endorsement which has since evolved for this important measure to protect Social Security benefits against inflation.

H.R. 1 will offer other badly needed improvements in Social Security. Included will be (*a*) general benefit increases, (*b*) provision of 100 percent benefits to older widows, (*c*) liberalization of the earnings test, and (*d*) more realistic and fair minimum benefits for workers with many years of covered employment.

The latter proposal—involving a new concept in minimum benefits for those long in the work force—is extremely important. Too little attention has been paid to it and what it will do for lower income workers.

In simplest terms, this change will assure Social Security beneficiaries who have 30 years coverage a minimum benefit of $1,800 a year at age 65. For the insured worker and spouse the minimum would be $2,700 a year.

President Nixon's Income Assurance Plan

Even more important for today's retirees with low incomes—and there are far too many—is the provision in H.R. 1 for a beginning of President Nixon's Older Americans Income Assurance recommendation.

It changes Old Age Assistance provisions of the Social Security Act so as to offer income supplements which would bring every person 65 and over up to a national income standard regardless of whether they have regular Social Security benefits or not.

This Older Americans Income Assurance plan, urged last year by President Nixon, is the most far-reaching legislative proposal to take

the elderly out of poverty sent to the Congress in over 30 years by any President.

Probable adoption of this amendment is especially pleasing to me because the concept was first offered as legislation by my predecessor as ranking Republican member of the Committee on Aging, the late Senator Winston L. Prouty of Vermont, and because it has long been urged by Republican members of the special committee.

Like the proposed new approach to minimum regular Social Security benefits, the President's income assurance plan, and details of its operation, have received too little attention in the new media. In consequence it is little understood by older Americans.

Most importantly it will be a long step toward meeting income problems of single and widowed older women and other persons who had little or no chance to qualify for Social Security. Among the latter are countless retired public employees—whose contribution to America has been second to none—such as policemen, firemen, and teachers.

I do not believe the payment levels under income assurance provisions of H.R. 1 are quite high enough. I am sure President Nixon shares my belief. But adoption of this proposal will be a dramatic and far-reaching stride toward eliminating poverty amoung the elderly.

Initially the Federal income standard would be $130 monthly per individual and $195 per couple. In 1974 it would rise to $150 and $200. This, of course, is as passed by the House and may be amended in the Senate.

The manner of qualification for individual income supplement deserves special emphasis.

Certification and administration will be by the Social Security Administration, not by welfare officers.

A person whose income from other sources falls below the Federal standard may go to his or her Social Security office to make application and that office will process it.

Recipients will be treated with dignity due a person to whom America owes a great debt.

My emphasis on H.R. 1 in these remarks should not be interpreted as suggesting that I believe this one bill is either the beginning or end. I emphasize it only because of its immediate importance and time limitations on me today.

A Major Movement Is Underway

The truth is: America, and particularly the national Government, under leadership of President Nixon, is engaged now in a major movement to improve the lot of older Americans.

Other aspects of America's dynamic involvement in creation of a new, realistic, compassionate and understand policy toward the elderly will certainly be covered by other Senators in this morning's colloquy.

The 1971 White House Conference on Aging still lives.

Under instructions from President Nixon, the Honorable Arthur Flemming, distinguished Chairman of the Conference, and the administration's whole apparatus in aging is vigorously at work promoting continued involvement of older persons themselves in conference objectives.

It was quite evident from Dr. Flemming's testimony before our committee Thursday that there is a real commitment to action. Other Senators this morning will undoubtedly comment on this in greater detail than my time permits.

The President's Cabinet Level Committee

That the highest levels of the administration are involved is manifest by the President's appointment of a Committee on Aging in his Domestic Council under Chairmanship of HEW Secretary Elliott Richardson. Participation as members of this committee by other members of the President's Cabinet assures a level of coordination of Federal activities in aging on a scale totally new in Government.

The President's personal concern is also shown by this appointment of Dr. Flemming as Presidential Consultant in Aging on a continuing basis. This concern unquestionably will be reaffirmed in the President's forthcoming message.

Progress in Past 3 Years

While we look to the future—and much remains to be done—it would be a great error to ignore progress made in the past 3 years. This Government has not been idle.

My time allows me only to mention a few examples. Other Senators will certainly, in the course of this colloquy, elaborate upon them and add others.

When we have passed H.R. 1, we will have increased Social Security benefits by over one-third in this short period.

President Nixon's price control program is striking vigorously at the terrible toll of rampant inflation which hits so hard at retirees.

The President's initiatives for improving care and standards in nursing homes will greatly help the quality of life for the elderly least able to care for themselves.

Increasing money for the Administration on Aging by fivefold will permit major expansions in services for older persons.

Growth in opportunities to older Americans for new involvement in life's mainstream are provided through increased funding of numerous programs including RSVP, the Retired Senior Volunteers program, the Foster Grandparents program and others.

Momentum Must be Accelerated

To these ongoing items of encouragement to older Americans must be added the President's proposals for elimination of premium payments for part B of Medicare, and new legislation on private pension programs to assure that they provide maximum benefits to participants.

America is on the move in the field of aging.

Let us resolve that we will all do what we can to maintain and accelerate momentum generated by the President and the White House Conference.

Older Americans deserve the best that we can offer: Income adequacy, independence, full availability of necessary services and facilities; and opportunities for involvement in family, community, and national life.

AN EMPLOYMENT POLICY FOR OLDER WORKERS

Mr. RANDOLPH. Mr. President, the recent White House Conference on Aging represented a notable achievement, not just for 20 million Americans now past 65 but for all Americans.

It brought together 3,400 delegates from every State in the Union and from all walks of life to deal with the everyday realities facing the elderly. It provided a forum to consider a broad spectrum of issues—ranging from income, health, and transportation to long-term care, the special problems of minorities, and the rural aged. It even included a special session on Aging and Blindness, at which I had the privilege to speak. And the relationship between being old and blind cannot be understated. Nearly half of all new cases of blindness will occur among persons 65 and older.

Equally important, the Conference provided an opportunity for a good, honest exchange of ideas. It was also a time to challenge many notions about aging, to take stock of existing programs, and to consider what future direction our policies should take.

That process was initiated more than 1 year ago when 6,000 community forums were held throughout the Nation. There, the elderly and others laid the groundwork for much of the discussion and policy proposals at the national Conference. At these "speak out" sessions, older Americans discussed their problems fully and frankly. They told us in down-to-earth language what it means to be old, what it means to be poor, and what it means to be neglected after working most of their lives to make our Nation as great as it is today.

Even more important, the White House Conference developed an action plan with well-defined goals to make the later years a time to look forward to, rather than to fear or regret. And that is a major reason I have joined the Chairman of the Senate Committee on Aging (Mr. Church) in this colloquy on the State of the Aging.

As Chairman of the Subcommittee on Employment and Retirement Incomes for the Committee on Aging, I will direct my remarks primarily at issues and policies concerning job and service opportunities for the so-called older worker.

THE CRITICAL YEARS

Many key indicators now strongly suggest that the critical years in the work lives of adults occur during the middle 40's or early 50's. This is the time when large numbers of mature workers may find themselves in an impossible situation—they are too old to hire but too young to retire. Yet, this is precisely when their responsibilities are growing. At this point, the older worker is typically paying out on his car, home, furniture, or schooling for his children. And the loss of a job can create a double dilemma, not only in terms of his immediate responsibilities but also his economic situation 10 or 20 years from now—when his anticipated retirement benefits will be reduced markedly.

Along about age 40 or 45, unemployment begins to increase. Once unemployed, the older worker runs a greater risk of being without a job for a longer period of time. For unemployed persons 45 or older, the average period of being without work is about 16 weeks. This

is nearly 35-percent longer than the national average. Today about one of every three unemployed persons 45 and older—in contrast to one in five for younger individuals—has been searching for work for 15 weeks or longer.

Another very serious and growing problem is age discrimination in employment, even though legislation was passed more than 4 years ago to outlaw such practices. With unemployment continuing to mount during recent months, the pressures for forced or early retirement have been intensified. Now large numbers of older workers are finding themselves involuntarily retired because of subtle forms, and in some cases overt acts, of age bias.

In addition, many employed older workers find themselves in "dead-end" type jobs with no chance for advancement. As a consequence, large numbers are now underemployed.

Despite the very severe problems confronting mature workers, our Nation lacks an effective and coordinated manpower policy to maximize their employability. By whatever barometer one would choose to use, they have been largely ignored or overlooked in our work and training programs. Last year, persons 45 and older represented only 3.7 percent of all enrollees in our manpower programs. Yet, their proportion of the total unemployment, long-term joblessness, and the civilian labor force is at a level 6 to 10 times above their participation rate in existing work and training programs.

1971: Highest Unemployment in 10 Years

Before discussing what concrete steps can be taken to increase employment and service opportunities for older workers, a few comments about our unemployment situation would be appropriate.

Last year we were informed by high level administration officials that 1971 would be a "good" year. Yet, the evidence at the end of the year leads to only one conclusion: 1971 was a disastrous year for all workers, and especially for older jobholders.

It was a year in which the jobless rate hovered at 6 percent. It was a year in which unemployment was at or near the 5 million mark. And it represented the highest unemployment in 10 years.

Unfortunately, those disconcerting facts do not stop here. Unemployment compensation payments, for example, reached an all time high of $4.8 billion, nearly 73 percent higher than during fiscal 1970. The number of major labor market areas with substantial unemployment grew to 54, a ninefold increase when compared with January 1969.

During this same period, joblessness has jumped sharply from 2.7 million to 5.1 million, for an astounding 89-percent increase. Today more than 1.2 million workers have been unemployed for 15 weeks or longer, and 600,000 have been searching for more than 6 months.

Middle aged and older workers—individuals 45 and older—have also felt the crushing effects of our widespread joblessness. Nearly 400,000 were added to the unemployment rolls during the past 3 years, representing a 67-percent increase since January 1969. Today 1 million mature workers are looking for work.

Yet, these figures—depressing as they are—reflect only a portion of the overall dismal jobs situation for mature workers. They do not, for example, include the labor force "dropouts," those who have given up the active search for work. Today, there are nearly 2.5 million men in the 45 to 64 age category who have withdrawn from the work force, oftentimes involuntarily. Assuming that just 25 percent of these individuals wanted and needed jobs—and this is probably a very conservative estimate—there would be another 625,000 middle aged and older men added to the unemployment rolls. And this does not even include the many women in this age bracket who have also dropped out of the labor force.

A classic example of the high level of hidden unemployment in the United States was revealed in a recent Federal study right here in Washington, D.C. Under the standard method of calculating joblessness, the unemployment rate was 4.8 percent. However, if the "dropouts" were also added to this figure, the level would soar to about 13 percent.

However, even those lucky enough to have jobs are feeling the economic squeeze in other ways. Many older workers are now being asked to accept pay cuts, and in some cases rather steep reductions, only as an alternative to becoming unemployed. Yet, their household and family responsibilities continue to grow. Moreover, many workers in their 40's and 50's are reaching a plateau in their capacity to increase their earnings by occupational advancement or promotion.

The net impact of these trends is that we may now be witnessing the emergence of a new class of elderly poor including:

Persons in their late 50's or early 60's who are now being eased out of the job market;

Individuals who take actuarially reduced Social Security benefits only as an alternative to sporadic work patterns prior to retirement; and

Workers who have just given up after prolonged periods of fruitless search for employment.

The latest poverty statistics provide additional evidence to support this ominous warning. From 1969 to 1970, for example, there was a 100,000 increase in poverty for persons aged 55 to 64, from 2 million to 2.1 million. In addition, another 100,000 persons 65 and older were added to the poverty rolls during this same period.

These trends, however, are not inevitable. They can be reversed because our Nation certainly has the ingenuity and capability to resolve these pressing employment problems.

What is needed now is a joint effort by the administration and Congress to translate the far reaching goals of the White House Conference into action programs for mature workers.

Employment for Older Persons

One of the cornerstones of any national employment and training program for older persons must be based upon this very fundamental principle: Our policies must be sufficiently flexible and responsive to meet the many and varied needs of mature workers. A different ap-

proach or thrust, for example, may be necessary for varying age groups.

Most older Americans, and especially senior citizens, prefer to have meaningful choices depending upon their desires, capabilities, and needs. At a very minimum, these basic alternatives should be available:

To work or retire;
To work part time or full time; or
To work for pay or as a volunteer.

Unfortunately, many elderly persons do not have these choices today. Increasingly our Nation seems to regard earlier and earlier retirement as inevitable, and perhaps even desirable. During the past 30 years, for instance, labor force participation for men 65 and older has declined from 42 to 27 percent.

But instead of forcing retirement at an earlier or arbitrary age, we should attempt to offer aged persons greater freedom of choice. One such option is service by the elderly in their communities. Today a growing need exists for the development of a national service corps. Many communities are practically crumbling at the core because they are unable to provide vital public services for their citizens. And one of the largest untapped sources of talent today is the older worker.

A major advantage of community service employment, in my judgment, is that it can be tailored to the special needs of the elderly participants. Equally, important, it can provide a dignified means for older Americans to help themselves by helping others.

Establishment of a national senior service corps is long overdue because there is so much that needs to be done in our country: in hospitals, community beautification, schools, libraries, conservation of our natural resources, antipollution programs, and a whole host of other areas. We have several prototypes under mainstream which show beyond any doubt that these programs work. Now we need to go beyond the demonstration stage to a new national program which utilizes the talent and experience of older Americans. And the Older American Community Service Employment Act, which would provide new service opportunities for persons 55 and older, would be a major step forward in making this goal a reality. For these reasons, I urge early and favorable action on this measure, a bill which already has strong bipartisan support in the Congress.

Today many crucial services are not provided simply because of manpower shortages and the absence of adequate facilities. One striking example is in the field of day care.

It is now estimated that there will be a need for perhaps 500,000 additional day care workers during the next 10 years—particularly if more and more women continue to enter the work force. Older persons, I strongly believe, can provide a valuable source of talent for providing these services. Several programs, such as Foster Grandparents, have clearly demonstrated the natural empathy between the elderly and young children.

In acting on day care legislation during this session, serious consideration should be given to adopting a provision to encourage the employment of older persons in these programs. For elderly individuals, this could provide an effective means to supplement their retirement income. Equally important, the young children in our Nation would be provided quality and personal care.

These same reasons would also be applicable for expanding the Foster Grandparent program, which enables elderly persons to render supportive services for neglected, retarded or disadvantaged children. Once again, I urge that this successful program be fully funded. Additionally, I urge that the concept of the Foster Grandparent be broadened to include services to homebound older Americans.

Today, many older Americans believe that retirement will shut them off from any meaningful participation in their communities. Quite frequently, this can lead to medical or psychological problems which purposeful activity might have avoided.

For many of these individuals, serving as a volunteer in their localities can be a time for fulfillment in allowing them to remain active during their later years. Many of these individuals have lived vigorous lives. And there is absolutely no reason for them to retire from life simply because they retire from their jobs. They have marketable skills, and can still make valuable contributions in a wide range of activities, including: rendering services in hospitals or nursng homes; tutorng young children; assisting schools as playground monitors or teachers aides; and many others.

One of the most potentially effective volunteer programs for older persons is RSVP, the retired senior volunteer program. For the coming fiscal year, I urge that RSVP be fully funded to provide more opportunities for other Americans to render services in their communities.

Employment for Those Not "Retirable"

A comprehensive employment program for mature workers must also take into account the special needs of those who are not retirable, particularly individuals in their 40's and 50's. There are now about 42 million persons who are in the 45- to 64-age category. Yet, our Nation still lacks an effective and comprehensive policy to increase their opportunities for employment.

Lack of job opportunities for mature workers constitutes a tragedy not only for them and their families, but also for our Nation. No economy can reach its maximum productive capacity when some of its most experienced, talented, and skillful players are sitting on the sidelines. In the same manner that any successful operation needs the blend of seasoned veterans and fresh new talent, so does our work force.

Much more can be gained, I firmly believe, through a national effort to establish a comprehensive program to provide training and other services to enable mature workers to compete in our technologically advanced society. And my Middle-Aged and Older Workers Employment Act can be an important step forward in achieving this goal. Already 18 members of the Senate have joined me in sponsoring this legislation, which can provide the training and other essential supportive services to enable unemployed or underemployed inviduals to move into new and better paying jobs.

Increasingly, it is becoming apparent that many older workers are without jobs because of circumstances beyond their control:

Their skills have been rendered obsolete by technological advances;

They lack the necessary training to move onto gainful employment; and

Massive layoffs have contributed to the widespread unemployment throughout the Nation.

Many of these individuals can, however, become productive citizens again with a flexible and coordinated manpower program which is responsive to their special needs.

The Middle-Aged and Older Workers Employment Act, I strongly believe represents a sensible and effective effort for meeting the unique and growing employment problems confronting older persons. There has long been a need for this approach, and I urge early enactment of this legislation.

Equally significant, we must not overlook legislation which has already been enacted into law. In many cases, these measures can also help to remove the barriers to job opportunities for older workers.

One significant example is the Age Discrimination in Employment Act, which was approved with bipartisan support in 1967. However, much more is needed than the passage of legislation. Effective enforcement and proper funding are also crucial. In fact, the implementation stage usually determines, to a very substantial degree, the success or failure of hard-won legislative victories.

Most candid authorities acknowledge that job discrimination on the basis of age is still a real problem today. This conclusion has been documented time and time again at hearings I have conducted as chairman of the Subcommittee on Employment and Retirement Income. Most recently, this was brought to the attention of the subcommittee during its hearing in Miami on the subject of "Unemployment Among Older Workers."

Unfortunately enforcement of the age discrimination law has been carried out in a very timid manner by the Department of Labor. The first suit was not filed until late in 1969. And only a small number of court proceedings have been instituted since that time. Moreover, enforcement of the law is the responsibility of the Wage and Hour and Public Contracts Divisions. However, these units also oversee the Fair Labor Standards Act, the Walsh-Healey Public Contracts Act, the Davis-Bacon Act, and several other related statutes. But, less than 10 percent of their time is allocated to age discrimination activities.

