THE NATION'S RURAL ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 1—WINTERSET, IOWA

AUGUST 16, 1976

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The Nation's Rural Elderly:

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Part 2. Ottumwa, Iowa, August 16, 1976.
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MONDAY, AUGUST 16, 1976

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Winterset, Iowa.

The committee met at 9:45 a.m., pursuant to notice, in the Madison County Multipurpose Center, 114 North Second Street, Winterset, Iowa, Hon. Dick Clark, presiding.

Present: Senator Clark and Representative Thomas R. Harkin.

Also present: William E. Oriol, staff director; Deborah K. Kilmer, professional staff member; David Harf, legislative assistant to Senator Clark; John Guy Miller, minority staff director; and Alison Case, assistant clerk.

OPENING STATEMENT BY SENATOR DICK CLARK, PRESIDING

Senator CLARK. The meeting will now come to order.

Let me welcome all of you here this morning; I am particularly pleased that you came by. This is, of course, a hearing of the Senate Committee on Aging. I want to start off by particularly thanking the Hillbilly Band. You were great. [Applause.] We are very pleased that you came.

I also want to thank the people who made the arrangements for the facilities of the center for us to use. We have a number of witnesses—actually, panels of witnesses—today.

We were scheduled to start at 9:30, but we are a little bit past that, so I think we will go right ahead.

I want to make a brief opening statement and then we are going to hear from Mr. George Orr, executive director of the Iowa Commission on Aging.

Today the Senate Committee on Aging is represented here in Winterset at the start of a major inquiry into the problems and way of life of the Nation's rural elderly. In other words, we are emphasizing in these hearings, not just problems of the elderly, but, more specifically, problems of older people who live in small towns and in rural areas generally.

I asked that we meet in this community in order to set a tone of grassroots participation in all or most of the hearings that follow. Our subject—or group of subjects—is best seen up close. We cannot hope to know what's happening in rural America if we simply stay in Washington, D.C., and that is why these hearings are being held here.

I have been a member of the Senate committee since January 1975. Last year, when the Older Americans Act was up for extension, I suggested to our committee chairman, Senator Frank Church of Idaho,

that the committee hold a hearing to determine whether older Americans in rural areas were receiving their fair share of attention and help under that act.

He agreed, and I chaired that hearing. I was very glad to have the opportunity to do so.

The witnesses made a great case for flexibility and responsiveness in Federal requirements. As a result of the hearings, I attempted to advance legislation to achieve those purposes. We didn't achieve all that we wanted to, I must say, but I will certainly be offering legislation again in the next session as well.

Federal Programs for Rural Elderly

Federal policy on the rural elderly is not expressed solely through the Older Americans Act that you are familiar with. There are, of course, many other programs that affect older people. There are programs like the medicare program. It is supposed to provide equitable benefits to all older Americans throughout the Nation, but if, as in many parts of Iowa and other States, the older persons can't get to a doctor or if they have no doctor to get to, then one wonders how effective such programs are.

There are housing programs that the Federal Government sponsors through the Department of Housing and Urban Development and through the Farmers Home Administration, but again, if bureaucratic insistence upon inflexible standards stay blind to rural needs, then Congress certainly ought to act.

Then there is, also, the U.S. Department of Transportation which has funded literally hundreds of small transportation bus systems intended to serve the elderly and the handicapped. But again, if red-tape and fragmentation are getting in the way of real development of transportation systems which can become a working part of the community in which they serve, it is very hard for them to achieve that goal.

I could give other examples of Federal policies and practices which I think disturb many of us in the way they are sometimes carried out. I particularly will invite testimony on this at this hearing and other hearings. I will do so because I believe that we, as a Nation, have failed to do what we said we were going to do when we held the White House Conference on Aging in 1971.

We said that we were going to develop a national policy on aging. Certainly we have made progress since then, there is no doubt about that, and I think we are proud of the progress that has been made with centers of this kind and many of the programs that you are familiar with. But in terms of arriving at a set of national objectives and working toward them, we frankly have a very, very long way to go yet.

Now part of the problem has been within the executive branch. In my opinion, President Ford and his predecessors have beeen somewhat reluctant—in some cases, rather negative—when it comes to action on aging. I know that the President, in fact, went on record for 2 years in a row as favoring the so-called medicare reform plan which would actually cost medicare participants more and give them somewhat less. That measure was successfully opposed.

Another part of the problem has been the rather strange and strained economic state of the Nation—obviously inflation, along with unemployment. I think in many cases we have not faced up to those problems either.

In any case, we know that there are a number of programs that are working effectively in this part of the State and we are particularly anxious to hear about those. So the purpose of these hearings, simply put, is to listen to people who are involved in them.

Examination of Programs

Most of our witnesses—in fact, all but a very few—are people who are over 60 or over 65, and we simply want to hear from them—whether they think these programs are working. If so, in what way they are working. We also want to hear about their weaknesses. In other words, what are we doing right, what are we doing wrong, and what should we be doing better? That is really what it is all about in one sentence.

With that we will start. I did want to introduce three or four people so if you have a need to contact them or need particular information, and so forth, you will know who they are.

On my immediate right here is Bill Oriol, the staff director for the Senate Committee on Aging; John Guy Miller, at the far end, is the minority staff director; Debbie Kilmer, in the middle, is a professional staff member of the Committee on Aging; Alison Case, assistant clerk of the committee; and Annabelle Short, who is the court reporter.