Since insufficient time is being devoted for enforcement of the act, it is no wonder that the age discrimination law is being thwarted. Quite clearly, the Wage and Hour and Public Contracts Divisions need to be beefed up to strengthen the enforcement of the act. For these reasons, I urge that the Congress approve full funding to hire additional personnel to enforce the law fully and effectively. Additionally, I recommend that these new individuals be assigned on a full time basis to implement the act.

Today, many older persons are still being deprived of an opportunity to carry on their livelihood because of advancing age. But a job should not be off limits simply because a man's hair is "greying" a little bit at the temples. And, its high time that we launched a systematic and forceful effort to eliminate employment bias solely because of age.

A Program for the 1970's

For far too long a time, our Nation has lacked comprehensive and coordinated policies to maximize employment and service opportunities

for older workers. With unemployment continuing to remain at a persistently high level, many middle-aged and older persons will need further training to prepare them for technological changes in our society as well as new opportunities for public service jobs.

My policy proposals, I believe, represent a sound and sensible effort to launch a long-awaited national employment policy for older workers.

The benefits of this undertaking await us all level.

For many unemployed workers today, a job can provide a financial passport for independence and self-respect.

The worker's family will also benefit because a regular paycheck can mean a richer and fuller life.

And our Nation will benefit when persons on the welfare or unemployment rolls move back on to the payrolls and become taxpayers.

STATE OF THE AGING MESSAGE

Mr. Moss. Mr. President, I am joining the members of the Senate Special Committee on Aging this morning as we present our state of aging message.

I am going to speak briefly on the subject of nursing homes. In this regard, I find myself in a rather unique position, for it is within this area that the administration has made its one major effort to help older Americans.

There seems to be little doubt that before June of last year when the disintegration of plans for the White House Conference caused the appointment of Dr. Arthur Flemming, the administration had a poor record on the subject of aging. I was moved to comment in 1969 that apparently aging ranked in Mr. Nixon's priorities just above raising funds for the Democratic National Committee. Few of us will ever forget the statements by Robert Finch, then Secretary of HEW, and other spokesmen who announced a shifting of policies from caring for the aged to caring for the young.

But with Dr. Flemming's help the White House Conference must be counted a success. The delegates met their responsibilities admirably and issued a mandate to the Congress and the Executive. We ask the question today whether the administration will lead the way to improvement and whether we in the Congress can expect cooperation. We certainly hope for cooperation.

My subject today is nursing homes principally because I have been chairman of the committee's Subcommitteee on Long-Term Care for the last 7 years.

This subcommittee has conducted numerous hearings, including some 19 in our current series which began in July 1969. These hearings have led to legislation, in fact, to the very legislation on which the Department of Health, Education, and Welfare is relying for its recent enforcement efforts.

While my first concern has always been America's most underrepresented and declassed minority, the 1 million who suffer the compound burdens of illness and advanced age, I would join my colleagues as they highlight other issues.

Perhaps 16 million out of our 20 million elderly need more substantial income.

Medicare still only covers 47 percent of their health costs with premiums and deductibles rising continuously.

Some 6 million live in substandard housing.

Escalating real estate taxes rip into fixed retirement incomes are to the point of becoming confiscatory in many of our States.

We must come to grips with these important problems this year. Left neglected they will only return in amplified form an unwelcome legacy for the future.

With the same urgency, Mr. President, we must attack the problems of some of our nursing homes where unsanitary conditions, poor food, lack of dental care, theft, lack of adequate controls on drugs, and negligence leading to death and injury are the order of the day.

More and more these conditions are being brought to public attention. Individuals and groups from levels all of society have protested these abuses.

We have encountered some resistance; some nursing home associations have sought to prove that abuses are few if not nonexistent. But others such as the American Nursing Home Association have been more positive. They admit the great problems and stress the reasons for them are inherent in our society. If only a fraction of the evidence we have received is valid then we have a serious problem.

President Nixon took notice of these conditions in a June speech before the American Association of Retired Persons. He promised the Secretary of HEW would announce proposals in implementation of his pledge to eliminate substandard homes. The Secretary did announce an 8-point plan, the progress of which my subcommittee has been monitoring. At the same time the President promised that nursing homes would receive special attention at the White House Conference on Aging.

On this last point we can be positive. Nursing home problems received anything but special attention at the White House Conference. There was but one special concerns session on long-term care and that was as an afterthought.

As far as the President's 8-point plan is concerned, it is still too early to judge but I was genuinely impressed by the testimony of Under Secretary John Veneman whose assurances were most welcomed.

On the whole, however, this 8-point package is strictly enforcement. It calls for the training of 2,000 State inspectors, the addition of 150 people in HEW enforcement, the consolidation of responsibility for enforcement in one individual as responsible, and the insistence on compliance with Federal standards or face the cut-off of Federal funds which don't comply.

Enforcement is certainly necessary. I have been asking the Department of Health, Education, and Welfare to take a vigorous role and enforce the standards that my 1967 bill wrote into law. But enforcement is only one of the five major problems in this field.

The other four upon which we need discussion are:

Lack of a Clear Policy With Regard to the Infirm Elderly

The rhetoric speaks of care and concern, but the reality is poor care, no care, or just plain neglect. We continue to follow the policy used by other societies for the ill elderly. and that is abandonment. When

families are confronted with what to do with a loved one grown old, there are currently no acceptable options available.

To deal with these root causes, I have introduced legislation providing under Medicare:

1. Up to 100 days in a nursing home for all Americans over 65. (Such care is available at present only to a narrow minority of elderly who have acute posthospital, postoperative needs.)

2. Establish outreach services, mobile health units, homemaker services, and expanded home health services which would look toward treating the elderly in their own homes.

3. Senior citizen day-care centers so working families could have the security of knowing their senior citizens had supervision by day.

4. Authorizing on an experimental basis the subsidizing of a family to take care of their elderly in their own homes.

The Absence of the Physician From the Nursing Home Setting

Almost none of our medical schools emphasize geriatrics as a specialty. Doctors, generally speaking, avoid the nursing home; they find the work unattractive and unrewarding. In nursing homes, the practice of medicine is conducted almost entirely by telephone. The committee discovered that doctors nationwide do not view bodies of patients who have died in nursing homes before signing death certificates.

As a solution to these problems, I have introduced legislation including:

1. A bill to create a National Institute of Geriatrics within the National Institutes of Health.

2. A bill to provide fellowships and categorical grants to medical schools to establish pre- and post-doctoral programs in geriatrics.

3. A bill authorizing up to $500,000 to six medical schools to establish departments of geriatrics.

4. A bill to encourage medical schools to train a new category of health professionals called "physicians' assistants" who could work with and at the direction of physicians, and ease the current medical shortage.

The Reliance on Untrained and Inadequate Personnel

There are about 1 million patients in nursing homes and about one-half million employees, or a ratio of 0.5 nurse per patient, compared to average ratios in hospitals of 2.6 nurses per patient. The bulk of nursing home employees or aides and orderlies are overworked and underpaid. It is little wonder that there is a turnover rate of 75 percent.

Legislative solution: My bill authorizing HEW to establish in-service training programs for aides and orderlies and to work out with colleges and professional organizations such as the American Nurses Association, a career ladder whereby aides with experience and educational training could progress from aides to LPN's to finally become registered nurses.

The last major problem is the lack of built-in financial incentives in favor of poor care.

Currently Medicaid payments to nursing homes typically provide a flat rate of perhaps $14 a day. This amount is immediately cut back

when the patient becomes ambulatory. The incentive is thus to keep the patient in bed. Further this $14 a day is not enough to provide the kind of care that is needed. Thus we employ a system where 80 percent of the nursing homes are for-profit institutions, and tell them that the only way that they can make money is by cutting care and services. Each individual operator can decide for himself how much to allocate to care and how much to profit. There is absolutely no accountability. If you cut back on food and nursing staff, you can make a fortune on $14 a day.

The solution that I have suggested for this problem is:

Encourage States to adopt incentive reimbursement systems such as the Connecticut points system where a nursing home, in effect, is graded and placed into classes A, B, C, et cetera. The better the nursing home in the State's estimation, the higher the rate of reimbursement. A class A home, for example, might receive $18 a day, a class B home $17 a day, et cetera.

These reforms are greatly needed and I hope we can act quickly to enact some of the bills that I have introduced. Other bills that I have introduced will plug major gaps into the existing law and provide greater tools to aid HEW in their enforcement effort. Of these S. 2924 is most significant. This bill will apply the life safety code of the National Fire Protection Association to intermediate care facilities. ICF's as they are called are currently the only category of federally assisted nursing homes which are not required to comply with this rigid fire code. It is worth noting that the last three nursing home fires that we have had, Salt Lake City in September, Honesdale, Pa. in November and Cincinnati this January have been intermediate care facilities. Most experts agree that the code should be applicable.

As a companion measure to this bill I have introduced S. 2923, to provide FHA insured loans to help nursing homes purchase fire safety equipment. If we are going to insist on higher standards then we must be willing to help pay for them.

I am suggesting that we have a long ways to go to make our nursing home system. But I should like to end on a positive note. We recently held hearings entitled "Positive Aspects in Long-Term Care."

At these hearings I was genuinely impressed by the impressive and innovative programs which function so well in some of our nursing homes. The proposals ran the gamut from unit-dose drug systems to bringing some efficiency into the nursing homes dispensing of drugs to a unique program to train nursing staffs.

Marshall Horsman of the Beaumont Convalescent Center in Beaumont, Calif., talked about his implementation of a plan of "sensitivity training" for his staff. Each member of the staff must play the role of a patient for a full 24 hours. The experience of being totally disabled and dependent on the staff for food and comforts is very helpful in causing the staff to see things through the eye of the patient and results in better care, contends Mr. Horsman.

These are hopeful signs, and I am sure most of us who have been in this field for some time will agree that conditions in our nursing homes have greatly improved in the last few years. I am sure that we can expect further improvement in the near future. Working together, all of us, the Government, the provider, and the employees of nursing

homes can, I am sure, hasten the day when going into a nursing home will not be looked upon as the first step of an inevitable slide into oblivion.

A FEDERAL ADVOCATE FOR OLDER AMERICANS

Mr. EAGLETON. One of the hallmarks of a civilized society is the degree to which that society esteems, and provides for its older members. If this Nation is to become truly civilized in this respect, there are responsibilities that must be met by all of the public and private institutions through which society operates—responsibilities that clearly are being shirked at present.

First and foremost, the Federal Government has a responsibility to guarantee an income above the poverty level for every older American and to protect that income against inflation.

Clearly, we have failed miserably in this responsibility. Today nearly 5 million older people—one out of every four—live in poverty. Fifty-one percent of all single or widowed elderly women have incomes below the poverty level.

These income problems begin even before persons reach age 65. Middle-aged and older workers, that is, those aged 45 and older, are a special case in today's troubled economy. As compared with the rest of the work force, proportionately more older workers are unemployed. They stay unemployed for longer periods of time and fewer opportunities and governmental resources are available to help them get back on the job. Since January 1969, the number of unemployed middle-aged and older workers has nearly doubled. About one out of every three unemployed persons 45 and older has been out of work for 15 weeks or longer. One out of five has been unemployed for longer than 27 weeks. Millions of others are not represented in these figures. Discouraged by their inability to obtain work, they have ceased looking for a job and have withdrawn from the work force altogether.

In many cases, loss of work today means a forfeiture of future security as well, in the form of nonvested pension benefits. The labor subcommittee of the Committee on Labor and Public Welfare, is currently conducting studies to inquire into the loss of pension benefits which so often occurs when a worker is laid off in midcareer.

We know that older workers have the accumulated skills and the strong motivation which employers claim are in short supply. They have the disciplined habits acquired through a lifetime of work. Yet, our youth-oriented society has a tendency to shunt this older group aside and to ignore the enormous resource it represents.

We also have a responsibility to make certain that our older citizens have access to adequate health care. Typically, older people have one-half the income of other Americans but their health care costs are twice as high. Today, older Americans as a group have out-of-pocket expenses for medical and hospital costs nearly equal to those for the year immediately preceding the advent of Medicare. There are a number of causes underlying this condition—greatly increased costs, more awareness of need for services and a larger number of elderly, among other things—but it serves to point up the widely felt need for an improved health service program for senior citizens.

Meeting these and other needs will require the best efforts of all of us who are seeking to improve the circumstances under which older people live in our society—circumstances which today too often make for a cruel and impoverished existence. The Committee on Labor and Public Welfare's Subcommittee on Aging, which I have the honor of chairing, has sought to meet its responsibilities to senior citizens by working for the passage of legislation that deals directly with many of their major problems.

In the last session of Congress, we were successful in having enacted S. 1163 which provides funds to the States to conduct nutrition programs for those aged 60 and over—programs that furnish meals in a group setting and, further, deliver meals to the elderly homebound. We have conducted hearings on legislation to improve the employment conditions of middle-aged and older workers by greatly expanding the modest existing program of community service employment (S. 555) and by authorizing special counseling and training programs for these workers (S. 1307). We expect to act on this legislation in ample time for floor action during the current session.

We have also conducted hearings on legislation relating to biomedical and behavioral research in aging and problems associated therewith. Legislation under consideration includes S. 887, my bill to establish a National Institute of Gerontology and S. 1925, introduced by the distinguished junior Senator from New Jersey (Mr. Williams) which would promote research in aging by establishing a comprehensive and systematic plan for such research. Additional hearings on this subject will be conducted in California under the chairmanship of the ranking majority member of our subcommittee, the very able senior Senator from California (Mr. Cranston).

In an effort to assist a part of our older population that is among the most impoverished, I have offered an amendment to H.R. 1 that would make immediately effective the minimum income provided therein in the adult assistance program, thus eliminating the 3 year phase in period contained in the House bill. Another amendment I have offered to H.R. 1 would insure that no person now receiving aid to the aged, blind, or disabled will receive a lesser amount under the new Federal program.

Beyond these concerns, the elderly face enormous problems in other areas such as housing, transportation, education, nursing homes, et cetera. It can truly be said that their needs and interests cover nearly the whole spectrum of governmental activity.

Unfortunately, there has been a dearth of the kind of leadership and coordination that is required if the various departments of the Federal Government responsible for particular areas of concern to the elderly are to function effectively. The Older Americans Act of 1965 established the Administration on Aging within the Department of Health, Education, and Welfare with the intention that it be a high level agency that could act as a focal point within the Federal Government for the interests of older Americans.

The Administration on Aging, however, has never fulfilled the high expectations held for it. Under both Democratic and Republican administrations, it has been downgraded and partially dismantled. Hearings held separately by our Subcommittee on Aging and jointly with the Special Committee on Aging have revealed an almost total lack of

confidence in the ability of the Administration on Aging, buried three levels down in HEW, to act effectievly as an advocate for the aging or as a coordinator of Federal programs for the aging.

Prior to the establishment of the Senate Special Committee on Aging, an analogous situation existed in this body. Numerous committees have jurisdiction over the problems of older Americans, each pursuing its own goals with little regard for the activities of the others. The Special Committee on Aging was created to overcome the difficulties resulting from this fragmentation of authority by focusing on the whole host of interrelated problems afflicting our senior citizens.

The record established by the Special Committee on Aging over the last decade has been magnificent. Without intruding upon the legislative authority of other committees, it has greatly influenced their work and that of government at all levels through its leadership and advocacy of the cause of older Americans.

This experience provides a striking example for the executive branch. There, too, responsibility is diffused and leadership and coordination are lacking. The expiration this June of the Older Americans Act provides us with an opportunity to revive the hope embodied in the original act when passed in 1965. It has become evident that we cannot count on a minor office buried in the vast reaches of the Department of Health, Education, and Welfare to provide the leadership that is needed.

I intend to begin hearings next month that will develop the information necessary to determine the best possible organizational structure on the Federal level for older Americans. We have the benefit already of a number of studies and reports on this subject from such groups as the President's Task Force on Aging, the Advisory Council to the Senate Special Committee on Aging, and the White House Conference on Aging. We intend to give full and serious consideration to these and all of the other proposals that will be offered at our hearings.

I particularly look forward to receiving the views of the administration with respect to legislation to succeed the Older Americans Act. In recent months, President Nixon has on several occasions stated in general terms his commitment to improving the lot of the elderly. The real test of this commitment, of course, will come in the specific programs and policies the administration proposes to achieve that end.

Unfortunately, our experience in the past has found, too often, that the word has failed to be matched by the deed as the administration has consistently opposed one after another of the programs for the elderly considered by our subcommittee. Older Americans do have many friends in Congress, as witnessed by our discussion here today. But Congress can authorize wonderful programs and they will come to nothing if those within the executive branch of the Government who set priorities, make the budgets and have the power to withhold funds appropriated by Congress do not really understand or care about the problems of senior citizens.

I hope that the President's recent statements mark a new direction in this administration's heretofore undistinguished record with respect to older Americans. If that be so, I pledge my full cooperation in the effort to enact the legislation and appropriate the funds so

desperately needed. In any case, the Subcommittee on Aging will continue its work to promote the welfare of those who have gone before us and to whom we owe so much.

HELP TO THE AGING

Mr. HANSEN. As one who has served some years on the Special Committee on Aging, and more recently on the Committee on Finance, I welcome today's review of progress in aging and reaffirmation of our hopes for full recognition of older Americans through prompt solution of the many problems which face them.

The splendid spirit of bi-partisan concern which has distinguished the Committee on Aging—with its broad responsibility to review all matters affecting the elderly—and the Finance Committee—whose role in major legislation on behalf of older Americans, including social security, is so important—is a source of great personal satisfaction to me.

As evidenced in Wyoming's White House Conference and our other activities in aging, there is no partisanship in our State on this vital question. I am confident a similar spirit prevails elsewhere. Needs of older Americans are too important to permit division. We must all work together.

It is equally gratifying to observe a new spirit of dedication to the rights, needs, and aspirations of older persons in the executive branch of the Federal Government.

INVOLVING ELDERS IN POLICY FORMULATION

Beginning with President Nixon's call, early in 1970, of the recent White House Conference on Aging, this new recognition by the executive branch and its several departments has been amply demonstrated by efforts during the past 2 years to involve our elders in decisionmaking and policy formulation on matters related to age.

This leadership, springing from the highest levels of the executive branch, encourages my belief that America is on the move in meeting the challenge in aging.

If we are to meet this challenge to improve quality of life for our elders—through satisfaction of basic physical needs, protection of social rights, and promotion of new opportunities for involvement in America's mainstream—such dedication by all parts of government at all levels is essential.

Beyond this, there must be reinforcement of congressional and presidential leadership by other elements of society in a spirit of unity which recognizes our debt to older Americans and the contributions they can still make—are eager to make—to their country.

At Wyoming's State Conference on Aging last summer, which I was privileged to attend, there was clear evidence of such a spirit.

The Wyoming meeting, one of many which preceded the White House Conference of 9 weeks ago, recognized that satisfaction of basic needs for the elderly—adequate income, access to quality medical care, improved transportation, invigorating educational and recreational

activities, and decent housing, and nutrition—is of primary importance.

No less vital, in the judgment of those at the conference, is the need for enlistment of society's total resources to assure older Americans opportunity to participate in day to day responsibilities and privileges of America's life as fully as their capabilities and desire warrant.

At the Wyoming conference it was evident that older persons have much to offer. We will short-change ourselves, and do injury to them, if we don't give them full opportunity to function as first class citizens.

Older Citizens—An Important Resource

Our older citizens are an important national resource.

President Nixon has promised action to assure older Americans new opportunities which have never existed before. This is because he firmly believes that our senior citizens are a resource we need desperately today. I share his belief and endorse his commitment.

At a time when a recovery of family life is needed more than it has ever been; at a time when there are community service tasks which go begging for want of manpower; at a time when we need to restore the perspective of the past, older persons cannot and should not be forced to sit on the sidelines as mere observers as they too often have been in recent years.

I am deeply impressed with the program President Nixon has developed to meet the needs of older Americans.

The President's Five Goals

Through his program, President Nixon shows promise of meeting five goals which must be met if we are to make fullest use of our older citizens. Through his program, the President shows promise of creating a new national attitude on aging, bringing about a new prosperity for them, helping them to regain self-sufficiency, improving health and nursing home care, and giving older Americans an opportunity to serve where, for one reason or another, they could not before.

Let's take each of these one-by-one.

Changing national attitudes will take time. It will also take leadership from many sectors of society.

White House Staff on Aging

President Nixon has already demonstrated that he will provide leadership to bring to the fore the problems and importance of our older Americans. He has established two new positions on the White House staff—the positions of Special Consultant to the President on Aging and Special Assistant to the President on Aging—held respectively by Arthur Flemming and John B. Martin. This is the first time in history that older people have had direct representation on the White House staff.

To reinforce these two officials in developing and implementing appropriate programs for older Americans, the President has established a Cabinet Committee on Aging.

He convened the second White House Conference on Aging—the first having been called by President Eisenhower.

White House Conference Followup

Testifying last Thursday at a Special Committee on Aging hearing, Dr. Arthur Flemming, the President's consultant on aging emphasized the administration's intentions to vigorously followup on work of the White House Conference. I suggest that every member of the Senate should read Dr. Flemming's testimony when it is published.

The speed with which transmission of conference section recommendations and the administration's stated intention of effective follow-through is most encouraging.

This speed, which contrasts with the languid treatment of the first White House Conference 10 years ago, suggests that a new commitment to America's elders is at hand. It is a tribute to the thousands who have worked so hard to bring a new awareness to our Nation that we must go full steam ahead.

To give sharper focus to the problems of the aged, the President included a special section on older Americans in his State of the Union message—another first.

More Than Rhetoric is Needed

Hawaii's distinguished senior Senator Hiram L. Fong has already spoken of the President's efforts to create a new prosperity for older Americans. Let me only add my conviction that he means business with them. The President knows that all the rhetoric and all the good wishes he or anybody can offer will mean nothing unless they are coupled with a serious and sincere effort to assure older Americans a fuller share of life's material resources.

It is from that knowledge that the President's efforts to help older Americans gain self-sufficiency stems.

The President has ordered the establishment of a system through which older Americans can readily gain information on all benefits for which they may be eligible; has increased the Administration on Aging budget fivefold to $100 million so that new homemaker, transportation, nutrition, and community service programs can be made available; has made housing money more readily available to older citizens so that they can purchase homes in a variety of settings, and has helped launch a major national effort to voluntary organizations which will help older Americans gain the service they desire in their homes. We can expect more action along these lines in the period ahead.

President Nixon's Health Care Initiatives

Despite Medicare and Medicaid the problem of obtaining health and nursing home care has remained critical. Many studies, articles, and documentaries have demonstrated the disgraceful treatment some of our older citizens have received in their declining years. The President has faced this problem forcefully and courageously. He instituted an 8-point program to raise nursing home standards and even went so far as to prohibit Federal funds to those that were found substandard, something no other President has ever done. This program includes:

1. Training 2,000 nursing home inspectors within 18 months.

2. Authorizing 100 percent Federal funding of State Medicaid inspections.

3. Appointing a single responsible high level official at HEW to direct improvements in nursing homes.

4. Enlarging the Federal enforcement program by adding 150 positions.

5. Establishing a program of short-term courses for health personnel who work in nursing homes.

6. Assisting the States in establishment of investigative units.

7. Undertaking a comprehensive review of long-term care.

8. Cutting off of Medicare and Medicaid funds to substandard homes.

Testimony by HEW undersecretary John G. Veneman, and Assistant Secretary Merlin K. DuVal, M.D., who has responsibility for implementing the President's nursing home initiatives, was presented to the Committee on Aging in October. It was evident then that implementation of the 8-point program is well under way.

President Nixon has asked the Congress to eliminate the $5.80 monthly Medicare fee which will give older Americans a total of $1.5 billion in new benefits. He has implemented a strong program to upgrade nursing home care. He has supported the Medical Manpower Act so that more doctors, nurses, and aides will be available to help care for all our Nation's citizens, including older Americans.

President's Pledge To Increase Opportunities

The programs I have mentioned so far are all exciting and important. But what is most exciting personally to me is the President's efforts to give older Americans an opportunity to serve where no such opportunity existed before. We have long focused on youth involvement—and involvement of our young people in public affairs and service is most important.

Young people have a dream of a fine new world. They have a desire and hope that they can play a major part in making that fine new world a reality. They should be given the opportunity to realize this dream. Older people want to help them realize these aspirations.

Certainly most older Americans have lived their lives with a primary goal of improving life for their children and grandchildren—the young of today. They have worked hard to give tools to the young for making better life a reality.

For this, as well as their many other contributions, our elders deserve our thanks and a national commitment that independence and a chance to participate is not denied them in their later years.

Older Americans, however, still have dreams which they want to achieve first hand, as persons. The right to pursue such dreams of service to their fellowman and country is as essential to their dignity as are adequate incomes and recognition of their past contributions.

President Nixon's commitment to assurance of that right is most gratifying to me.

That is why the President requested action to triple the Retired Senior Voluntary Program to $15 million; to double the Foster Grandparent Program to $25 million; and Operation Mainstream funding—to help older people find jobs—to $26 million. If these programs con-

tinue to be successful, I am assured that they will be increased even more. As for myself, I am confident that they will work and we will find in our older citizens a resource of significant magnitude.

President Nixon has said, "Old age, which should be a time of pride and fulfillment—pride and fulfillment looking back and looking forward—is too often a time of isolation and withdrawal. Rather than being a time of dignity, it is often a time of disappointment. And the growing separation of older Americans also means that we are not taking full advantage of a tremendous reservoir of skill and wisdom and moral strength that our Nation desperately needs at this moment in history."

I endorse those sentiments. I endorse also the substantive proposals President Nixon has made to back them up. I believe they should also have the full and complete support of every member of this body.

DIGNITY AND COMFORT: THE PROMISE OF RETIREMENT

Mr. GURNEY. The technological revolution of 20th-century America has produced profound changes, not only in our standard of living, but in our way of life. Perhaps the most affected by these changes are our senior citizens, who now face a set of problems not confronted by previous generations. Today, no one questions that these problems exist and must be dealt with in a meaningful manner. The real crux of the matter is how they are to be dealt with; to consider the elderly as a special group with special problems is necessary, but to segregate them in the process of solving their problems, is doing them a distinct disservice. Comfort with dignity—and I cannot put enough stress on dignity—is the ideal goal.

Our senior citizens are special, not simply because of their present status but because of what they have contributed. They do not want to be treated "differently" from other parts of society any more than anyone else does. Nor do they like to be placed in the same category as welfare recipients. They have worked all their lives and have earned their retirement; to be lumped in with people who are, all too often, considered too lazy to work is repugnant to them. Mail from my elderly constituents indicates this only too clearly. Many senior citizens will refuse welfare assistance—such as food stamps—because they feel it to be degrading. Similarly, they feel degraded if they are shunted off from society because of their age; many feel they have much to contribute and looked upon retirement as an opportunity to do more for their community rather than less.

Our senior citizens have earned their retirement and they should be able to enjoy it rather than have to endure it. Providing for their physical comforts while overlooking their emotional well being—their sense of dignity and pride if you will—is not an adequate answer.

This problem of balancing physical comfort with emotional well being is further complicated by the unusual set of economic circumstances confronting most elderly Americans.

Senior Citizen Population

First of all, senior citizens constitute an evergrowing proportion of our population. In 1970, they comprised 4.1 percent of our total population; today about 10 percent. In my home State—Florida—that proportion is almost 15 percent. Quantitatively speaking, the under-65 population is 2½ times what it was in 1900, but the over-65 group is 6½ times as large. Add to this the nearly 10 million people age 60–65 in the country today—over 200,000 of them in Florida—and the proportion grows. Realistically, given the number of people 60 and over who are retired and given the fact that many of our programs for the elderly start with people 62 and over, it is more accurate to think in terms of 30 million senior citizens.

Unfortunately, this older population is essentially a low-income group, even though there are a good number of wealthy senior citizens. In 1970, half of the 7.2 million families having heads of household aged 65 or over had cash incomes of less than $5,953 and almost 25-percent made less than $3,000. Of the 5.8 million senior citizens living alone or with nonrelatives, half had incomes of less than $1,500. In many cases, the combination of reduced income and accelerating inflation has brought about a decline into the low income or poverty classifications. What we need to do is to fulfill the promise of Social Security which was—and is—to insure that a person is adequately provided for in his retirement years. People who have paid Social Security all their lives in this expectation and who, due to limited income, may not have had enough money to invest in other retirement plans deserve no less.

Social Security Amendments

I feel, and have felt, that an increase in Social Security benefits has been needed for a long time. I tried to get these benefits increased last year, independent of welfare reform, and I feel that they are essential this year, even if getting them passed means separating them from H.R. 1.

H.R. 1, as we have heard, contains a number of laudable proposals in the area of Social Security reform. I fully support changes that would: (1) Increase Social Security benefits by 5 percent effective July 1, 1972; (2) provide for an automatic cost-of-living adjustment in benefits; (3) increase a widow's benefit from the present 82.5 percent of her husband's benefit to an amount equal to 100 percent of the deceased husband's benefit; and (4) eliminate the earnings limitation on Social Security recipients or, if that is impossible, to set the limit at a minimum of $3,000.

All these provisions would provide additional direct income for the recipient, a step recommended by the 1971 White House Conference on Aging and one consistent with preserving the dignity of the senior citizens. Increased benefits and safeguards against inflation simply fulfill the promise of Social Security and make the law more equitable. They do not carry the same stigma that is so often attached to the welfare programs that elderly Americans would otherwise be forced to depend on. In this regard, President Nixon's older Americans'

income assurance plan is right on target; by having applicants for benefits apply to a Social Security office rather than a welfare department, utmost dignity can be maintained.

Health Care

Next to inadequate income perhaps the most vexing problem for the elderly is health care. Medical costs have risen astronomically in the last few years, spurred by the same inflation that has cut so deeply into the purchasing power of the elderly. Faced with a much greater likelihood of needing medical care than the rest of us, the senior citizen finds himself with less money than ever to pay higher costs than ever. Even with Medicare, the squeeze is causing many senior Americans to do without medical treatment they badly need. It is my belief that certain improvements are necessary to reverse this situation.

First, we must develop incentives for cost cutting in the provision of health services. These incentives do not exist at present. Demonstration projects, better planning, and more prudent funding are essential if health costs are to be kept down.

Second, there needs to be a limitation on coverage of costs by medicare. Medicare/Medicaid patients should not have to pay for nonessential services; if guidelines were established setting forth what constitutes reasonable health costs in a given area, unnecessary charges might be avoided.

Third, extended care facilities should be required to meet certain minimum standards to insure patient safety and the proper use of Medicare funds.

Fourth, the rules concerning coverage of physical therapy—a service so frequently needed by the elderly—under Medicare should be relaxed to permit senior citizens to be reimbursed for therapy sessions at a therapist's office. Such a change should be more convenient and less costly to the person needing the treatment.

Finally, I believe that professional standard review organizations should be established to help insure quality health care.

Housing

Another concern of pressing importance to the elderly is where to live. I say, where to live, instead of just housing, because, while there is a definite need for additional housing units for the elderly, at least two-thirds of our senior citizens own their own homes—most of them mortgage free. The problem—more times than not, is—can the senior citizen afford to live in his own home or should he move into an elderly housing facility? It would seem, for several reasons, that every effort should be made to help those who have their own homes and want to continue living in them to do so.

First, a majority of senior citizens do not really want to live in elderly housing because such housing makes them feel like they are being segregated from the rest of society.

Second, there is often a sentimental attachment to living in their own home.

Third, it is less expensive for them, and for the government, to live in their own homes, provided they are able to do so.

Fourth, these homes can often be a source of income if, for instance, rooms are rented out.

Various means have been suggested to help keep the elderly in their own homes. Aside from cutting inflation, which is essential and which is taking place, the burden of steadily increasing property taxes presents the biggest problem. The senior citizen, on his or her fixed income, cannot afford to pay out a good percentage of it to cover property taxes; if they could be given a tax break or better yet, if the burden of the property tax could be reduced, as President Nixon suggested in the state of the Union address, many senior Americans would not be financially forced to move.

Another factor that forces the elderly to leave their own homes is upkeep and repair. Both are expensive and often these tasks are beyond the physical capability of the senior citizen. However, if means were found to reduce these costs—for example, senior citizens co-ops that contracted for upkeep services—this problem could be at least alleviated.

Other ways of keeping the senior citizen in his own home include such things as volunteers—perhaps other senior citizens—looking after the needs of elderly homeowners on an organized basis within the community.

Improved transit systems—I shall discuss this a bit more in a minute—will help them get around to do the necessary errands. However, not all senior citizens by any means have the option of living in their own homes. For these people elderly housing, designed to meet their particular needs, is essential and at a cost they can afford. More detailed efforts should be made to better ascertain the "need" for such elderly housing, and to make sure that such programs that do exist are effectively administered and do not overlap.

In housing, as with everything else, the key to the problem is dignity. Segregating the elderly into retirement communities, while it has certain advantages, has the drawback of making seniors feel that they are second-class citizens that have to be taken care of separately for their own good. To many senior citizens that thought is just as abhorrent as being associated with those on welfare.

One could go on for hours on the needs of the elderly, but rather than do that, I would like to touch upon one final trouble area—transportation.

Transportation

Crucial to the desire of older people to be a part of the community is mobility. It is also essential if one is to shop competitively, or to run many of the day-to-day errands, or to have a social life. Mobility is freedom; for senior citizens it represents freedom to enjoy the fruits of their labors.

However, advancing years make it difficult and often dangerous to drive, harder to walk, and more difficult to negotiate public transit. Economic woes often rule out getting a chauffeur or taking taxis, so public transportation becomes very important. For some, even the bus is too expensive; for others, particularly those in the rural areas, public transit is unavailable or unaccessible and therefore useless. Several remedies come to mind. The most obvious is extension and improve-

ment of our system of public transit. Another is reducing fares for senior citizens if they have a Medicare card. The latter plan is being used in Washington, D.C., and its effects should be studied for future reference. Eliminating the need for the elderly to travel is not really an answer, for like most people senior citizens prize their ability and right to move about.

In going over these matters this morning, I have obviously left out or just lightly touched on a lot of things—things like employment for the elderly, social services, taxes and tax breaks, and safety standards. These are all relevant and related topics and they need attention. Obviously they cannot all be tackled at once but neither is it fair to expect the senior citizen to wait indefinitely. I think these hearings, the committee work, the White House Conference on Aging and the President's proposals and deep interest, are all indicative of a growing awareness that we cannot forget those to whom we owe so much. This, I believe you will all agree, is an encouraging sign. Our senior citizens deserve the best; they have earned it.

FOLLOW-UP TO THE WHITE HOUSE CONFERENCE ON AGING

Mr. PERCY. I am pleased to join the distinguished chairman of the Senate Special Committee on Aging (Mr. Church), the distinguished ranking member (Mr. Fong), and my colleagues in this tribute to our senior citizens.

As my colleagues have pointed out, there are 20 million Americans over age 65. A full one-quarter of them live at or near the poverty level, and while poverty is declining among other age groups, it is increasing among the elderly.

In other words, a minority of the population, our elderly—I will not say aging because we are all aging—those 65 years or over, is the only minority group in America today where conditions are getting worse rather than better, where the incidence of poverty is increasing rather than decreasing for them.