Now we will be keeping an exact record that will be published. Those of you who wish to have copies, please leave your name with us before we leave, or drop a letter to me, Senator Dick Clark, U.S. Senate, Washington, D.C., and we will be happy to send those to you.

Well, I would like to start. We are going to be holding six hearings—four of them in Iowa, one in Nebraska, and one in South Dakota—in the next 3 days.

We are going to be hearing first from George Orr, the executive director of the Iowa Commission on Aging, who has a long history of public service to the State of Iowa. George, we are very pleased to have you come down to visit with us.

Then we are going to be having a panel of people from various areas nearby: Mr. Goeldner, Mrs. Hazel Stroeber, Mr. Willis Sprunger, and Mrs. Lucille Anderson.

Following that, we are going to be hearing from Woodie Morris, and then another panel with Mr. Pals, Mrs. Forsyth, and Jack Fickel. That will take us up to about 12 noon, I think.

We also have a form in case there are others here who do not have an opportunity to speak and who would like to be included in the record. It simply says:

> Dear Senator Clark: If there had been time for everyone to speak at the hearing in Winterset, Iowa, on August 16, 1976, concerning the Nation's rural elderly, I would have said the following.

So if you have testimony you would like to submit or write out, and so forth, we would be very happy to include that in the official record of the hearing as well.[1]

So, George you may proceed in any way you think appropriate.

[1] See appendix 4, p. 90.

STATEMENT OF GEORGE W. ORR, EXECUTIVE DIRECTOR, IOWA COMMISSION ON AGING, DES MOINES, IOWA

Mr. ORR. Thank you, Senator.

Senator Clark, members of the committee, and the others who have come here to work on these hearings, ladies and gentlemen, I am George Orr. I am a new director to the program but not new to Iowa, since I was born and raised in this State. I have a few things I would like to highlight with the Senator's and your indulgence.

You know, it seems to me that not having had direct experience with this, other than my natural life processes which somewhat qualify me for my job, we are long overdue to address the problems that I think will confront all of us at one time or another.

We are long overdue and, as I think about it, I guess I really had not given it a whole lot of thought. Maybe you did not either until it is right there, and then we try to figure out the best way that we can help.

I think that many people have been put out into retirement—and I don't say this as a dig at our distinguished U.S. Senator—because of mandatory retirement. As I look around and I see us working with our program to employ older Iowans—reemploy, I should say, because they want to work because they are productive—everything is going for them and they can look back on a lifetime of experience to bring those resources together.

We seem to satisfy many of the things that we are trying to do in this program which is to cause people to be independent longer, maybe forever—to stay in their homes and to be happier in that respect.

"I STILL HAD A LOT IN ME"

I talked to so many Iowans who said, "Well, gee whiz, I still had a lot in me," and you can tell by talking with a person because they are out working at something else now that they do have a lot to offer. So I am wondering—this is my own view, Senator—whether maybe that could be a basic problem.

If you want to look at just what 5 years would mean in terms of continued employment for those in high stress, those who are capable physically, mentally, and in all other respects, what a difference this would make.

Well, that is something that seems to me that maybe we ought to start looking at. I think if I read the experts around the country, those who write gerontology, that this is the coming thing—to consider using these valuable human resources a longer period of time.

I am particularly happy to be here with you because this is, I think, following Senator Clark's lead, what we really need. This is where the U.S. Congress can become aware. Right here is where the problems are that confront Iowans.

I think it is wonderful that this round of hearings is going to reach so many Iowans and I am just pleased as punch that we have got a full room here today.

The Senator was kind enough to write me a letter here a few weeks ago and he has asked for a more detailed report on some of the things that we are doing that are of concern to his special committee. For in-

stance, the report on the water and pesticides programs, the health facilities educator and, as it applies to rural areas, the information referral services and the older worker specialty employment.

Now I have already made reference to that latter one, and it is going well. I am also pleased to say that the legislature of the State of Iowa for the second year put its second $100,000 into this program to employ older Iowans.

If the first year was successful, and it was, the second year is steamrolling right on behind it. There are people being employed now who otherwise were sitting on their hands. They are very capable people and they have literally made placements up in the thousands, and we look for that to continue. That program seems to have a terrific impetus.

Information and Referral Service

The information referral program is kind of new. It was decentralized from the State, and the information and referral—meaning that when people have a question and they want to ask about that, they want to know something that might be particularly bothering them—where do you call? Where do you get the answer?

Well, we had one line prior to this and it went into the State. It was a 24-hour WATS line and it attempted to treat this, but a much better way would be to decentralize it to the 13 areas that we have in the State.

Now some of those are functioning already and, in fact to this date, they are receiving in those four areas that are doing it—four combined areas—to the tune of about 2,000 calls per month, and that would be expected to rise as the others get their capability. They are going to take your questions and your concerns, and they are going to try to give you an answer on them.

Now the other things I will cover more completely in the report to you, Senator, but I might just say this in closing, and then the hearings can really commence. What I found when I came to the State was that we had a need to, I think, reduce some of the bureaucracy and some of the excess layering that I saw there. I pledge to you that is what we are going to do, and I think there is a very good reason for that.

Every time we build another layer of somebody doing something, it costs money. Now the Congress or our State appropriates this money and I think, if I am reading it correctly, they want the majority of each and every dollar to go out to the place that it was really for—that is, for our elderly people in Iowa.