The elderly are among our neediest citizens—if not the neediest—but because they are neither loud nor militant nor quick to complain, their problems have gone largely unnoticed in years past.

Delegates to the recently concluded White House Conference on Aging did much to change this, however, in focusing the Nation's attention on senior citizens. During the Conference, the problems of the elderly in such areas as income maintenance, health, housing, employment and transportation were stressed, and major recommendations for congressional action in each area were issued. In making these recommendations, the delegates laid the foundation for a national policy on aging—something we have always lacked but desperately need.

Although the delegates refrained from endorsing specific legislation pending before Congress, they did endorse certain ideas already incorporated into existing bills.

Mr. President, let me comment here on hearings that the Committee on Aging held last week under its chairman, the distinguished Senator from Idaho (Mr. Church).

I can recall, when first coming on the Aging Committee, that the hearings were not very well attended. The hearings last week were overflowing with interested citizens. I was pleased to note that the average age level was not more than 60 years old—probably it was closer to 40 or 50. It is encouraging that an increasing number of young people are working this field, trying to improve conditions for the aging.

The hearings held last week are evidence of national concern. We are developing, through the efforts of a great many people working in this field, a national conscience with respect to this problem.

Action Congress Can Take

One of the bills now before Congress which is of interest to the elderly is H.R. 1, the comprehensive Social Security Amendments of 1971. Among other features, this measure calls for a 5 percent across-the-board increase in Social Security benefits, full benefits for widows, automatic benefit increases to protect recipients against inflation, and a liberalized retirement test.

The Social Security Earnings Limitation

In recent testimony before the Senate Finance Committee, I endorsed each of the above proposals, and urged that the earnings limitation be raised immediately to $2,400 and to $3,000 by January 1, 1974.

I think among the most ludicrous situations we have today is the fact that if a person retires at 65 and continues to have an income of $100,000 a year in interest and dividends, he still gets his full Social Security benefits if he is not working. But if that Social Security check is necessary for a working man or woman in order to live, he can only get the full amount of the check up to $1,680. After that point, deductions are made, and once a person makes $2,880, he receives no benefits from Social Security—despite the fact that he has paid into the system for years and years and years.

In addition, even more ludicrous is the fact that if a person has to work beyond age 65, he has Social Security deducted from his wages before receiving his net pay. So, even after age 65, he continues to pay for Social Security and the deductions are made from his earned income. This system seems to indicate that there is something wrong with getting earned income.

If one receives unearned income from dividends or interest, he has no deductions made for Social Security.

However, if one has earned income necessary to supplement his Social Security income, he does have deductions made.

Of all the crazy things we have ever done, this seems to be the most unfair. We must eliminate the limitation. I am delighted that the Finance Committee this year is reconsidering the earnings limitation. I think we ought to literally take it off.

Social Security is like insurance. We pay for it. And people resent very much indeed, after paying for perhaps over 40 years, not getting benefits if they have some earned income coming in.

H.R. 1 is now under active consideration by the Finance Committee, and I am pleased to note that Chairman Long has given his word that the bill will be reported to the Senate floor by early March. And if he

gives his word, he means it. The passage of H.R. 1 will enable us to further many of the goals set forth by the White House Conference on Aging.

HOUSING AND TRANSPORTATION

Housing and transportation were cited earlier as areas of major concern to the elderly. It is noteworthy, therefore, that the Senate Banking, Housing and Urban Affairs Committee is currently meeting in executive session on housing legislation. When a bill is reported to the Senate floor, I hope it will contain two specific provisions.

The first provision would call for an additional Assistant Secretary of Housing who would deal exclusively with housing problems—and I add the word "opportunities"—for the elderly, and who would act as a spokesman and advocate for the elderly within the Department of Housing and Urban Development. We need a person within HUD who is sensitive to the housing needs of the elderly and who is high enough up in the bureaucracy to be able to cut through the redtape and present these needs directly and forcefully to the Secretary.

Secretary Romney has done a magnificent job in trying to get hold of the bureaucracy within HUD in the best sense of that term. That is his responsibility in HUD. He not only has improved the efficiency of his department in Washington, but he has also done more than any other cabinet official to my knowledge to decentralize and place responsibility in the field. However, not until we get one assistant secretary whose life work is to take care of the housing needs of the elderly are we going to have them adequately taken care of.

I have discussed this matter with the Secretary and with his very able Under Secretary, Mr. Richard Van Dusen. I am hopeful that he can see fit to make this one personnel assignment, possibly by Executive order.

The second provision which I hope the Banking Committee will include would call for operating subsidies for failing mass transit systems. Good mass transit is of vital importance to the elderly, and yet mass transit companies are going broke across the country. We must take action to prevent mass transit from going completely under, lest the poor and the elderly, and others who are dependent upon mass transportation, become totally isolated.

On this subject, the White House Conference delegates said this:

> The elderly, like everyone else in society, must depend upon the ability to travel for acquiring the basic necessities of food, clothing, and shelter as well as employment and medical care. The ability to travel is also necessary for their participation in spiritual, cultural, recreational, and other social activities. To the extent the aged are denied transportation services, they are denied full participation in meaningful community life.

I know that the senior Senator from New Jersey (Mr. Williams) shares my interest in both an additional Assistant Secretary of Housing to deal with the elderly and in emergency financial assistance for failing mass transit systems. I am pleased to note that he is not only a member of the Senate Special Committee on Aging, but also of the Banking, Housing and Urban Affairs Committee. I know that it is his intention to see that action is taken.

These, then, are steps that Congress can take almost immediately to advance the goals of the White House Conference on Aging.

Administration Action

Actions taken recently by President Nixon to elevate the status of senior citizens in his administration are encouraging. The President has called for a fivefold increase in the budget of the Administration on Aging. He has submitted major legislation to Congress to remedy serious deficiencies in our private pension plans. He has indicated his administration is ready to implement quickly the Kennedy-Pepper bill to provide hot, nutritious meals for the elderly in community settings, when this measure passes the House—and I understand that this measure is under consideration on the House floor today. And through his appointment of Dr. Arthur Flemming as Special Consultant to the President on Aging, the President has acted to insure that the elderly will receive greater attention within the executive branch.

In his role as Chairman of the White House Conference on Aging, Dr. Flemming made every conceivable effort to make the conference a good and open one. Commissioner John Martin of the Administration on Aging has also done a fine job. I think they made a fine presentation when they appeared as witnesses before the Subcommittee on the Aging and Special Senate Aging Committee last week. They noted that there is a momentum building up in the country in the field of aging. I know that the administration has higher priorities in mind than the low status we relegate at the present time to the problems of the aging—lower, in fact, than other industrialized nations in the world according to their aged citizens relative to their national resources.

I think Dr. Flemming deserves the recommendation of all of us for his handling of the conference, and I believe he will continue to act as a strong advocate for the elderly within the administration.

Government Can Only Do So Much: Citizens Must Help

I think the Aging Committee should call upon citizens outside of Government as well to assure a better life for our senior citizens.

Congress can pass laws, and the President can issue executive orders to help aged citizens, but we cannot hope to fulfill their spiritual, social and emotional needs. These needs can only be fulfilled by society as a whole. It is up to individual citizens to look after their parents and grandparents, and to honor their fathers and their mothers.

It almost makes one weep when he visits a nursing home for the elderly on a Sunday afternoon and finds 110 elderly people looking at the blank walls, at the television or at each other. On some days there is not a single visitor to talk to the patients in the nursing homes. This is something that the Government cannot do.

This shows an utter lack of compassion on the part of the American people for others, the lack of desire to visit others and to help each other.

This country was built with the spirit of helping each other, and cooperating with and assisting one and another. Certainly that was true in the West. The country was developed there by means of people helping their neighbors.

The least we can do is to give a little attention, a little time, and a little thought and consideration to the poor and to the elderly who are in poverty.

Sometimes nourishment for the soul is much more needed than nourishment for the stomach.

The very fact that society, through many of the programs we have instituted, has reached out to care for the needs of the poor probably does more for their morale than for their physical being.

I am very appreciative of the fact that a number of the members of the Senate Aging Committee have appeared here today to give voice to their deep concern and to urge our colleagues to take care of this matter.

I would say that there is good reason to believe that this administration will continue to do—as it has done in the past—more to close the hunger gap than any other administration in history.

I trust that this administration also will go down in recorded history as the administration that did more to alert the Nation to the need for assigning a higher priority to the aging and to those who need and deserve our support and help.

The elderly worked hard to make this country the great country it is and to provide the bountiful harvest we now have; it is only fitting and proper that they share in the benefits and proceeds of this great society.

HOUSING—A CRITICAL NEED

Mr. WILLIAMS. Mr. President, the recent, historic White House Conference on Aging has given the Congress and the executive branch new mandates for action on aging during the 1970's.

The message of the conferees who met 2 months ago was plain and compelling. In down-to-earth language they told the Nation that the elderly's time is now.

A new, compelling national policy on aging—as expressed at the conference—must now be translated into early action if that policy is to have any real impact upon the aged of today and tomorrow.

Their challenge cannot be ignored.

Their challenge cannot be met by election year promises and post-election forgetfulness.

To respond to that challenge, Democrats and Republicans alike in the Congress must take immediate action within the next few weeks and months.

To keep the challenge from falling into obscurity, a bipartisan congressional coalition—in alliance with the administration whenever it is receptive—must then sustain that effort.

As a member of the Senate Committee on Aging and as its former chairman—and now as Chairman of the Senate Committee on Labor and Public Welfare—I say here and now that I will do all in my power to make the 1970's a decade of accomplishment for older Americans, rather than a period of continuing disappointment, frustration, and mounting anger.

For that reason, I am pleased that the senior Senator from Idaho, my successor as chairman of the Committee on Aging, initiated a Senate floor discussion of the state of the aging. He, together with com-

mittee members representing both parties, are providing a congressional springboard for implementation of White House Conference recommendations.

My intention today is to discuss the problems that come before the Subcommittee on Housing for the Elderly, on which I serve as chairman.

But, before turning to those problems and the policy shortcomings which help produce them, I would like to point out that the White House Conference recommendations in other areas are identical or similar to proposals I have advanced within recent years, such as:

Major increases in Social Security benefits;

Establishing a floor under the income of every older American;

Liberalization of the retirement test under Social Security;

General revenue financing for a portion of the Social Security program;

Extension of Medicare coverage to include out-of-hospital prescription drugs;

Part-time employment for older Americans in worthwhile service projects right in their own home communities;

Extension of home health services under Medicare to provide alternatives to more costly forms of institutionalization;

Greater opportunities for adult education;

A greater research effort into the aging process, as well as social issues affecting older Americans;

More useful assistance to middle aged and older workers who face long periods of unemployment when layoffs or plant shutdowns occur;

Greater attention to transportation needs of the elderly;

A reversal of recent policy decisions which tend to downgrade the role and functions of the Administration on Aging;

More responsive governmental attitudes to the especially intense needs of those older Americans who are members of minority groups;

A greater emphasis upon health maintenance, or preventive medicine;

Realistic alternatives to institutionalization of the ill, disabled, or isolated and helpless elderly.

Nowhere were the similarities in objectives more apparent than in the field of housing. The conferees agreed with many recommendations which I support and which the Senate Committee on Aging has made in recent annual reports.

In this address, I will discuss the most vital of those recommendations.

In this address, I hope to describe in broad terms actions that can lead to the implementation of a new national policy on housing for the elderly in the United States of the 1970's and the decades beyond.

Housing: No. 1 Cost for Elderly

But first, the question must be asked: Why is housing now such a critical problem for older Americans?

Part of the answer lies in the fact that housing is the No. 1 expenditure for older Americans.

They spend about 33 percent of their total income for shelter, in contrast to 23 percent for younger persons.

Thirty-three percent of anyone's income is a cruel bite, but for those on retirement income the bite is even more painful because most incomes are so desperately low:

We're talking about an age group including 6.5 million persons—one out of every three persons of age 65 and over—who are below or very near the poverty line.

We're talking about an age group in which more and more people are living into their 70's, 80's, and 90's, trying to stretch savings, annuities and Social Security over many more years than had been the case in the past. As they grow older, medical bills are likely to increase, and Medicare pays only 43 percent of their total medical bill.

In addition, many of our older persons are living in the very areas where the greatest deterioration of housing units is taking place.

At least 60 percent are in urban areas, many of them in the inner city.

Thirty-four percent are in rural areas and 5 percent are on farms. And many are attempting to live in large old houses meant for big families rather than for an elderly couple or a widow or widower.

An overwhelming majority—70 percent—of older Americans are homeowners, and 80 percent of their holdings are free and clear of mortgages or other claims against ownership. Equities of $25,000 or more exist on more than 50 percent of these dwellings.

But home ownership does not guarantee satisfaction or security. Threatened by the ever-rising property tax, many older persons are trying to make do in old houses badly in need of repair, or even beyond repair.

All in all, an estimated 6 million persons—almost 30 percent of all older Americans—live in unsatisfactory or substandard housing.

Generally speaking, the lower the income the greater the problem.

Old-age assistance recipients, for example, are hit particularly hard: perhaps 45 to 70 percent live in deficient housing; 15 perecnt have no running water; 30 percent no flush toilets; 40 percent of the housing has one or more other major defects.

Complicating the situation further, many older persons find it impossible to stretch limited incomes far enough to provide maintenance or repairs. Often, failing health or limited physical mobility may sharply restrict their ability to rehabilitate or maintain their homes.

Should homeowners move into rental housing? This is easier said than done. Rental units in the past few years have been showing a mere 5-percent vacancy rate. Apartments along the eastern corridor are showing only 2.8 percent. Federal programs, as I will discuss later, have provided only sporadic and limited help.

The net impact is that millions of older Americans are finding themselves in an impossible housing situation.

Whether they live in a home that is really not suitable for their needs or in apartments in older city neighborhoods, they stand in need of alternatives.

But acceptable alternatives are in tragically short supply.

The Federal Response

Given the great and growing need for housing within the economic reach of the elderly, the Federal Government has offered several significant, but limited, initiatives.

All Government programs taken together produced only 336,000 units for the elderly or an average of about 35,000 units annually between 1960 and 1970.

This one-third of a million units roughly corresponds to the annual net increase in the number of citizens who make it to their 65th birthday in the United States. At that rate, this Nation would barely maintain its present rate of desperate inadequacy.

Another comparison may also help make the point. The President's Committee on Urban Problems developed some statistics from which the Committee has made a conservative projection of the need of the 5 million elderly below the poverty line. They say that there is an immediate need for 120,000 units a year for this group alone. Compare that estimate with the 35,000 total annual production for the last 10 years.

Faced by such facts, the present administration might be expected to declare that an emergency exists, and emergency action is called for.

But the last word from Secretary Romney—presented by his emissary at a hearing I conducted in October—was that there is no reason to suspect that elderly families with adequate income "cannot compete effectively in the general housing market, and therefore, achieve their appropriate share of the housing produced."

His startling conclusion, however, ignores one basic fact: older Americans live on about one-half of the income of those still in the work force.

Moreover, the administration's conclusion was based upon two assumptions which have very little relevance for the elderly:

1. Overcrowding for all age groups diminished between 1960 and 1970.
2. Plumbing in housing for all Americans improved during the same decade.

A close look at these assumptions reveals that overcrowding is really not a serious problem for most elderly homeowners. Many now live in old family houses that are too big for them or they live alone in apartments.

As for bigger and better plumbing, everyone likes it. But here again, the Secretary has not chosen a criteria which necessarily has special meaning for the elderly. Since 70 percent are living in homes bought many years ago, they are either likely to have had plumbing in the first place or are unable to pay out the dollars needed for rehabilitation.

Administration perspective on housing for the elderly was expressed in another way by another HUD representative at a hearing last year.

Eugene Gulledge, Assistant Secretary and Federal Housing Administration Commissioner, said that the administration was proud of its record in increasing overall housing production, largely through the interest subsidy mechanism. He said:

> Because housing for the elderly is an integral part of our production goals, and because most of our assisted programs can and do serve their needs, it follows that larger and larger numbers of our senior citizens are now being given the opportunity to live in decent housing, appropriate to their needs.

But you can't house citizens in rhetoric.

HUD funds helped produce only 41,000 units for the elderly last year, and much of that was possible only because of a "pipeline" or backlog of applications from an earlier—and abandoned—program.

I have discussed numbers of units to show the lack of responsiveness of Government programs, but our national failure can be measured in other terms.

To this end, the resolutions of the White House Conference on Aging are both an indictment of our current efforts and a clarion call for action on a much broader scale.

White House Conference Recommendations

Mr. President, many of the individual sections at the White House Conference produced eloquent statements of need and proposals to meet those needs.

But the housing section, in my judgment, merits special praise for the eloquence of its statements, the depth of its convictions, and the high quality of its recommendations.

The major call was for "a national policy on housing for the elderly worthy of this Nation," enjoying a high priority and embracing not only shelter but needed services of quality that extend the span of independent living in comfort and dignity, in and outside of institutions, as a right wherever the elderly live or choose to live.

The housing section participants declared:

> Availability of housing in great variety is imperative. Such housing should respond to health and income needs and provide a choice of living arrangements. It should include sales and rental housing, new and rehabilitated housing, large and small concentrations. It should be produced by public agencies and by private profit and nonprofit sponsors, with incentives to encourage such housing in all communities.

Needs of minority groups, the disabled, and the aged in isolated rural areas would receive special concern and priority. A decent and safe living environment, "the inherent right of all elderly citizens," would become an actuality at the earliest possible time.