Every time we build something in, some artificial, bureaucratic, or administrative type of a control—it takes so many pennies away from that dollar, meaning that fewer pennies then get out to where they ought to go. That is what we are going to be doing.

We have already found that we can literally cut one heck of a lot of these things out and not feel any loss of momentum because of the way we are going to do it. This means that we could almost within a very short time, start swinging more money out which was allocated to our areas, as we have already done. So I hope this will meet with your satisfaction. Time will tell. I know that we are going to accelerate the nutrition sites throughout the States. That is coming up very fast and we are going to be coming up with about 122 percent

of what we did before, and that is a real number—122 percent of what we did before. That means we are going to be expanding both on nutrition, nutrition sites and, more importantly, aiming at the nutrition site with respect to where the people need the service.

Sites Not Always Convenient

Sometimes bureaucrats look at a map and they say, "This would be a peachy place for that nutrition site," but then they find that the people that it would serve maybe are scattered someplace else. It does not make too much sense, does it? It means you have to go into expensive transportation systems that you might not need otherwise. But if transportation is needed, we are going to try to get it there, and that is another thing that I believe is going to be very valuable. I am glad to hear a reference to that this morning, too.

Ladies and gentlemen, I certainly appreciate the opportunity to talk with you for a few minutes this morning and I hope that these hearings are going to give all of us a much better insight as to what the real need is.

Thank you very much, Senator.

Senator Clark. Thank you very much, George.

I think your point about mandatory retirement is particularly well taken. It seems to me, if you travel around this State and other parts of the country, that mandatory retirement in many ways is the most discriminatory practice that we have in this country. The fact that you have reached the age of 60 or 65 certainly ought not disqualify you from pursuing the occupation or profession that you have and that you prefer.

When you think of the number of talented people that have achieved many of their greatest achievements after age 65, you think of artists—Picasso, who died just a year or so ago—many of the great musicians—people who had their greatest years in their sixties, their seventies, and, in some cases, in their eighties.

I think it is not only true in the arts, but out of the arts. I think if there is one thing that we need to do in terms of reducing discrimination in this country, it is to eliminate mandatory retirements. I agree with you.

We are very pleased that you came, George, to get us started. In other hearings, we are going to be pursuing some of the things that you talked about, particularly employment programs—the kinds of things that you referred to in your testimony.

Thank you very much.

Now we are going to ask the panel here in the front row to come right on up to the desk and we will proceed with your testimony.

We are going to hear from Mr. Goeldner, Mrs. Hazel Stroeber, Mr. Willis Sprunger, and Mrs. Lucille Anderson.

As I understand it, Mr. Goeldner has a prepared statement, and others are just going to say what is on their mind or we will have questions and answers, however we decide to proceed.

Mr. Goeldner is chairman of the Central Iowa Area Agency on Aging, over at Earlham. I have had the pleasure of meeting him on many occasions before. He is formerly the publisher and editor of the newspaper in Earlham.

Mr. Goeldner, you may proceed in any way you like.

STATEMENT OF L. R. GOELDNER, CHAIRMAN, CENTRAL IOWA AREA AGENCY ON AGING, EARLHAM, IOWA

Mr. GOELDNER. Thank you, Senator Clark and friends.

It was suggested that I give a brief review of changes in rural Iowa during the past number of years. I think most of us here this morning can remember back in the early part of the century. Back in the early days the size of farms were smaller. What is considered an adequate size now—80 acres—would support a family, and 160 acres was considered a rather large operation. All the members of the family worked back in those days. We didn't hear of nursing homes. As a last resort, an older person would have to go to the county poor farm, which was considered just a pretty bad situation.

Most of the older people—grandparents or a maiden aunt—would live in with the family and contribute help with the farm chores and things for their remaining days.

Later on, when World War I came along, greater production was required to take care of our allies and our needs here in the United States. A sort of prosperity developed through the war needs. After the war, this continued for a short time and then we didn't need as many supplies as were required earlier, and the demand fell off.

In 1929, most all of us remember the crash when troubled times began, and we had the depression. Many lost their farms, their homes, and their life savings. People who would consider themselves fairly well to do found themselves destitute.

IMPACT OF THE DEPRESSION

At that time, relief programs were set up. One of them at that time to help those who didn't have resources was called old age pension or old age assistance. This was not a very satisfactory situation for the persons who had to receive it because they had been more or less independent. Now they had to sign over any assets they might have to the State or, if they stepped out of line, they could stand the chance of losing this pension.

Following this, we began to get our social security program established, and even with its many faults it seems to be the best program that has been improvised so far. It has restored a certain amount of dignity to the older persons who need assistance in their older days.

When World War II came along the greater strife became evident in agriculture. The farms needed to be larger, our equipment began to develop, and the horsepower began to disappear. Eventually, everything was mechanical.

The farmer in the depression time was assisted by new programs which allowed him to store his grain and to receive a loan so he could maybe take advantage of a higher market. There was land taken out of production which he received revenue for so there would not be a surplus on the market.

It is not uncommon today to have farms 800 or 1,000 acres. One farmer may operate 1,000 acres of land. He has probably an investment of maybe $50,000 to $100,000 in his equipment.

Back in the earlier days, a younger man could start out working and then rent a farm and, after a period of time, own it. In today's time it would take a large amount of money to buy the land, to buy the equipment, and stock his farm.

The older people today, when they get beyond the point where they can live in their own homes, go to a nursing home where they are taken care of for the remainder of their days.

I think that takes care of it.

Senator CLARK. Thank you very much.

Mrs. Stroeber, did you want to make any statement or were we just going to have questions and answers?

Mrs. STROEBER. Statement.

Senator CLARK. Very good.

STATEMENT OF HAZEL STROEBER, MACKSBURG, IOWA

Mrs. STROEBER. I am one of the aging. I am nearly 80 and I have lived alone on my farm since 1972 when my husband died. I am in fairly good health, only my eyes are so poor I cannot drive my car. I think, too, most of the people, as they become older—one of the biggest problems is transportation; although any time I had a real need to travel, there was always some of my neighbors or some relatives who would take me, but at times I felt very much like I was imposing on them and that maybe sometimes I was becoming a nuisance.

So I was really overjoyed when I read in the paper that there was a new minibus coming to Winterset and which would come out to Macksburg and take us in here to Winterset once a week on Monday mornings.

So right away I made an appointment with my dentist. The only time I could have was 11:30 and that is the time they eat lunch here so I didn't get to eat lunch with the group that day. The dental offices are at the edge of town, so after the driver brought me, he turned around and took me back out to the dental office; then at 12 o'clock he was there waiting to bring me back uptown.

Of course I could not eat here so I ate a little lunch at one of the restaurants, did shopping, and went to the grocery and gathered up a whole lot of groceries. The bus driver told me, "You must eat an awfully lot from the the amount of groceries you buy." I do buy quite a bit and put in the freezer because I am out 16 miles from town. Someone always will get me some, but then sometimes I need to have things there in that freezer, so I buy quite a bit whenever I get my groceries.

Well, on that first Monday, Delcie Bush and I were the first two that came in. We were the first two that used the minibus.

Senator CLARK. How long ago was that?

Mrs. STROEBER. February of this year.

TRIPS PROVE TIME CONSUMING

The next week I had an appointment with the doctor and that took up quite a bit of time. Then the next week I brought in my income tax and talked with a lawyer, and that took quite a little time.

Now there were three times that whoever brought me would have lost quite a bit of time, so I felt it was very much worthwhile. There are other times that I need to go to the bank and business and things, so in a business way it has helped me very much and I know it has relieved the pressure on some of my neighbors.

We ladies rather enjoy coming in on the bus. If we have nothing else, we come in and shop. The men—I think the big thing they like are those meals. [Laughter.]

Senator CLARK. Sounds typical.

Mrs. STROEBER. All of us live in homes by ourselves; we are all single living in our own homes. They are older homes. I don't think any of us have a fancy home. My house is over 100 years old, but we put in new floors, new windows, insulated it, and it is quite comfortable. I live there very comfortably and the minibus does help.

Now I do go to town once in a while. I don't depend on the minibus altogether; people bring me in for different things. There is something closed that is not open Monday and so other people do bring me in part of the time, but that minibus does help.

Everything that I can, I schedule for Monday, so I do not bother my friends.

Macksburg is just a little town of 142 people. There is nowhere that you can buy medicines. We have no doctor there. It was founded by a doctor—a Dr. Macks founded Macksburg 100 years ago. I have been around there for 40 years and there has not been a doctor there.

Senator CLARK. So the closest doctor would be what, 17 miles?

Mrs. STROEBER. About 16 miles. Well, maybe by the time you get in town it probably might be 17 miles. If you go the other way, it is a couple miles on farther to Greenfield. All of these are county seat towns. I don't know whether any of the little towns have a doctor any more.

Greenfield is the county seat to the west of us and I am 19 miles from it, so we are quite a little distance from a doctor. Of course, you know I must get appointments with my doctor on Monday; I can't get in through the week.

Senator CLARK. That is right; you can only get sick on Mondays. [Laughter.]

Mrs. STROEBER. I keep a kind of standing appointment once a month for a check-up, so I get along very well there.

A number of the people want to know why in the world don't I move in here to Winterset, but there is a housing shortage here. There is wonderful, low-cost housing for the elderly, but it is only half big enough. Because I own my farm, I could not get in there anyway. I might have to go up to the top of some of these stores and have a great long staircase to climb to find an apartment.

ADVANTAGE TO LIVING AT HOME

I am much more comfortable at home where I can have my garden, my flowers, and I can watch my crops grow, and go out and look my cattle over and see how they are doing, and so on. Usually if you live on your own place you see little things that need repair and things that somebody else does not notice. If it is stopped right in the beginning, it does not cost nearly so much to take care of.

This spring, we had so much dry weather. I thought, "I have never been down to that pond yet this spring. I should be going down to look at it." So I went down. It is quite a little walk down there but, I thought, I must go down and look. The pond supplies drinking water for the cattle. I went down and looked, and it was the lowest the water level had ever been while we had been there. I went around the pond.

Here was a little trickle of water flowing out and it was already only about half. Now it was not a big stream, but it was flowing. When that pond was so very, very low, and I discovered that, somebody might have pointed to that dry hole—would have come and told me that my pond was dry, that there had been a little ditch formed and the water was running out.

But I found it when it was a small amount running out and I immediately called a man that has a bulldozer to come and repair that dam, which he did. So there are a lot of little things that you can see and take care of if you are out on your own farm.