Specifically, the section report called for the following:

1. Construction of 120,000 federally assisted units for the elderly each year.
2. Supportive service for the residents of federally assisted housing projects and the use of these housing projects as the base for outreach programs to serve the general community.
3. Relief from escalating property taxes which are becoming confiscatory in many States.
4. The incorporation of architectural and design standards in housing to meet the special needs of the elderly. Only 180,000 of the 336,000 units built in the last 10 years were specifically designed for the elderly.
5. The revitalization of section 202 which provided direct loans to nonprofit sponsors desiring to make available housing for the elderly. The delegates specifically requested that the senior housing administrative component of HUD have audit responsibility for this program and that the portion of 236 funds going to the elderly should be placed under this same management.
6. Rent supplements increases. To date there have been only 162 projects and some 4,200 persons of all ages served by this program.
7. The promulgation of new programs which would assist families to care for their relatives in their own homes.

8. The development of physical and environmental security standards for housing for the elderly. Perhaps in recognition that crime and the likelihood of fires in high-rise structures are becoming more and more threatening.

9. More HUD research to deal with the health, physical and social aspects of housing. HUD's budget for research last year was only $30 million and most of that was spent on the development of modular and mass produced housing.

10. Establishment of the office of Assistant Secretary of Housing for the Elderly within HUD who would be a highly visible advocate for older Americans. This official would have statutory authority to create and implement a national policy of housing needs for the elderly.

The White House conferees would not have had to make such far-reaching recommendations, of course, if present programs were anywhere near adequate. Taking a look at those programs, here is what we find:

LOW RENT PUBLIC HOUSING

Low rent public housing continues to be the largest Federal program serving the need of the elderly, providing 282,000 of the 336,000 units constructed during the past decade. But this number falls short of the documented need. Long waiting lists are typical in some areas. And many older Americans are too "poor" for public housing.

Today there are some urgent indications that the program is in trouble. Heading the list, is the serious problem of crime which threatens the very existence of the aged. This point was made very forcefully at hearings I conducted last October when witnesses described murders, rapes, muggings and the terrorizing of old persons throughout the United States.

Undoubtedly crime is a major reason for the high vacancy rate at some public housing projects. In St. Louis, for example, the vacancy rate is approaching 40 percent because many individuals prefer the discomforts of the slums to the constant threat of danger to themselves and their property.

Additionally, poor management plagues much public housing. Maintenance is usually minimal, and quite frequently nonexistent. As a consequence many tenants are made to feel like unworthy welfare cases rather than proud individuals.

Despite these shortcomings, the public housing program has served many older Americans effectively. What is needed now is essential reform, instead of outright abandonment.

RENT SUPPLEMENT PROGRAM

Another program with great potential for elderly tenants is the rent supplement program. But it now serves only about 4,200 persons. And many older Americans are discovering that a badly needed Social Security increase can push them above the qualifying income limitations, and eventually lead to a forfeiture of this valuable assistance. This problem is symptomatic of the urgent need for further improvements in the rent supplement program.

SECTION 235 HOUSING

Another program requiring reform is FHA Section 235, which provides homeownership assistance for low- and moderate-income families. With the Federal Government underwriting the interest cost above 1 percent, this is undoubtedly one of the most costly programs ever conceived. Several leading authorities have pointed out that a $15,000 home could cost the Federal Government nearly $25,000 in interest subsidies over a 40-year period. Additionally, this program has been attacked because:

FHA has permitted real estate speculators to sell substandard homes at inflated prices, oftentimes receiving as much as a 150-percent markup.

It has led to instant slums in certain instances because of shoddy workmanship, poor site planning, and substandard materials.

SECTION 202 AND SECTION 236: A MOUNTING CONTROVERSY

Now I would like to turn to the section 236 interest subsidy program which provides rental units for low- and moderate-income families of all age groups. Under this program, the Federal Government assumes the difference in interest from the market rate less the 1 percent paid by the sponsor.

Unfortunately this program has led to the abandonment of the popular Section 202 housing for the elderly program, which authorized direct loans at 3-percent interest to nonprofit sponsors.

I have consistently argued that the Congress intended the 202 and the 236 programs to coexist. However, HUD administrative decisions have required the mandatory transfer of all 202 applicants to 236.

This is extremely shortsighted, in my judgment. By now the arguments pro and con on this issue are well known:

1. Section 202 has been one of the most successful housing programs in our history, providing 45,000 units without a single failure during the 10 years of its existence.

2. It was one of the two housing programs exclusively for older Americans and specifically designed for their needs. By contrast section 236 serves all ages and has no special design criteria for seniors.

3. Section 202 loans were repaid to the Government with 3 percent interest. The amount of this yearly interest return created a revolving fund which meant that the same funds could be used again and again. On the other hand section 236 can result in staggering costs for the Government over the long haul. A $3 million project can, for example, cost the Federal Government $8 million in interest over a 40-year mortgage.

A National Housing Policy for Older Americans

A brief description of existing programs and the recent White House Conference recommendation makes a compelling case of the need for a new national housing policy for the elderly.

Just as evident is the fact that some of these needs are more immediate than others. As always we must face the question of priorities. I will focus on a few of these critical items, although they must continue to be viewed as part of a broader policy.

At the same time I am happy to report that the Senate Committee on Banking, Housing, and Urban Affairs, of which I am a member, has acted favorably on some of the following proposals. I understand that the Committee's report will be released on February 28.

One.—The first and the most pressing need in my judgment is to resolve the dispute over 202 and 236. I am painfully aware of the fact that the elderly are not served when the Congress and the administration engage in years of argument about the means of providing housing. On the other hand, we in the Congress are charged with the responsibility to initiate programs which are efficient and economical.

My position is essentially for the coexistence of sections 202 and 236. I believe this is what the Congress really intended all along. Accordingly I have proposed and the Senate Housing Subcommittee has accepted a $100 million increase in the appropriation for section 202 which will raise total authorizations from $650 to $750 million. At the same time I believe that section 502 of the administration's housing bill, S. 2049, should be perfected to assure that the successor program to 236 is responsive to the special needs of the elderly. My amendment to this effect has also been agreed to by the Committee.

Two.—Another critical problem for aged homeowners is the property tax, which in many cases is imposing an intolerable drain upon limited incomes. Large numbers are now being forced to liquidate their assets in order to pay for this mounting burden. Many are being forced onto the poverty rolls because the tax remains unchecked. In a 3-year period—from 1967 to 1970—property tax revenues increased by about 35 percent. And there appears to be no end in sight.

In far too many cases, a badly needed Social Security increase may be obliterated by a sharp rise in property taxes or rent. There is also compelling evidence to suggest that the elderly are hardest hit; many aged homeowners are turning over 20, 30 or 40 percent of their total income to the local assessor. In some cases, the tax bite is more than 50 percent of the retirement benefits.

A classic example occurred in my own State of New Jersey, where one elderly widow, with an annual income of only $1,176, was paying $796 for property taxes. This came to almost 70 percent of her total resources, leaving her only about $7 per week for food, clothing, transportation, medical care, maintenance of her home, and other expenses.

This is not an isolated story. The elderly are now being squeezed through the property tax wringer in every State of the Union. Their problems have reached crisis proportions and require immediate far-reaching attention.

It is heartening to note that many State and local governments are now considering various alternatives to make the property tax more equitable, especially in view of the recent decisions in California, New Jersey and elsewhere. However, it is quite likely that many years will elapse before all the issues related to these landmark cases are fully and effectively resolved. In the meantime, the overwhelmed elderly homeowner needs some form of relief from these confiscatory taxes.

And any proposal granting relief, I believe, should be based upon these fundamental concepts:

It should be available to the tenant as well as the homeowner. This is essential because renters also feel the pinch from high property taxes, since this burden is frequently shifted by the landlord to the tenant.

Relief should be directed primarily at low- and moderate-income older Americans.

A "tier" or "step" system should be employed to provide the greatest assistance for the very low income person.

Relief should be as direct as possible and without cumbersome procedures to be eligible. For example, it may take the form of a tax refund or rebate for persons whose incomes are too small to file a tax return.

Property tax relief should be linked to property tax reform.

Federal assistance should be available to States which include these principles in any legislation to provide relief for aged homeowners and tenants.

The advantages of this approach are many. First, it can provide a badly needed element of economic justice by removing oppressive burdens for elderly persons who simply lack the resources to be saddled with this overwhelming responsibility. Second, it can provide urgently needed relief without the negative connotations associated with welfare, since the local public assistance office is bypassed. And finally it can deliver the most effective relief for persons in greatest need—the low- and moderate-income aged homeowner and tenant.

Three.—Another part of my legislative package will deal with rehabilitation of existing one-family or two-family homes.

Mr. President, I am well aware that the rehabilitation of such structures has fallen under a cloud of suspicion because of recent criticisms of the 235 program, as described earlier.

My rehabilitation program, however, would differ considerably from the mechanisms used under 235. Instead of rehabilitating for one family or couple, my proposal will call for renovation in such a way that several elderly persons could share a private house formerly occupied by only one family or couple.

A model for this kind of program already exists. The Philadelphia Geriatric Center, improvising with fragments of existing programs, has purchased nine row homes in an age-integrated neighborhood adjacent to its hospital, nursing home, and apartment units. Several of the homes have already been renovated to furnish low-cost housing for three or four elderly persons in each building. Each person has a private efficiency apartment and each person has access to a common living room and kitchen-dining area.

Center officials describe such an arrangement as "intermediate housing" which is especially suitable for persons who may not require the degree of service provided by institutions and yet do not wish to live in large age-segregated buildings. Center officials screen potential tenants to assure compatibility with other tenants and compatibility with the very concept of intermediate living. In addition, the center provides services: the elderly are not put in a "unit" and then forgotten, as is so often the case in other forms of housing.

I believe that the Philadelphia experiment should be applied on a broader scale, and I am now attempting to determine whether new legislation would be needed to do so, or whether HUD can be persuaded to use existing authority to provide incentives for similar projects under varying circumstances in Philadelphia and perhaps in other cities.

Four.—Just as I believe that present programs should be explored for possible authority for the intermediate housing program, so do I suspect that much more could be done with present resources for other purposes.

For that reason I will soon write to Dr. Arthur Flemming, Chairman of the continuing White House Conference on Aging and Special Consultant to the President on Aging, to propose the following:

Dr. Flemming should meet with representatives of HUD, HEW, and other appropriate departments or agencies to design and implement—at the earliest possible date—several prototype projects which mobilize existing programs for experimental purposes.

Please notice that I use the word "prototype," not "demonstration." In bits and pieces, in one way or another, many concepts related to housing have been tested and have proven their worth.

The trick now is to put the demonstration successes together into prototype projects which will combine several useful concepts at once. And a number of models already exist for possible future development, including:

In an urban setting, living units should be mixed with buildings offering intermediate and more extensive medical care. Service centers should be established. Youngsters could be recruited into a security corps. A day care center could be provided for young and old.

In a suburban setting near a college campus, housing should be provided to promote interchange between retired persons and students. Outreach could be provided for satellite services, and the communication between young and old could lead to development of a center for gerontological studies.

In rural areas, experiments should be conducted to promote greater flexibility in the use of Farmers Home Administration loans.

Dr. Flemming—known as a man capable of cutting redtape and transforming concepts into action—is now in an ideal position to win clearance for these prototype projects in a matter of months, instead of the 2- to 3-year processing period which so often hamstrings innovative proposals.

Five.—Public housing certainly has a place in any housing program for older Americans, despite the very critical problems I discussed earlier.

But, several improvements are needed now to improve this program. A major step forward, in my judgment, would be to implement the congregate meal services provision of the 1970 Housing Act. This measure would broaden public housing coverage to include central dining facilities for elderly persons who cannot move around well enough to do their own cooking or shopping.

Perhaps even more significant, this proposal could have potentially far reaching implications on a number of key fronts. It can enable many elderly persons to remain in their own homes, rather than being unneccessarily or prematurely institutionalized at a much higher public cost. Most older Americans would prefer to live in their own home, instead of a nursing home. Equally significant, this measure can provide the heart of a new approach for social services for the aged. It can also provide the foundation for a comprehensive and coordinated network of services for their total housing needs.

Despite the overwhelming support for this concept, HUD has been dragging its feet in implementing this vital reform. Not one project has been built under this measure, even though this legislation was signed into law more than 1 year ago. For that matter, regulations to implement this provision were approved only recently. This slow-motion pace must end now, and I urge HUD to begin steps immediately to implement this measure.

Equally important, security arrangements must be substantially improved. Today far too many elderly tenants are living under a form of "house arrest." They live under a constant fear of being mugged, robbed, beaten or vandalized.

However, several steps can be taken to control and prevent crime in public housing neighborhoods. For example, Federal funding to help housing authorities improve lighting can help immeasurably. In several communitiess where lighting has been improved in high crime areas, there has been a significant reduction in the crime rate. This was clearly revealed in a recent survey of 1,300 police officials throughout the Nation. Of this total, nearly 85 percent reported a drop in the crime rate with an improvement in street lighting, and with good lighting, 42 percent of the officials reported a 50-percent reduction in crime.

And above all, Federal funding must be released to provide trained security personnel at public housing projects. This measure can be one of the most important weapons in our arsenal to make public housing projects safe for its occupants. The Congress spoke out forcefully and clearly in the 1970 Housing Act that this provision should be implemented. And now is the time for HUD to carry out this strong expression of congressional intent.

Other arrangements should also be explored, including:

Additional security personnel at public housing projects during the first part of the month when elderly tenants receive their Social Security checks;

Development of a system to process lost or stolen food stamps;

Promotion of cooperative arrangements with local police departments to provide greater security during the evenings or at times during the month when the aged receive retirement or public assistance checks; and

Proper design of public housing facilities, to minimize the tenant's vulnerability to crime.

Six.—Clearly, a policy and program on housing for the elderly will not take shape until HUD provides organizational muscle to make things happen.

As things stand now, HUD is divided into two major halves: production and management. Housing for older Americans too often falls in between the two divisions. Even though a small unit of housing for the elderly and the handicapped struggles nobly, it is understaffed and tucked away into the boondock regions of the management section of HUD.

We need an advocate for the elderly in HUD. And that advocate should have the power to make policy and to make certain that the policy has high priority.

For that reason, I call again for action on my bill, S. 1935, which would establish the post of Assistant Secretary for Housing of the Elderly. I might add that I was most pleased that the White House conferees adopted this proposal as one of their major recommendations.

The Assistant Secretary would, as I have indicated, be a visible advocate of the elderly, he would administer and coordinate housing programs for older Americans. His office would serve as a clearinghouse for information and would be in the position to formulate a comprehensive response to the needs of the elderly.

The Secretary would be in charge of administering my new housing program when it passes the Congress which would include elements of the old direct loan program along with appropriate services including the social, nutritional, health, and recreational needs of citizens.

As specified in the White House Conference recommendation, he would have charge of that portion of 236 funds earmarked for the elderly and would be responsible to see that the goal of 120,000 units for the elderly is met.

The Assistant Secretary should institute a number of demonstration projects which I am now proposing:

1. Projects to test increased physical (fire) and environmental safety (crime) of federally assisted housing projects.
2. A pilot program to assist families to house their elderly in their own homes, on a much more extensive basis than now contemplated.
3. Housing allowances for the elderly.
4. Senior citizen day-care centers.
5. Proposals to aid older Americans in the repair and rehabilitation of their homes.

I am pleased to announced that the Housing Subcommittee has accepted an amendment to the administration's Housing Consolidation Act (S. 2049) which calls for the creation of the Office of Deputy Assistant Secretary of Housing for the Elderly. Certainly this is an important step toward meeting the goal of my bill S. 1935 and the recommendations of the White House Conference.

I must say that I am gratified that the Housing Subcommittee of the Senate Committee on Banking, Housing and Urban Affairs has adopted the three amendments I have already mentioned. This is a fine beginning toward realizing the goal of an effective national housing policy. But it is only a beginning.

I have attempted today to offer some of the ingredients of a comprehensive national policy, the elderly unlike younger families spend most of their time in their homes and apartments. It is therefore vital that Federal programs endeavor to provide them with more than just the cold basic bricks and mortar. It should be our goal to allow our older Americans to live in dignity independently as long as they can or desire to do so. This is little more than the basic right of all men. The alternatives are a loss both to the community and to the individual. I won't quote statistics about how many of our elderly are unnecessarily institutionalized at this point except to point out that each case represents a failure of society. The time has come to keep the promises easily made and so easily broken to our older Americans. It is time a decent and safe living environment becomes a reality for our 20 million elderly.

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HEALTH CARE FOR THE ELDERLY

Mr. MUSKIE. I said in 1961 that "our democracy may well be judged on the contributions it makes to those who have given so much during their active life in building the strength of our communities, States, and Nation." I still feel that way.

We have made a great deal of progress in dealing with the problems of the aged. But, as the White House Conference on Aging last fall made clear, we still have an enormous distance to go.

What we need most is a new way of thinking about our aged citizens. We are talking about 1 out of every 10 citizens. And in 50 years, 15 percent of all Americans will be over 65; a third of these people, 15 million, will be over 75.

The Maine delegation to the White House Conference summed up best, I think, the mental approach we have to take. In their eloquent "The Credo of the Elderly—A Philosophy of Aging," they said:

> America must consider and decide ways of achieving purposeful, primary goals to give aging man the choice of a return to a fuller existence, or America shall continue to relegate aging man to the back door stoop of history so he may invisibly and unnoticed slide into extinction. This last choice is not acceptable.

I agree with this credo. My distinguished colleagues of the Senate Committee on Aging are discussing today various aspects of the problems we must face. I want to talk about a field in which I have some special experience, the health problems of the elderly.

My special responsibility on the Aging Committee is as chairman of the Subcommittee on Health. In addition, I have felt that health ranks with income as the twin issue of crucial importance to almost all older Americans.

I want to outline briefly the dimensions of the current health care crisis as it affects the elderly. In doing so, I will draw upon the findings of hearings conducted last year by my Subcommittee on Health of the Elderly as well as other special studies and inquiries made by that subcommittee.

Then, I want to turn to the health recommendations of the White House Conference on Aging. These recommendations—if implemented promptly and effectively—can serve as a meaningful agenda for the 1970's in the field of health care for our senior citizens.

The key to the health picture today for older Americans is rising costs and reduced programs. This situation is well documented in a report of the Senate Committee on Aging entitled, "A Pre-White House Conference on Aging: Summary of Developments and Data," released immediately prior to the Conference. The following paragraph from that report summarizes the current crisis:

> Health care costs keep going up for all Americans. But for the older person the problem is compounded. He has only about half the income of those under age 65, but—even with Medicare—he pays more than twice as much for health services. He is doubly likely to have one or more chronic diseases than young people, and much of the care he needs is of the most expensive kind. And, while costs go up, services available under Medicare and Medicaid go down—a process which was accelerated considerably in 1971.

Several illustrations—out of many which could be cited—will demonstrate the problem of rising costs.

The premium for part B of Medicare has increased greatly since the program went into effect in July of 1966. At that time the part B premium was $3 monthly. By July 1 of 1971, the figure stood at $5.60 a month. And on December 31 of last year, the administration—through HEW Secretary Richardson—announced that, as of July 1, 1972, the monthly premium would be raised to $5.80. That means the elderly will be paying almost twice as much for part B premiums as they did when Medicare began.

Secretary Richardson made yet another announcement—earlier in 1971—that again led to increased health care costs for the elderly. On October 1 of last year, he declared that the deductible on the hospital bill of the elderly would increase to $68 on January 1, 1972. This deductible for part A hospital insurance was $40 when Medicare began in 1966. Subsequent increases were to $44 in 1969; to $52 in 1970; and to $60 in 1971.

And still another increase in cost was placed on the shoulders of the elderly who become ill at the start of 1972. Medicare beneficiaries with hospital stays of over 60 days began paying—as of January 1, 1972—$17 a day for the 61st through the 90th day, up from the prior cost of $15 daily.

Charging Medicaid recipients for benefits received has recently emerged as a new problem affecting the indigent elderly citizen who is trying to cope with medical expenses.

In March of 1971 the Governor of California proposed copayment charges for the welfare poor on Medi-Cal, which is the Medicaid program in California. The Department of Health, Education, and Welfare in Washington approved this plan in May of 1971, under a waiver of its regulations allowing States to initiate "small-scale experiments" in welfare administration.

A Medi-Cal reform bill became law in October of 1971. It required copayment for provider services and prescription drugs.

The administration—through HEW—ruled that the Governor of California could implement on an experimental basis the copayment plan in the so-called reform legislation. The HEW ruling allows California to experiment with the copayment approach for 18 months, beginning January 1 of this year.

The HEW approval of the California copayment plan represents the first time that any jurisdiction has been permitted to impose charges on those receiving Medicaid. Such payments are prohibited by Federal law, but HEW lawyers have maintained that the law does not exclude experimenting with them, which is what was authorized in California.

My Subcommittee on Health of the Elderly conducted a hearing in Los Angeles in May of last year which attempted to assess the impact of cutbacks in Medicare and Medicaid. At the outset of that hearing, I said:

> Recent cost-cutting cutbacks and regulations have saved money, but at the price of denying urgently needed health care to our older citizens. By placing limits on care available and by increasing costs, we have merely decreased the health and happiness of our older people. Too often, the choice for them must be made between food and medicine.

Witnesses at my Los Angeles hearing discused the copayment provisions of Medi-Cal and other Medi-Cal cutbacks as well, including

limiting reimbursements to two doctor visits a month; requiring prior authorization by a State consultant for all except emergency hospitalizations; and a slash of 10 percent of reimbursements to providers of health services.

Dr. Robert Peck, chairman of the Los Angeles Chapter of the Medical Committee for Human Rights, called the copayment provisions "heartless and hopeless." "And if, in fact, the doctors will attempt to collect this $1 per visit," Peck asserted, "they will find they will spend $5 in the collection procedure and will end up not collecting after all."

One month after implementation of the Medi-Cal cutbacks, Los Angeles County faced a backlog of 26,000 cases. Dr. John Anthony Smith, president of the Interns-Residents Association of Los Angeles County, told us that the hospital where he is employed in Los Angeles saw 1,164 Medi-Cal patients in April of 1971, 218 of whom were referrals by private physicians. The 218 were a tenfold increase over referrals of the previous month.

Another witness, Dr. Hubert L. Hemsley, president of the Charles Drew Medical Society of Los Angeles, testified that the Medi-Cal cutbacks were depleting the poverty area of badly needed medical resources.

Further cutbacks—both Medicare and Medicaid—are written into the provisions of H.R. 1, which is scheduled to reach the Senate floor sometime soon.

H.R. 1 would increase the deductible under Medicare part B supplementary medical insurance from the present $50 to $60, effective January 1, 1972.

H.R. 1 would also make the elderly subject to a $7.50 daily copayment charge for each day in the hospital from the 31st to the 60th day. Under present law, the patient is subject to the $68 deductible, and, after meeting that charge, pays nothing on his hospital bill through the first 60 days.

H.R. 1 contains at least four cutbacks affecting Medicaid.

One provision in H.R. 1 would repeal the existing provision requiring States to have comprehensive Medicaid programs by 1977.

A second H.R. 1 provision requires maintenance of effort by the States for only the basic Medicaid services. States can thereby reduce—without prior HEW approval or utilization control—other services, including outpatient prescription drugs, dental care, and eyeglasses.

Another H.R. 1 provision would impose cost sharing on Medicaid recipients.

A fourth provision in H.R. 1 is designed to encourage greater outpatient care under Medicaid. To accomplish this, there would be a cutback of Federal matching funds for Medicaid by one-third after 60 days of care in a general or tuberculosis hospital; 60 days of care in a skilled nursing home unless the State establishes an effective utilization review program; or 90 days of care in a mental hospital.

From this summary it is easy to see what we face: For the elderly seeking decent health care, there are rising costs and reduced programs. We see this situation in announcements from HEW. We see this situation in the Medicaid copayment schemes in California implemented with the approval of the administration. We see this situ-

ation in those provisions of H.R. 1 which, if enacted, would lead to further cutbacks in Medicare and Medicaid.

What did the President have to say about this health care crisis when he spoke to the delegates at the White House Conference on Aging just last month? And how did his remarks compare to the response of the delegates themselves to the serious and deepening health problems of the elderly?

The President—I am sorry to report—gave scant attention to health care in his remarks to the conference delegates.

Mr. Nixon spoke of eliminating the $5.60 monthly premium for part B of Medicare. Yet—as I've already indicated—the administration announced afterward, New Year's Eve, that as of July 1 of this year the elderly would be paying $5.80 a month for this premium, making the charge about double the amount when Medicare began. So where does the President and his administration stand on this issue?

The President also spoke of the desirability of extending Medicare to cover prescription drugs. Yet, the President's own Task Force on the Aging—almost 2 years ago—made this same recommendation.

Eliminating Medicare part B premiums and extending Medicare to cover prescription drugs are both worthy objectives. Both were favored by the delegates to the White House conference, as indicated in their recommendations. And I have been a strong supporter of these two Medicare reforms—restating my support for both on the floor of the Senate as recently as November 11 of last year.

It is comforting to know that the delegates to the White House Conference came forth with solid recommendations in the health field, which—if followed by quick and meaningful implementation—can lead to improved health care now for America's senior citizens.

The President has failed to lead—but the elderly are here to show us the way. What do they tell us?

First, the mental health special concerns session recommended the early establishment of a Presidential Commission on Mental Illness and the Elderly, with responsibility for implementing recommendations made at the White House Conference on Aging, and also charged, in general, with policymaking and oversight responsibilities in this long-neglected area. I am deeply gratified by this Conference recommendation, because it supports the bill which I introduced on December 1, 1971—S. 2922—for the creation of such a Commission. A proposal for this Commission came from a recent report of the Senate Special Committee on Aging—"Mental Health Care and Elderly: Shortcomings in Public Policy"—which was prepared at the direction of Senator Church and myself.

Second, the Conference section on physical and mental health asserted that "the U.S.A. must guarantee to all its older people health care as a basic right" and the delegates went on to say that "a comprehensive health care plan for all persons should be legislated and financed through a national health plan." I am in strong agreement with these sentiments.

I am a cosponsor of the Health Security Act that will provide national health care for all Americans. The time has come for this kind

of program. As I said at Einstein Medical College last year, we need a medical bill of rights for all Americans.

I said:

> The first medical right of all Americans is care within their means. Admission to a hospital or a doctor's office should depend on the state of an individual's health, not the size of his wallet.
>
> The second medical right of all Americans is care within their reach. Even if we guaranteed the payment of health costs, millions of our citizens could not find sufficient medical services.

Third, the Conference section on physical and mental health also declared that special attention must be given "to the development of adequate, appropriate alternatives to institutional care." Legislation which I have cosponsored in the Congress—S. 882—would promote this objective by authorizing payment under Medicare for services performed by a household aide.

In addition, there is no doubt but that we have to move toward new and more extensive alternatives to institutional care. We need to do that and we need to think about systems of community health care for the elderly.

Fourth, conferees at the section on physical and mental health urged that "special attention should be given to increasing the funds available for basic research and for operational research with a strong suggestion that a gerontological institute be established within the National Institutes of Health to provide the essential coordination of training and research activities." This purpose would be realized through S. 887 which I have cosponsored.

We need to pass S. 887. We will not be able to help the aged with their special problems as much as we should until we understand more. We need to know more about the processes of aging and we need to encourage our best scientists to work in this field.

Fifth, the Conference delegates were deeply concerned—as I am—with the cutbacks in Medicare that have threatened to erode completely this program which even now pays only 43 percent of the medical expenses of the elderly. I have outlined earlier some of the suggested cutbacks in Medicare and Medicaid contained in H.R. 1. The section on physical and mental health at the White House Conference called for "expanding the legislation and financing of Medicare" while a national health plan is being worked out by the Congress and the Nation. The hearings on "Cutbacks in Medicare and Medicaid"—conducted by my Subcommittee on Health of the Elderly—have vividly demonstrated the severe impact that any further diminution of Medicare would have on our Nation's older population. The Conference delegates are aware of this. I can only hope that the present administration can and will show the same sensitivity to this—and every other—health care imperative for senior citizens.

We have at this moment a unique opportunity to move ahead in health—and in every area of concern to the elderly. White House Conference recommendations are linked to election year momentum to provide this special chance to help those who have done so much for us. This is an opportunity that we must not pass by.

THE RETIREMENT REVOLUTION

Mr. MONDALE. Mr. President, the White House Conference on Aging took place 8 weeks ago and we on the Senate Special Committee on Aging have good reason to thank the delegates.

They have produced a challenging body of recommendations on matters of immediate and long-range concern to older Americans of today and these who will be the older Americans of the future.

And so it is not only appropriate but almost mandatory that the Senate Committee on Aging should give careful attention and comment on the Conference recommendations.

After all, the committee called for such a conference.

After all, many of the recommendations are similar or identical to those sought by the committee in recent reports.

Therefore, it is a duty as well as a pleasure to join with other members of the committee in this state of the aging message. In a few moments, I will give my position on several of the key recommendations related to income, health care, long-term care, and housing.

But I would like to deal first with what I, as chairman of the Subcommittee on Retirement and the individual, have described as a "retirement revolution."

That revolution is already well underway. It is already altering the living patterns of a nation.

That revolution, however, is only beginning to demonstrate just how far-reaching it will be.

What is happening—or beginning to happen—can be described in a very few words.

Retirement is now affecting more people for more years in their lifetime than ever before. And if present trends continue, more than a third of our lifetimes will be spent in what is now called retirement.

And yet, despite this clear trend, most persons today are unprepared for retirement when it overtakes them. Some are overwhelmed by a condition which has been described as "retirement shock." Physicians have told my subcommittee that the sudden transition from full-time work to full-time leisure actually can result in deteriorating health. A combination of sharply reduced income, a loss of role in life usually defined in terms of the job held by the person, and adjustments that so often must be made in living arrangements can take a devastating toll.

If retirement begins earlier, the shock may be even greater.

If retirement extends into the 70's, 80's, and 90's of a person's life—as is increasingly the case—even adjustments will be necessary as the "young elderly" become the "old elderly."

Looking ahead, we always talk of the year 2000 as a faraway milestone separated from the present by a comfortable time buffer. But it's only 28 years away, or only two White House Conferences on Aging away. It's as near in the future as the start of World War II is recent in the past.

What is going to happen to the dimensions of retirement as an institution in those 28 years?

As a recent Committee on Aging report pointed out:

Approximately 42 million Americans are now between their 45th and 65th birthdays. Since each year 1.4 million persons have their 65th

birthday, between 45 and 50 million middle-aged persons of today will reach that age by 2000. Compare that figure with today's 65-plus total of 20 million.

In many ways, new retirees will differ markedly from the majority of today's retirement group. They will have more education. They will be more accustomed to higher rates of pay and will want greater income security in retirement. And they will probably be more able-bodied at the time of retirement and will be less likely to settle for what is so aptly described as "enforced idleness."

A third of today's elderly are under 70 and the median age is under 70. Only 1.3 million—one out of every 15—are 85 or older. By 2000 more persons will be at the end of the age spectrum. Nearly two out of three—a number equivalent to the entire 20 million 65-plus generation of 1971—will be over age 75.

And there will be more women and more single persons. Today's ratio of elderly women to men is 139 to 100. By 2000 it will be 150 to 100.

As for life expectance, this is certainly the least predictable factor of the future older American. The subcommittee has been told that dramatic gains are possible, and there is room for debate here. But. it does seem certain that more people will be in better health during the retirement years than is now the case.

Overwhelming as the statistics of future retirement may be, sheer numbers define only part of the challenge.

We should be at least as concerned about the well-being—the quality of life—of future retirees as we are about projected increases in their numbers.

The White House conferees were concerned, and many of their recommendations have meaning for the future as well as the present.

Conference Recommendations

First and foremost, the conferees said that life in old age must be more than merely bearable.

Their calls for more adequate retirement income and for better housing and health care reflect that conviction.

But even these essential improvements are not enough.

There must be satisfaction as well as security in retirement years, and there must be alternatives to present patterns of work and retirement.

In this brief summary I can discuss only a few of the Conference recommendations that, in my judgment, will help develop greater retirement satisfaction and more flexibility in work patterns. The following—and others—are receiving careful subcommittee attention:

Arbitrary retirement age

As the section on employment and retirement put it:

Our society presently equates employability with chronological age rather than with ability to perform the job.

The section participants called for a flexible policy based upon workers' desires and capabilities, job opportunities for people 65 and

up; and—on the other hand, opportunities for gradual or trial retirement before age 65.

In my view, a great deal of thought and hard questioning must be directed at many of our attitudes and practices related to age 65 as a sole criterion for retirement. Business, labor, and retirees of today should work out new arrangements. As I have said before, the immense Federal establishment should become a model employer in terms of devising new work-life patterns. But progress is still slow. However, my Federal Employees Preretirement Assistance Act, S. 1393, would be a major step forward in overcoming this inertia at the Federal level. Briefly, this measure would provide the operating framework for new work-lifetime patterns, such as phased retirement, trial retirement, sabbaticals and new types of part-time employment for older persons. Once again, I urge early and favorable action on this legislation.

PRERETIREMENT EDUCATION

Many Conference recommendations dealt with the need for more widespread and accessible preretirement training. Here again, the Federal Government could be a model. And here again, S. 1393 can be particularly helpful. It would, for example, establish a comprehensive program of preretirement counseling and assistance for all Federal employees who are eligible or approaching retirement. As a model employer, the Federal Government is ideally situated to provide the necessary impetus for other employers to institute such helpful practices for their employees. And with such a national approach, older Americans can be much better prepared for the crucial adjustments in retirement.

EDUCATIONAL OPPORTUNITIES

Once in retirement, a man or woman should be a likely candidate for renewed, organized education.

But the White House conferees made it clear that most of the educational resources of the United States are inappropriate, inhospitable, or downright uninteresting to most older Americans. Two Conference recommendations are worthy of special consideration:

For older persons to participate in educational programs, agencies, organizations, and government must provide incentives. These incentives should be aimed at eliminating specific barriers to the availability and accessibility of educational services for older persons including transportation, free attendance, subsistence auditing privileges, relaxed admission requirements, flexible hours, convenient locations and subsidies to sponsors and removal of legal barriers.

Emphasis should be given at every level of education to implement and expand the expressed educational objective of "worthy use of leisure." Education must be directed toward an acceptance of the dignity and worth of non-work pursuits as well as toward development of leisure skills and appreciations.

The conferees have made a number of specific recommendations for changes in existing programs and several innovative approaches. Each is receiving subcommittee scrutiny.

In addition, Senator Frank Church—chairman of the full Senate Committee on Aging—and I as subcommittee chairman have agreed that a committee study on educational opportunity for the elderly should soon be released.

"ADVOCATES OF OUR OWN CAUSE"

One of the most challenging statements at the Conference was made by the section on retirement roles and activities.

Participants declared:

> Twenty million older people with talents, skills, experience, and time are an inexhaustible resource in our society. We represent all segments of the population; our abilities, our education, our occupational skills, and our cultural backgrounds are as diverse as America itself.
>
> Given proper resources, opportunities, and motivation, older persons can make a valuable contribution. We are also capable of being effective advocates of our own cause and should be included in planning, in decisionmaking, and in the implementation of programs.

Mr. President, I am convinced that this statement was made largely because the conferees felt that the elderly are often talked about, but not consulted often enough when Government and private agencies try to work on their behalf.

Myopic as it may seem, the planners don't consult those they're planning for.

But models already exist for greater participation by the elderly. The Boston Council of Elders, for example, has provided the elderly a voice in public programs that serve them. The council has been incorporated; it now is the contracting agencies for several useful governmentally-supported projects.