If I was in town, I would not know about it. As I say, I enjoy being out in the country.

Anyway, it is just a very small sum that we have to pay to ride in, which I pay each time when we come. I have felt this service is worth very much more to me than that, and I do give a larger contribution a couple of times a year—a single contribution—because I feel that it is worth that much to me—it is worth more to me.

Senator CLARK. Well, I am going to have some questions but I think before I question you, we are going to go on through and hear the other panelists.

I want to get all of your comments on a number of different things, so rather than asking you questions right now, I think I am going to come back a little later.

Next is Mrs. Lucille Anderson from Melcher, Iowa.

STATEMENT OF LUCILLE ANDERSON, MELCHER, IOWA

Mrs. ANDERSON. Melcher is a former mining community. I am just 15 miles from Knoxville, the county seat, and I have got a lot to say about transportation. We have had a bus for the past 2½ years and it goes to each of the towns in the county. There are six small towns.

Senator CLARK. Would you give your county?

Mrs. ANDERSON. Marion.

We have it on Friday and we have so many wanting to go that they call me to make a reservation. We have two trips on Friday with other towns. There is just one because they don't have so many wanting to go. There is no transportation to any of these small towns; none of them have anything, and people love to go to Knoxville.

A lot of them don't get out of town otherwise; they don't get away from home. They have the chance to go to the doctor, get medicine, go to the bank, go for the congregate meals, and whatever their needs are.

Of course, as I said, there are some that just never leave the house otherwise and it has been a godsend to them. We used to have the railroad; the railroad is still there, but we had a passenger train twice a day which was a big help. We went to Des Moines, but we don't have anything like that now.

Senator CLARK. How long ago did that train stop running, do you know?

Mrs. ANDERSON. Just the past, I would say, 5 or 6 years. I don't remember exactly.

Well, the passenger train—it has been longer than that, but we don't have the freights through any more either. I suppose it has been 20 years or more since we have had the passenger train.

Elderly Desire Independence

Of course, there are lot of people who will take you, but a lot of them just don't think about it. One thing I found out about these older people, they like to be independent, and if they can go on their own, they are not about to ask a relative to take them.

About 25 percent of the population in Melcher is elderly, and I imagine 25 percent of those are widows. They mostly ride in the van. I guess the men that have cars prefer to go that way. We do have some ladies that have cars and can drive, but they don't feel that they can trust themselves to drive any more.

I was born in Melcher and we had all kinds of businesses. We had just about anything that we needed there, but we don't have that any more. We had a nice clinic there and we had doctors coming from Des Moines but, as of the middle of June, they quit doing that so most everybody goes to Knoxville to the doctor or to get their medicine.

Of course, for a long time we didn't have pharmacies there. We had a sundry store, but they would order the medicine from the pharmacy in Knoxville and it would be picked up, so that was a big help. We don't have that any more. It is quite a chore sometimes.

Like the other lady said, you have to get sick on a certain day. Even when we had the doctors we could not get sick at night. I should take that back. We have a very nice rescue unit and the rescue van takes people, so we do have that.

That is true of all the little towns down around there. Any time that anybody can improve the transportation, fine. They need other things besides that. They need to take trips; they need to get out and see a little bit of the country, which they can't do.

Usually in the fall—in October—we have the use of the van on two different Mondays, and they go places. Last year we went to Lake Rathbun as the leaves were changing. We had a sack lunch with us and everybody enjoyed that—just to get away and for something to do.

Of course, housing is a big need, too. The majority of the people are on social security, but there are several older miners and their wives that are getting black lung benefits, which I am also getting as of last November. My husband signed up for it in October 1970 and he passed away in January 1971. I was turned down four times, but I just would not give up. If anybody told me something I could do, I did it.

Then in January 1974, I read in the paper where they were going to reopen some of the old applications, so I wrote to the social security representative about that and had an appointment with him. He said the only thing left that I could possibly do would be to ask for a hearing, which I did in February. I heard nothing until June 1975, to inform me that I had a hearing for July.

In the letter they suggested that I bring an attorney with me.

Well, I went to see the county attorney, but he was going to be in court that day. Then I saw three others; the last one said that it would not do any good for him to go with me as I had no more evidence to present.

Well, the main reason I wanted the hearing was to find out why I was turned down—what they were basing their opinion on. So my daughter and I went alone and I got to see all the documents—everything that had transpired in that 5 years. I saw the judge, and when I left his office my daughter and I both had the same opinion that that was the end of it, but he told me that he would not even look at this further information until October and I would hear by the end of the year.

In October I received a letter that he had decided in my favor, so the latter part of November I got a check, and it was retroactive. One thing I think could be done is to hurry it up a little more, especially for that hearing. Of course, there are a lot of people that don't get it even after the hearing. It is more or less up to the judge—what he decides to do about it.

I know for a fact that it is a wonderful thing that they have that and it really helps a lot of the people that do not get very much social security.

I believe that is all.

Senator CLARK. Thank you very much.

I want to hear now from Willis Sprunger, then we are going to have some questions and comments back and forth.

I had the occasion to meet Willis earlier this morning because I went up to visit the North Ward Plaza housing area where he lives. That is a very, very remarkable place, by the way. I had a chance to visit with most of the people there and to see various apartments, and so forth.

I hope, Willis, you might talk a little about where you lived before, how you happened to go there, and what your views are of living in the North Ward Plaza.