In some model city neighborhoods, consultation with the elderly and participation by the elderly is much more advanced than in typical Federal programs. The Committee on Aging has received fragmentary reports on other impressive experiments in self-advocacy and self-direction by the elderly. I believe the committee should gather more information on this subject. As Senator Church has suggested, incentives should be provided for the development of community or regional councils of elderly citizens for a direct voice in governmental and perhaps cooperative public-private efforts.

MULTIPLE JEOPARDY OF MINORITIES

At first, it appeared that the White House Conference on Aging was going to ignore or minimize the harsh problems encountered by elderly persons who happen to be members of minority groups. But, as protests intensified, Conference Chairman Arthur Flemming announced that "special concerns" sessions would be held on problems encountered by aging and aged blacks, Indians, Mexican-Americans, and Asian-Americans.

Those sessions centered, understandably, on critical issues related to low-income, limited access to health facilities and housing, inequities in Social Security coverage, and appalling deficiencies in research activity and knowledge about minority elders.

But participants at each minority special concern session also voiced a common complaint which is at the root of many of their other difficulties. They felt that Government programs too often are unresponsive or even unaware of the special problems which exist when a person is old and out of the majority mainstream. Mexican-Americans, for example, are acutely aware of the language barrier that so often comes between them and services or benefits—including Social Security and

Medicare. Blacks made a strong statement asking for more adequate representation at all levels and throughout policy-level bodies and program groups. Asian-Americans challenged the "myth" that their elderly are taken care of by families and therefore do not need or want participation in well-designed Government programs. Indians described the "unique relationships between our people and the Federal Government" and asked for adjustments in administration of programs for the elderly.

To the older person in a minority group, the "retirement revolution" may be a bitter joke. Many do not live long enough to become eligible for Medicare or Social Security. Many feel excluded from programs which appear to have been designed by the middle-class for the middle-class.

There can be no real satisfaction in the later years of life for all, until the needs of minority groups are really understood and met. The Senate Committee on Aging has already done some work with minority groups; it should do far more.

RURAL OLDER PEOPLE

A particularly forceful statement was issued by another "Special Concerns" session, one dealing with the rural elderly. Sheer distances between people—their report said—complicate all other problems: transportation, delivery of services, and loneliness. In addition, a large proportion of persons in rural America are old:

> Nationally, one out of every 10 of our citizens is old; in rural counties that ratio is often one in five. As the younger people are forced to leave to find jobs, they gave a shrinking tax base and a growing scarcity of services. Rising property and sales taxes in rural areas are becoming increasingly oppressive to older rural people. Retirement income is lower in rural areas, too. Few workers in rural areas are covered by private pension plans. Income in their later years must come from Social Security, from savings, from continued employment or from welfare.

Participants in the rural special concerns session were particularly concerned about "a critical shortage of paid jobs for those who wish to work." Rural areas have one-third of the poverty in this Nation, yet they get only 16 percent of the Federal manpower funds. As the conferees said:

> National programs designed to provide part-time community service work for older rural people, such as Green Thumb and Green Light (funded under Operation Mainstream) have found the opportunity to serve and also earn is eagerly welcomed by rural older folk.

Fortunately, the means to upgrade those two programs and others—such as foster grandparents, and senior aides—is at hand. S. 555, the National Older American Community Employment bill, would bring such pilot programs into a broader, ongoing effort. At first the administration opposed that bill. Now President Nixon has indicated that he sees the light, and that more funds should go to service programs for the elderly. As a sponsor of S. 555, I hope that he gives a clear, unmistakable signal of support for the particular bill.

CHURCHES AND PRIVATE AGENCIES

Government has an essential role to play in helping to make retirement more satisfying. But Government would be shortsighted indeed

if it were to ignore the rich resources that can be found in our churches, national organizations, and private agencies.

White House conferees recognized this fact often in their report. For example, the section on spiritual well-being said:

> Government should cooperate with religious organizations and concerned social and educational agencies to provide research and professional training in matters of spiritual well-being to those who deliver services to the aging.

The section members recommended that the Government provide financial assistance for the training of clergy, professional workers, and volunteers to develop special understanding and competency in satisfying the spiritual needs of the aging.

Here, it seems to me, is a sensible way of providing limited Government help that would have multiplier effect. The idea is for Government to provide appropriate incentives or help, but not to dictate or dominate.

Another channel of potential activity was described at the special concerns session on the elderly poor:

> Voluntary agencies and church groups in particular are called upon to serve as enablers for the elderly, to encourage and assist them in developing new roles in self-help, social action, and political action.

Whenever possible that self-enabling function should become part of Government activity, such as the model cities program. Here again, there lies an opportunity for direct cooperation between public and private resources.

Such alliances have already been examined in a few Committee on Aging hearings dealing with "sources of community support for programs serving older Americans." Testimony has been positive and encouraging in some cases, but too often the committee has been told of Federal policies or attitudes which balk real cooperation. Nonprofit sponsors of housing for the elderly for example, were dismayed at the delays and rising costs caused by the transition from the 202 direct loan housing program to the 236 interest subsidy program. Private agencies, often working with church organizations, have launched successful pilot programs to help provide much-needed services, such as meals-on-wheels or home health care. But the project too often is dismantled just when the need has been proven.

It seems to me that the committee should continue its investigations into sources of community support, and that it should identify the most common deterrents to genuine participation by private organizations. Many national organizations participated in the White House Conference and in the planning for the Conference. They have been encouraged to maintain that interest, and I hope they do.

RESEARCH DEFICIENCIES

As I indicated earlier, there is a great deal of guessing about future trends in life expectancy for older Americans. One reason for the uncertainty is that funding for research on gerontology—the biological process as well as related social issues—is so low.

Just before the White House Conference, members of the Gerontological Society prepared a report for the Committee on Aging. Their findings were startling and significant.

For example, at the National Institute of Child Health and Human Development—now the major center for aging research—there has been no growth in research programs since 1966. An NICHHD gerontology branch in Baltimore has only 120 employees as compared to the original projected staff of 272.

As for medical research in the care of the aging, the committee was told that a number of urgent medical problems that particularly affect the elderly are in urgent need of indepth research. The committee was told, for example:

> The cause of heart failure, the end point of so many aging hearts, is not completely understood. In some respects our thinking is not ahead of that of Thomas Hobbes, who in the 17th century regarded the heart as a spring and the failing heart as a worn-out spring. Much research remains to be done to discover what happens to the aged heart muscle fiber which causes it to fail independent of the disease.

Such research would be greatly stimulated by enactment of the National Heart, Lung, and Blood Act of 1972, which I introduced on January 20.

Another distinguished member of the Gerontological Society reported to the committee that all evidence indicates that only a few million dollars per year is spent throughout the Nation on social behavioral research on aging. He calls for an increase in research support to five times the current level, about $45 million.

How can sound public policy be developed on a foundation of inadequate reliable information? We must have working arrangements by which research findings can be translated as they become available into developing social programs. But we simply are not yet geared to that concept in this Nation, and this is particularly true in aging.

A good start toward correcting this situation could be made by enacting S. 887, a bill which would establish a National Institute of Gerontology to conduct and support biomedical, social, and behavioral research and training related to aging. My Subcommittee on Retirement and the Individual, I know, would have a large number of questions to put to such an Institute.

PLANNING FOR THE FUTURE

On other occasions I have talked about the need for establishment of a Council of Social Advisors to help develop a system of social indicators and other guides to help us arrive at more rational public policy on programs to serve the people of this Nation.

The White House conferees took a similar view. They warned that planning must not be confused with delay; it must never be used as an excuse for inaction. They said:

> Our Nation is constantly setting goals for itself in all areas of national concern. In the field of aging, as in other areas of concern, the priorities which we as a Nation set are most important. Indeed the very place that we give to the needs of our elderly today and in the future will be determined by the action we take now. Planning without action would be a cruel hoax. Action without planning would be an expensive exercise in futility.

Adequate planning on aging will never become a reality as long as the Administration on Aging remains in its present low place within the Department of Health, Education, and Welfare. The Older Ameri-

cans Act of 1965, which established AoA, expressed a noble hope that this agency could be a focal point for the Federal effort on aging. How on earth is that possible when the present Commissioner of AoA must report first to the director of the Social and Rehabilitation Service? Should the Secretary of Labor or the Secretary of Transportation pay heed to the tiny voice that comes down deep from the recesses of the Department of Health, Education, and Welfare?

An Advisory Council to the Senate Committee on Aging has offered a plan calling for establishment of an office on aging at the White House level and establishment of the position of assistant secretary on aging in appropriate agencies. That plan should be the subject of intensive legislative hearings early in 1972, in time for adequate discussion before the present authority for the Older Americans Act expires in June.

YOUTH AND AGING

Still another Special Concerns session at the White House Conference made the following statement:

> One of the major aims of the White House Conference on Aging should be to harness the activity and energy of youth and link it to the solution of the problems confronting the aging. Three areas of youth volunteer activity suggest themselves for immediate action:
>
> 1. Provide information to senior citizens regarding existing social services and financial resources.
> 2. Render direct service to senior citizens.
> 3. Act as advocates in behalf of the elderly.

The participants in that session also described the need for what has been called "life cycle education" as a mandatory component of all educational institutions. In other words, information about aging should not be held off until a person is aged. He should be aware, from his earliest schooldays, that all of a lifetime is one unit; development continues throughout a person's existence. It should not stop after education ends or employment becomes a fixed habit.

It happens that I am also Chairman of the Subcommittee on Children and Youth in the Senate Committee on Labor and Public Welfare. I will explore the possibilities for early cooperative action between the subcommittee there and the Subcommittee on Retirement and the individual.

CONCLUSION

Mr. President, I have dealt primarily in this address with issues related directly to the work of the Subcommittee on Retirement.

I feel, however, that I should make some comment on bills which I have introduced or cosponsored. I feel that early action on these measures can help to produce the kind of security and well-being that will make all facets of retirement more satisfying.

Heading the list, in my judgment, is my comprehensive proposal S. 923 for major improvements in Social Security and Medicare. Several provisions in this measure have already been incorporated in H.R. 1, including:

Significant increases in minimum monthly benefits for persons with long periods of covered employment;

100 percent benefits for widows, instead of only 82½ percent as under present law;

Liberalization of the retirement test;
Cost-of-living adjustments to protect the elderly from inflation;
An age-62 computation point for men;
Extension of Medicare coverage to include the disabled; and
Several other proposals.

However, S. 923 makes other major improvements, which I am hopeful can be added to H.R. 1. First, it provides a 15 percent increase, instead of only 5 percent as in H.R. 1. And this raise would be retroactive to January 1 of this year, rather than making the elderly wait until June to receive an urgently needed increase in their Social Security benefits.

The chairman of the Senate Committee on Aging (Mr. Church) has already provided compelling arguments for a more substantial increase in Social Security benefits. And I have only one further point to add to what he has said. Another stop-gap proposal is just not going to solve the mounting retirement income gap which continues to deepen for the elderly. Poverty has already increased by 100,000 for the aged during the past 2 years. And this fact alone underscores the need for major increases in Social Security benefits this year.

Additionally, S. 923 would make other far reaching improvements in Medicare. First, it would eliminate the $5.60 monthly premium payment for the aged under part B of Medicare. This change alone would be almost equivalent to a 5-percent increase in Social Security benefits for the average recipient. And it would also provide welcome relief because this payment now costs an elderly couple about $135 per year.

Second, it would extend Medicare coverage to include out-of-hospital prescription drugs. This protection was one of the major recommendations at the recent White House Conference on Aging. Several other noted authorities—including the 1971 Social Security Advisory Council—have supported this coverage. And now is the time for the Congress to extend this overdue protection for the aged.

Prompt action is also needed on two employment proposals, which I have sponsored with other members of the Committee on Aging, to increase employment and service opportunities for older persons. I have already made reference to one of these measures earlier, S. 555, which would utilize the skill and experience of older Americans by establishing a national senior service corps. A number of demonstration projects, such as Green Thumb and Senior Aides, have shown beyond any doubt that these programs work. Now, it is time to convert these prototypes into permanent, ongoing national programs.

Another key proposal is the Middle-Aged and Older Workers Employment Act, which would for the first time establish a comprehensive national manpower policy for the mature worker. Today persons 45 and older are being shortchanged by our existing employment and manpower programs. What is needed now is a comprehensive mid-career development services program to provide the broad range of employment services to enable unemployed or underemployed older workers to move into new or more productive employment.

Equally significant, I am hopeful that the House will act soon on the Nutrition Program for the Elderly Act, a bill which has already passed the Senate by a vote of 89 to 0. A national hot meals program for persons 60 and over is absolutely essential if we are to combat

hunger and malnutrition among the aged. With markedly reduced incomes, it is no wonder today that millions of older Americans go to bed hungry every night. But enactment of the Nutrition Program for the Elderly Act can help provide nutritious meals for nearly 600,000 elderly persons throughout the Nation. And in my own State of Minnesota about 11,000 aged individuals would be benefited by this legislation.

This measure, along with other proposals I have outlined earlier, can help make the later years a time for fulfillment and meaning. Once again, I urge prompt and favorable consideration of these bills.

PROBLEMS OF THE ELDERLY

Mr. HARTKE. Mr. President, I regret that I am not able to be present to engage in a colloquy with my distinguished colleagues of the Senate Committee on Aging. Nonetheless, I would like to offer a few remarks on the problems of the elderly in contemporary America. Both as a member of the Senate Committee on Aging and through my travels I have witnessed the misery and suffering that daily confronts the elderly American. What I have witnessed leads me to one conclusion—we must make a national commitment to end the social and economic injustice that presently afflicts 20 million senior citizens and will affect millions more in years to come.

The elderly of this country are entitled to a life of dignity and economic security. They have the right to expect that the country they served through their most productive years will not forsake them in their time of need. I believe that every older person should have enough income to buy nutritious food, decent housing, adequate clothing, and proper medical care. This past December delegates to the White House Conference on Aging recommended essentially the same goals. It is my sincere hope that the recommendations of the delegates be given priority consideration. It would add insult to injury if those proposals are simply pushed aside and forgotten.

Like the President, I feel legislative action for the aging should be forthcoming this session. Also, I am particularly concerned with some of the provisions of H.R. 1. Unfortunately, the President has not recognized the many inadequate provisions of H.R. 1. Therefore, I have introduced legislation that I hope my colleagues on the Finance Committee will favorably consider. The main thrust of the legislation that I have introduced is to provide for a 10-percent increase in Social Security cash benefits, an increase in the amount of money an older American can earn without suffering any loss in Social Security benefits, coverage under Medicare of prescription drugs needed to treat chronic illness and reduction in the waiting period for disability benefits from 6 to 3 months. It is my opinion that this legislation will overcome the inadequacies of H.R. 1 and provide the economic independence for older Americans that is so essential if we are to break down the last segregation in America—segregation of the aged.

In addition to economic obstacles, the delegates to the White House Conference recognized that major barriers for the elderly exist in the areas of health, housing, transportation, and other social services. If we are ever to have a better world for the elderly, we must provide

the resources, and meet the service as well as the economic needs of the elderly. There has been some experimentation in providing services for the elderly but the existing programs are insufficient. Recently, Congressman John Brademas and other members of the House subcommittee with jurisdiction over the Older American's Act introduced legislation to bring about far-reaching changes in providing services for the elderly. I have introduced similar legislation in the Senate. This is a broadly based and comprehensive effort to meet the needs of the elderly. It will establish programs to provide a full scale of health, education, and social services for the elderly. The legislation is aimed at the coordination of the presently existing but fragmented services and the creation of new programs to deal with those needs that have been neglected in the past.

These are but a few examples of the type of activity that needs to take place if the needs of the elderly are to be resolved. The needs of the elderly have been neglected for too long. We must make economic and social justice for the elderly a reality. We need only the will and the commitment to concentrated purposeful action.

1972—A YEAR OF DECISION FOR AMERICA'S SENIOR CITIZENS

Mr. BEALL. The 20th century has seen tremendous strides in man's effort to conquer disease, raise his standard of living, and in doing so—prolong the life of each of us. While many, I would be inclined to say most Americans, are able to make adequate arrangements for their "old age," an appalling number reach the twilight of their life without the resources to provide them with even the basic necessities of life.

I have a particular interest in and a fondness for America's senior citizens because these are the men and women who, by their hard work, patriotism and selfless efforts have made the 20th century America the wealthy, powerful Nation that it is today. The Nation owes these senior citizens a decent standard of living, personal comfort, and self-respect. During his address to the White House Conference on the Aging, President Nixon stated:

> We will be guided by this conviction: Any action that enhances the dignity of older Americans enhances the dignity of all Americans. For unless the American dream comes true for our older generation, it cannot be complete for any generation.

ACTION IS NEEDED NOW

The time has now come for definitive actions designed to solve the practical problems that confront our senior citizens. The findings and recommendation of the White House Conference will soon be forwarded to Congress along with the President's legislative proposals which are designed to implement them. The 92d Congress, if it chooses to do so, can go down in history as the Congress that accepted the challenge of meeting the needs of America's elderly citizens.

Obviously the No. 1 problem is to provide an adequate income. If each senior citizen can be assured of an income sufficient to meet his basic needs then we have come a long way down the road to solving this pressing national problem. H.R. 1 contains provisions that could pro-

vide a minimum income floor under the elderly. Social Security benefits can and should be increased, and future increases should be geared to the cost of living so that these benefits will be inflation proof. H.R. 1 also calls for the repeal of the $5.60 per month payment for part B Medicare. In addition, Congress should consider substantially raising the ceiling on the amount a person may earn and still receive his full Social Security benefits. This would enable the elderly to remain active, constructive and productive citizens—if they are able and willing to do so. The time has come for us to greatly liberalize the tax deduction for medical and dental care for the aging. A realistic-graduate scale for these deductions would grant a degree of financial relief to these citizens while at the same time directly contributing to their physical and mental well-being.

Mr. Chairman, I think it is appropriate to mention once again the bill that passed the Senate in late November and will, if approved by the House, provide a comprehensive nutritional program within title 4 of the Older Americans Act. I was delighted to hear the Honorable Arthur S. Flemming, Special Consultant to the President on Aging, unequivocally declare the administration's support for this program. With the President's leadership, this landmark legislation should clear the House of Representatives and become law later in this session. Dr. Flemming went on to state his determination to see that this program is fully implemented at the earliest possible date. Mr. Chairman, I ask unanimous consent that my remarks of November 30, 1971 with regard to enactment of S. 1163 be included at the conclusion of my statement.

Health Care for the Elderly

Two areas of health care which should not be overlooked in any discussion of the problems of the aging are the obvious needs for additional research into the special health problems of senior citizens. Second, we must examine ways to provide adequate, long term care for the elderly without automatically resorting to the expensive and frequently unsatisfactory institutions which now seek to fulfill this need. Practical alternatives must be found if our senior citizens are to derive the enjoyment from life that they so justly deserve.

Tax Relief

During the 1st session of the 92d Congress, the Senate passed with my support, a Federal tax credit—up to $300—for the property tax and/or rent of our retired citizens. Unfortunately, this provision was deleted from the Revenue Act of 1971 by the Joint House-Senate Conference Committee. I believe that a realistic approach should be implemented as soon as possible so as to provide immediate relief for our senior citizens who are property owners. In the long run we must seek imaginative new ways to finance State and local governments without such heavy dependence upon the regressive property tax. I would also hope that the President's Committee on School Finance will propose a viable alternative to the property tax which has traditionally supported our public school systems. This reform, coupled with the concept of revenue sharing (which has unfortunately remained stalled in Congress) would offer significant relief for the hard pressed prop-

erty owners in general and the elderly property owner in particular. Once State and local governments have received alternative sources of income it might become practical for Congress to devise a system that would dramatically reduce or eliminate the obligation of senior citizens to pay property taxes. Progress in this area would directly contribute to improving the housing conditions of our senior citizens, free still further their limited financial resources, and thus contribute to their general well-being.

CONCLUSION

In closing, Mr. Chairman, I would like to commend the President for the initiative that he has shown in efforts to come to grips with the problems confronting our Nation's senior citizens. The dramatic increase in the budget for the Administration on Aging, and his strong commitment to meeting the needs of our elderly citizens clearly indicates to me that 1972 can be and should be an historic year of decision. I would be remiss if I did not pay similar tribute to Dr. Arthur S. Flemming, whose distinguished career as an educator, as Secretary of Health, Education, and Welfare, and in a multitude of other capacities, clearly qualifies and equips him for the task he has been asked to undertake. I look forward to working closely with the President, with Dr. Flemming, with Secretary Richardson, and with Commissioner Martin as well as with my colleagues on the Subcommittee on Aging as we seek to convert the ideas generated by the White House Conference on Aging into practical workable solutions to the problems confronting America's senior citizens.

Mr. Chairman, President Nixon has clearly stated, not only his willingness but also his determination to lead this Nation in its efforts to solve the problems of the elderly. The executive branch is marshaling its existing resources, and the Nation's will for this effort. I believe that the executive branch is to be commended for its efforts to date, but the time has now come for the Congress to fully accept its responsibility to our senior citizens. I would hope that the 92d Congress would not only be prepared to accept this challenge but would relish the idea of contributing to this truly significant national effort.

NUTRITION PROGRAM FOR THE ELDERLY UNDER THE OLDER AMERICANS ACT OF 1965, AS AMENDED

Mr. BEALL. Mr. President, as the ranking Republican on the Senate Labor and Public Welfare Subcommittee on Aging, I strongly support S. 1163, a bill which authorizes a 2-year program of grants to the States for needed nutritional programs for senior Americans.

Mr. President, the overriding problem of senior Americans is inadequate income with the result that the income of nearly 5 million persons 65 and older is below the poverty level. Inadequate income is undoubtedly the reason why the nutritional food intake of senior Americans is often below the level deemed adequate. Food is a major expenditure for senior citizens, ranking second only to housing expenses and comprising about 27 percent of their limited budget.

S. 1163 builds on the successful experience under title IV which is the research and demonstration section of the "Older Americans Act." The nutritional projects funded under title IV have been most successful in responding to the nutritional needs of senior citizens. I am pleased that Maryland, in nearby Prince Georges County, had a demonstration project under title IV known as "Project Compas" which is being funded for its third year at the $62,918 level.

In addition, these nutritional projects have been successful in responding to other needs of senior citizens. For example, studies have indicated that the serving of meals in a group setting can overcome isolation, which is often a seri-

ous problem of senior citizens. The group meals also serve as a focal point for the delivery of other services to the aged.

Under this program $100 million is authorized in fiscal 1973 and $150 million in fiscal 1974 for grants to the States. Maryland, with 443,561 senior citizens over 60, would receive approximately $1.5 million in fiscal 1973 and $2.2 million in fiscal 1974. These funds would be used to underwrite the costs incurred by local projects for equipment, labor, management, supporting services, and food. To be eligible for Federal funds, a State would submit a plan to HEW which would guarantee that any nutritional project funded would provide at least one hot meal per day providing a minimum of one-third the recommended daily dietary allowance for an elderly citizen. The hot meal would be provided at least 5 days a week.

Mr. President, it is most appropriate that the Senate take action at this time, for at this very moment the White House Conference of the Aging is underway. This Conference will explore the full spectrum of senior citizens problems—income, housing, nutrition, transportation, education, and health, and property taxes—it is hoped that the Conference will provide the Nation, administration, and the Congress with the guidance and requirements necessary to meet the problems of aging. The ultimate test of the White House Conference will be the action taken to improve the living conditions of senior citizens. Senior citizens make up approximately 10 percent of the Nation's population and they are perhaps the most forgotten minority in the country. This is paricularly tragic, for these senior Americans have worked hard to earn their retirement and are responsible in no small part for the high standard of living that the Nation enjoys today. The bill being considered by the Senate today, I hope, is indicative of the action that will follow the White House Conference. I, for one, intend to study carefully the recommendations and do all I can to make certain that senior Americans will be able to live their retirement years with the independence and dignity they deserve.

Appendix 5

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee and multiple copies available for purchase from U.S. Government Printing Office.

One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

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Three asterisks indicate limited quantity, single copy available from committee supply.

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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.**

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Basic Facts on the Health and Economic Status of Older Americans, June 2, 1961.**

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A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**
Mental Illness Among Older Americans, committee print, September 8, 1961.**
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The Farmer and the President's Health Program, May 17, 1962.**
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Statistics on Older People, Some Current Facts About the Nation's Older People, June 14, 1962.**
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Housing for the Elderly, committee print report, August 31, 1962.**
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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.**
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War on Poverty as It Affects the Elderly, Report No. 1287, January 1966.**
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Homeownership Aspects of the Economics of Aging, A Working Paper, Fact Sheet, July 1969.[1]
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[1] Working paper incorporated into appendix of hearing.

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- Part 1. Washington, D.C., August 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Subcommittee on Housing for the Elderly:**
- Part 1. Washington, D.C., December 11, 1963.
- Part 2. Los Angeles, Calif., January 9, 1964.
- Part 3. San Francisco, Calif., January 11, 1964.

Subcommittee on Involuntary Relocation of the Elderly:**
- Part 1. Washington, D.C., October 22, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.
- Part 5. Los Angeles, Calif., December 5, 1962.
- Part 6. San Francisco, Calif., December 7, 1962.

Nursing homes:**
- Part 1. Portland, Oreg., November 6, 1961.
- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

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- Part 1. Washington, D.C., May 5, 1964.
- Part 2. Washington, D.C., May 6, 1964.
- Part 3. Washington, D.C., May 7, 1964.

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- Part 1. Indianapolis, Ind., February 11, 1965.
- Part 2. Cleveland, Ohio, February 15, 1965.
- Part 3. Los Angeles, Calif., February 17, 1965.
- Part 4. Denver, Colo., February 23, 1965.
- Part 5. New York, N.Y., August 2-3, 1965.
- Part 6. Boston, Mass., August 9, 1965.
- Part 7. Portland, Maine, August 13, 1965.

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- Part 2. Washington, D.C., April 28, 1964.
- Part 3. Washington, D.C., April 29, 1964.

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Part 4(a). Washington, D.C., April 6, 1964 (eye care).
Part 4(b). Washington, D.C., April 6, 1964 (eye care).
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Part 1. Washington, D.C., May 18, 1964.
Part 2. Washington, D.C., May 19, 1964.
Part 3. Washington, D.C., May 20, 1964.
Preneed burial service: Washington, D.C., May 19, 1964.**
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Part 2. St. Petersburg, Fla., November 6, 1961.
Part 3. Port Charlotte, Fla., November 7, 1961.
Part 4. Sarasota, Fla., November 8, 1961.
Part 5. Springfield, Mass., November 29, 1961.
Part 6. St. Joseph, Mo., December 11, 1961.
Part 7. Hannibal, Mo., December 13, 1961.
Part 8. Cape Girardeau, Mo., December 15, 1961.
Part 9. Daytona Beach, Fla., February 14, 1962.
Part 10. Fort Lauderdale, Fla., February 15, 1962.
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Part 1. Washington, D.C., August 1961.
Part 2. Trenton, N.J., October 23, 1961.
Part 3. Los Angeles, Calif., October 24, 1961.
Part 4. Las Vegas, Nev., October 25, 1961.
Part 5. Eugene, Oreg., November 8, 1961.
Part 6. Pocatello, Idaho, November 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 2. Boston, Mass., January 20, 1964.
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- Part 2. Newark, N.J., June 10, 1965.
- Part 3. Washington, D.C., January 19–20, 1966.

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- Part 1. Washington, D.C., January 17–18, 1967.
- Part 2. Tampa, Fla., February 2–3, 1967.

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- Part 1. Washington, D.C., June 22–23, 1967.
- Part 2. New York, N.Y., October 19, 1967.
- Part 3. Los Angeles, Calif., October 16, 1968.

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- Part 2. Ann Arbor, Mich., July 26, 1967.

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- Part 1. Washington, D.C., July 23, 1968.
- Part 2. Seattle, Wash., October 14, 1968.
- Part 3. Ogden, Utah, October 24, 1968.
- Part 4. Syracuse, N.Y., December 9, 1968.
- Part 5. Atlanta, Ga., December 11, 1968.
- Part 6. Boston, Mass., July 11, 1969.
- Part 7. Washington, D.C., October 14–15, 1969.

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- Part 1. Los Angeles, Calif., December 17, 1968.
- Part 2. El Paso, Tex., December 18, 1968.
- Part 3. San Antonio, Tex., December 19, 1968.
- Part 4. Washington, D.C., January 14–15, 1969.
- Part 5. Washington, D.C., November 20-21, 1969.

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- Part 4. Washington, D.C., Homeownership Aspects, July 31 and August 1, 1969—55¢.***
- Part 5. Paramus, N.J., Central Suburban Area, August 14, 1969—40¢.
- Part 6. Cape May, N.J., Retirement Community, August 15, 1969—30¢.
- Part 7. Washington, D.C., International Aspects, August 25, 1969—30¢.
- Part 8. Washington, D.C., National Organizations, October 29, 1969—30¢.
- Part 9. Washington, D.C., Employment Aspects, December 18 and 19, 1969—$1.00.
- Part 10A. Washington, D.C., Pension Aspects, February 17, 1970—60¢.
- Part 10B. Washington, D.C., Pension Aspects, February 18, 1970—70¢.
- Part 11. Washington, D.C., Concluding Hearing, May 4, 5, and 6, 1970—$1.00.

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- Part 1. Washington, D.C., July 30, 1969—60¢.***
- Part 2. St. Petersburg, Florida, January 9, 1970—50¢.***
- Part 3. Hartford, Connecticut, January 15, 1970—40¢.
- Part 4. Washington, D.C., Marietta, Ohio fire, February 9, 1970—40¢.***
- Part 5. Washington, D.C., Marietta, Ohio fire, February 10, 1970—25¢.
- Part 6. San Francisco, California, February 12, 1970—30¢.
- Part 7. Salt Lake City, Utah, February 13, 1970—30¢.
- Part 8. Washington, D.C., May 7, 1970—50¢.
- Part 9. Washington, D.C., August 19, 1970 (Salmonella)—30¢.
- Part 10. Washington, D.C., December 14, 1970 (Salmonella)—30¢.
- Part 11. Washington, D.C., December 17, 1970—50¢.
- Part 12. Chicago, Ill., April 2, 1971—$1.00.
- Part 13. Chicago, Ill., April 3, 1971—65¢.
- Part 14. Washington, D.C., June 15, 1971—25¢.
- Part 15. Chicago, Ill., September 14, 1971—75¢.
- Part 16. Washington, D.C., September 29, 1971—55¢.
- Part 17. Washington, D.C., October 14, 1971—$1.00.

Part 18. Washington, D.C., October 28, 1971.[2]
Part 19. Minneapolis-St. Paul, Minn., November 29, 1971.[2]

Older Americans in Rural Areas: (Cat. No. Y4:Ag4:R88/Pts.)
Part 1. Des Moines, Iowa, September 8, 1969—55¢.
Part 2. Majestic-Freeburn, Kentucky, September 12, 1969—15¢.
Part 3. Fleming, Kentucky, September 12, 1969—30¢.
Part 4. New Albany, Indiana, September 16, 1969—40¢.
Part 5. Greenwood, Mississippi, October 9, 1969—30¢.
Part 6. Little Rock, Arkansas, October 10, 1969—35¢.
Part 7. Emmett, Idaho, February 24, 1970—20¢.
Part 8. Boise, Idaho, February 24, 1970—30¢.
Part 9. Washington, D.C., May 26, 1970—30¢.
Part 10. Washington, D.C., June 2, 1970—25¢.
Part 11. Dogbone-Charleston, W. Va., October 27, 1970—40¢.
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970—25¢.

Sources of Community Support for Federal Programs Serving Older Americans: (Cat. No. Y4Ag4:C73—Pts.)
Part 1. Ocean Grove, N.J., April 18, 1970—50¢.
Part 2. Washington, D.C., June 8–9, 1970—70¢.

Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970—40¢.**

Legal Problems Affecting Older Americans: (Cat. No. Y4:Ag4:L52/2 pts).
St. Louis, Mo., August 11, 1970—50¢
Boston, Mass., April 30, 1971—25¢.

Evaluation of Administration on Aging and Conduct of White House Conference on Aging: (Cat. No. Y4:Ag4:Ag4/2/Pts).
Part 1. Washington, D.C., March 25, 1971 (50¢).
Part 2. Washington, D.C., March 29, 1971 (25¢).
Part 3. Washington, D.C., March 30, 1971 (30¢).
Part 4. Washington, D.C., March 31, 1971 (30¢).
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Part 6. Orlando, Fla., May 10, 1971 (30¢).
Part 7. Des Moines, Iowa, May 13, 1971 (35¢).
Part 8. Boise, Idaho, May 28, 1971 (30¢).
Part 9. Casper, Wyo., August 13, 1971 (25¢).

Cutbacks in Medicare and Medicaid Coverage: (Cat. No. Y4Ag4:M46/4/Pts).
Part 1, Los Angeles, Calif., May 10, 1971[1] (60¢).
Part 2. Woonsocket, R.I., June 14, 1971 (30¢).
Part 3. Providence, R.I., September 20, 1971 (60¢).

Unemployment Among Older Workers: (Cat. No. Y4:Ag4:UN 2/Pts).
Part 1. South Bend, Ind., June 4, 1971 (30¢).
Part 2. Roanoke, Ala., August 10, 1971 (30¢).
Part 3. Miami, Fla., August 11, 1971 (30¢).
Part 4. Pocatello, Idaho, August 27, 1971 (40¢).

Adequacy of Federal Response to Housing Needs of Older Americans: (Cat. No. Y4:Ag4:H81/3 Pts).
Part 1. Washington, D.C., August 2, 1971 (30¢).
Part 2. Washington, D.C., August 3, 1971 (20¢).

[1] Working Paper incorporated as an appendix to the hearing.
[2] Price not determined at time of this printing.

Part 3. Washington, D.C., August 4, 1971 (55¢).
Part 4. Washington, D.C., October 28, 1971 (30¢).
Part 5. Washington, D.C., October 29, 1971 (20¢).

A Barrier-Free Environment for the Elderly and the Handicapped: (Cat. No. Y4:Ag4:EN8/Pts).
Part 1. Washington, D.C., October 18, 1971.—30¢
Part 2. Washington, D.C., October 19, 1971.—30¢
Part 3. Washington, D.C., October 20, 1971.—30¢

Flammable Fabrics and Other Fire Hazards to Older Americans: Washington, D.C., October 12, 1971 (Cat. No. Y4:Ag4:F61) 40¢

OTHER DOCUMENTS AVAILABLE

Hearings before the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, available from the Special Committee on Aging are:

"Amend the Older Americans Act of 1965—S. 2877 and S. 3326", May 24, 25, and June 15, 1965.**

"Older Americans Act Amendments of 1967—S. 951", June 12, 1967.**

"Older Americans Community Service Program—S. 276", September 18 and 19, 1967.**

"White House Conference on Aging in 1970—S.J. Res. 117", March 5, 1968.**

"Amending the Older Americans Act of 1965—S. 3677", July 1, 1968.**

"Amending the Older Americans Act of 1965—S. 268, S. 2120 and H.R. 11235", Public Law 91-69, June 19, 1969.**

"Older American Community Service Employment Act—S. 3604"—Fall River, Mass., April 4, 1970; Washington, D.C., June 15-16, 1970.

"Extended Care Services and Facilities for the Aging," Des Moines, Iowa, May 18, 1970.

Hearing held by Select Committee on Nutrition and Human Needs in cooperation with the Senate Special Committee on Aging, Part 14: "Nutrition and the Aged, Washington, D.C., September 9-11, 1969.**

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