STATEMENT OF WILLIS SPRUNGER, WINTERSET, IOWA

Mr. SPRUNGER. I spent most of my life on the farm. That has been my past from the time I was a very young lad until I was disabled and could no longer farm. When I had to give up farming, we moved into town.

After we lived in town a year, we had our application in at the Plaza. There was an opening and we were offered the apartment that we have now. That has been our home ever since.

It has been 2 years since we moved in and I think it is a wonderful place to live. We have a lot of nice neighbors and I think I am acquainted with most of them now. It took a day or two to get acquainted, but there are not very many men there. There are mostly women there—just four men, and I am one of the four men.

Senator CLARK. You are one of the lucky ones, then.

Mr. SPRUNGER. Is that lucky? [Laughter.]

Senator CLARK. Yes.

Mr. SPRUNGER. I like the place very well. As I could no longer do the job I wanted. I had to give up on the farming. I think the place is just fine for a person to retire in.

I don't drive a car, but my wife does. Without her help, I don't know what I would do there. She does the cooking, keeps house, and drives

the car. Of course, I don't get to go as many places as I would like to go, but maybe I want to go too many places. [Laughter.]

Senator CLARK. You said you lived in an apartment when you first come to town. What are the advantages or disadvantages, let's say, of living at the Plaza compared to living where you did before you moved there?

Mr. SPRUNGER. Well, I just prefer the Plaza because it has its own heating system and it is a lot more even heat in the winter. We get too much heat in the summer, but I don't know what to do about that. We have an air conditioner, but if it runs long enough I freeze out and I have to go to the halls and visit with my neighbors a while to get warmed up again. [Laughter.]

CONVENIENT LOCATION

It is close to town; it is close to the grocery store. I don't go to the doctor very often any more. Maybe I should, but I don't. That would be five blocks, I believe, from the Plaza.

Senator CLARK. Can you walk to most of the things that you need from there?

Mr. SPRUNGER. My wife and I walked from the Plaza here this forenoon. I get awfully tired, and maybe I am a little lazy, but I would like to do more walking than I do.

Senator CLARK. How far are you from the grocery store at the Plaza?

Mr. SPRUNGER. A little over a block.

Senator CLARK. So you can walk to almost anything that you need. What about if you had to go too far? What would you do? What if you had to go someplace where you could not walk? What alternative do you have?

Mr. SPRUNGER. My wife would take me. We do go places away from Winterset, visiting. Some of our family live in Winterset and some of them live in Des Moines, but we don't drive to Des Moines.

Senator CLARK. Do you have access to a minibus—the people there who don't have cars?

Mr. SPRUNGER. Yes. I think I rode in the minibus once and that was a cold, snowy day. That was the last time I rode on the minibus. We have never called it since.

Senator CLARK. But if you didn't have a car, you would be using that more, would you not?

Mr. SPRUNGER. I certainly would. I don't think there are enough people who could ride on the minibus who do ride on it. They either don't know that it is available or they just don't want to ride on it. I don't know what the situation is, but it looks like a good deal for anybody that wanted to ride.

Senator CLARK. Let me ask you one other question, Willis. Do you know about how many people would like to get into the Plaza that are not able? I mean. the waiting list.

Mr. SPRUNGER. Well, I don't know how big the waiting list is. but there has been a waiting list long before we went there and there is still a waiting list. But I don't know how long it is. We had put our application in 2 years before we finally got in.

Senator CLARK. So there probably is a need for more units if they were built?

Mr. SPRUNGER. Oh, I am sure there is. I would not know how many more, but all the people that ever visited us there all think it is a wonderful place and they do ask questions like "How hard is it to get in?" I don't know if they are doing a little wishful thinking or if they are speaking for somebody else. I think that there would be more people come in if there was space for them or if there were more apartments or more available housing. In fact, I am sure that there would be more.

Senator CLARK. Mrs. Stroeber, I notice you said you stayed on your farm because you were able to; that is where your home is, and that is where you would prefer to live. You are obviously able to continue to live there and ride the bus in, and so forth. Have you ever had serious health problems where you felt that you were not going to be able to stay on the farm?

Mrs. STROEBER. Not in the last several years. Fifteen years ago I had cancer and was in the hospital for 3 months before I was able to come home, but my husband was still able to drive the car then. In these last few years I have been quite healthy.

Senator CLARK. The major benefit of any of the so-called elderly programs, as far as you are concerned, has been the bus?

Mrs. STROEBER. Yes.

Senator CLARK. That has been the most important thing as far as you are concerned?

Mrs. STROEBER. Yes; the transportation on the bus. Now it might be possible that, as years go on, if they build more onto that Plaza, that it would be nice. Even if they charged us more who could afford to pay more, still there would be any number that would love to live there, I am sure. As it is, I could not get in.

Senator CLARK. Let me ask you something else. It sounded as if you said when you come to town here, you come here to the meal site.

Mrs. STROEBER. Yes.

Senator CLARK. On Mondays—is that right?

THE MEALS PROGRAM

Mrs. STROEBER. Yes. I do not always eat here because if you have an appointment with a lawyer, if you have an appointment with a doctor, or some of those things, you can't get down there at 11:30.

Senator CLARK. But when you come here and eat, what do you see as the value of that program? In other words, is it a program that the Federal Government ought to continue—to try to help or not? What is your view of its value or the advantages or disadvantages of it?

Mrs. STROEBER. You mean of the meals?

Senator CLARK. The meals program, yes.

Mrs. STROEBER. I think there are big advantages, especially for the men folks who live alone. A great many of the people who have eaten here tell me that is the only hot meal they have in the day. Some of the older women just don't like to cook any more. As age comes on, it is more difficult to do things and it is easier to come here than it is to cook, so they don't cook.

Senator CLARK. Do you see any value to the program other than the food—other than the nutrition?

Mrs. Stroeber. Yes. They enjoy getting together. If somebody misses, they will say, "What was the matter? Why weren't you here before?" Of course, those that live here in town can come every day up until—I think on Saturday and Sunday it is not open, but they can come every day.

For us in the outlying districts, the bus just comes once a week. It takes a different corner of the county on different days, so we don't get in every day.

Did you hear the music when you came in?

Senator Clark. Yes, I certainly did.

Mrs. Stroeber. There is always some kind of entertainment. It is not always music—sometimes it is something else—but there is always some kind of entertainment. I think the last of the month there is a bingo game; I always notice that there are a lot more people here the day of the bingo game.

Senator Clark. So it is not just nutrition; it is a social get-together.

Mrs. Stroeber. Yes; socializing for a great many people. That has not been my reason for coming, because there is a little country church quite close to me. I am out in my own community and it is not necessary for me to come for that social life, though it is nice. As far as to come every day, I would not have time.

Senator Clark. You have to look after the cattle, you said.

Mrs. Stroeber. Yes, and I have to take care of my flowers and garden. Anyone who has a garden knows that weeds grow.

Senator Clark. I want to ask Mrs. Anderson some questions, if I may.

I was interested in the fact that you said that the doctors used to come to Melcher to the clinic from Des Moines. Did they come once a week, or what was that arrangement?

Mrs. Anderson. No, they came every day from the osteopathic college and they had been doing this for 2 or 3 years. It seemed to be going fine. They had a good business, but for some reason they decided they didn't want to drive down there any more. They were there for 5 days a week.

Senator Clark. Now you have no doctor at all?

Mrs. Anderson. We have no doctor at all; no. Years ago, Melcher had several doctors and dentists.

Senator Clark. How big is Melcher?

Population: 931

Mrs. Anderson. Well, as of the 1970 census, it was 931. It never was a great big town.

Senator Clark. That is a big town.

Mrs. Anderson. A big town, but I think around 1,200 is what it was at its peak.

Senator Clark. That is a big town for me. I was raised in a town of 450.

Mrs. Anderson. Then we have a large one. We have several new homes going up and the younger people are staying there, driving to Des Moines, Newton, or Knoxville to work. What we need is a good road.

Senator Clark. Now, according to my notes, there was also a pharmacy in Melcher until this spring; is that right?

Mrs. ANDERSON. Well, it was a sundry store. There was no pharmacy there, but the medicine was ordered from the pharmacy at Knoxville. One of the men that worked at the VA hospital picked it up and brought it in, so that was the one service that we could depend on.

Senator CLARK. Now you have lost that?

Mrs. ANDERSON. We have lost that.

Senator CLARK. So you have lost the medical center and the ability to get prescription drugs delivered in that way?

Mrs. ANDERSON. That is right.

Senator CLARK. If you need prescription drugs now, what do you do?

DRUGS DIFFICULT TO OBTAIN

Mrs. ANDERSON. Well, we wait until we can go to Knoxville and get them. Most everybody goes to the doctors there at the Collins Hospital Clinic. They can get their medicine there through the doctor or they can go to the drugstore in town and get their prescriptions filled.

Senator CLARK. Do a good number of people in Melcher receive benefits under block loan?

Mrs. ANDERSON. Yes. There are several of the old ministers still living there, but there are a lot of widows, too; several of them are getting it.

Senator CLARK. I know the long period of time that it takes to process the claims is the major complaint. I noticed you said that, too.

Mrs. ANDERSON. Yes.

Senator CLARK. What happened was, as I recall, about 2 years ago we passed new legislation saying that everybody who failed to qualify—and you referred to this in your statement—could reapply, and so suddenly there were literally tens of thousands of people who reapplied at the same time and it became an enormous problem.

Mrs. ANDERSON. Yes. I thought that was probably the problem because I had not heard for so long. Of course, when you are just sitting there wondering and waiting, all you are thinking about is yourself. I had just given it up. I thought, well, it is just one more time that I didn't get anything, but I would not give up as long as there was anything that I could do.

Senator CLARK. So as far as you are concerned, the major benefit of the programs that exist now is that you get black lung benefits and social security?

Mrs. ANDERSON. Yes.

Senator CLARK. What about the meals program—do you have access to that?

Mrs. ANDERSON. We don't have it in Melcher, but they have it in Knoxville. The people that want to go over there. We have one van which makes the trip at 9 o'clock and then there is another one at 10. If they want to eat, they try to go on the 10 o'clock van so they will be in Knoxville longer and will be able to eat. If they go at 9 o'clock, they come home before the time for the meal.

Senator CLARK. Do you have any housing programs in Melcher?

Mrs. ANDERSON. No. We need that, too.

Senator CLARK. Let me ask Mr. Goeldner a couple of questions, if I may.

I have a copy here of a magazine article published by the Department of Health, Education, and Welfare called *Aging*,[1]—the November 1963 issue. That is some time ago—nearly 13 years. It has an article in it about Earlham and their homemaking/home health aide nursing services, and so forth.

I was wondering if you might talk a little about some of the things that have happened in Earlham. It looks like you were doing these things already 13 years ago—a number of these new programs now in homemaking/home health care aides, and so forth. Tell us a little bit about the services affecting older people in Earlham.

Mr. GOELDNER. Well, we felt it would be well to keep the people in their own homes as long as possible, so we worked out this program with the assistance of some of the county welfare people in HEW. The State department of health was the agency that put up the assistance money, so we set this program up for the Earlham community. After it was in operation for a year or so, HEW suggested that we expand it, so presently it covers the entire Madison County.

Mrs. Murray Smith, who was here this morning, is presently director. When we first set up this program we had a number of different kinds of assistance, such as homemakers, meals-on-wheels and handyman services, friendly visitation or telephone visitation, visiting nurse, and transportation services.[2]

There was an elderly gentleman there who contributed his time. I think they paid him a quarter for each trip if he brought somebody downtown, or a little more if he took them to Dexter, Des Moines, or someplace else to the doctor.

We found that with this program many of the people spent their remaining days in their own home; otherwise, they would have had to go to a nursing home or some other place.

Some of them required more assistance than others. Maybe a homemaker would come in for half a day, two or three times a week or, if the person needed more help, they would come in every day for a part of the day.

Senator CLARK. Now, would you talk a little bit—in case there are people here who have not been involved in homemakers—about how they come into the home once a week, or more than that, and what kind of things they do?

HELP IN THE HOME

Mr. GOELDNER. Well, as people grow older, they need more help in things like vacuuming their house, cleaning the house or they need to have someone come in and prepare a meal for them. This was before we had congregate meals.

Maybe if there are some dirty dishes stacked up, they would wash the dishes—any particular need that the person might have. They might do a little laundry work for them or just take care of the extra things that take a little burden off the older person.

Senator CLARK. I am reading from the recent article that says that they had a meeting in Earlham with the home health aides, as well as homemakers, and the homemakers had assisted in 61 homes. I assume that is in one county.

[1] See appendix 1, p. 39.
[2] See brochure, appendix 1, Item 1, p. 41.

Mr. GOELDNER. That is Madison County.

Senator CLARK. During the month of June, totaling 844 hours of service by—in this case it was home health aides—and 35 visits to patients' homes were made by registered nurses. Can you talk a little about the home health aides and the nursing programs?

NURSES VALUABLE IN HOME HEALTH

Mr. GOELDNER. Well, I think the nurse, when she visits the home, if necessary, is capable of giving shots, taking blood pressure, and seeing that the person is taking their medicine properly—things of that nature.

Senator CLARK. So between those various programs, your people are able to live in their own homes much longer than they would otherwise.

Mr. GOELDNER. Yes, many of them have. Some of them lived out their remaining days; I know three persons now in nursing homes, but they lived in their own homes 10 years longer than they could have otherwise.

Senator CLARK. What about nutrition programs now in Earlham?

Mr. GOELDNER. Well, Earlham participates in the congregate meals program. Then, of course, the county bus comes over on Tuesdays to take those who need to ride the bus.

In the beginning when we first started congregate meals in the aging program, some of the people said, "Well, that is just for poor people," or "It is charity," or the like. They are getting over that notion now.

I think, as it was brought out here before, the people enjoy visiting, reminiscing, playing games, or having some music like they have here in the multipurpose center.

Senator CLARK. I want to thank you all very, very much for your testimony. It was most interesting. Thank you very much.

We are going to hear next from Dr. Woodrow Morris, and then following Dr. Morris we are going to be hearing from the other panel this morning with Mr. Joe Pals, Mrs. Forsyth, and Dr. Fickel.

Woodie, come right on up here, please.

We particularly wanted to have the doctor with us today because he played a very major role, in fact, in two White House Conferences on Aging, and I know he was appointed by the President to the National Task Force on Aging in 1970. I know that the chairman of this committee also appointed him a member of an advisory board of the committee in 1971.

I must say that I regret that in recent days Iowa has lost his services as chairman of our commission on aging. I think he knows more about problems of aging than anybody I ever met.

So we are particularly happy, Woodie, to have you here. You just proceed in any way you think appropriate.

STATEMENT OF DR. WOODROW MORRIS, ASSOCIATE DEAN, COLLEGE OF MEDICINE, UNIVERSITY OF IOWA, IOWA CITY, IOWA

Dr. MORRIS. Thank you, Senator Clark, for those kind words. I am not sure that it is all true, however, because I am following a panel that just participated a few moments ago who said almost all of the things I want to say better than I can probably say them.

I appreciate that panel's presentation very much because it was a most interesting discussion, and maybe what I can say will illuminate a little further some of the things they said.

I am delighted that you are back home, Senator.

Senator CLARK. Thank you.

Dr. MORRIS. We are always glad when you come back and conduct these important hearings. It is good to see Mr. Oriol, John Guy Miller, Miss Kilmer, and other members of the staff here.

Senator CLARK. I just want to say before you start, because I didn't make this a part of the record, that Dr. Morris is associate dean of the College of Medicine at the University of Iowa.

Dr. MORRIS. Well, as most of you folks know, I have been long interested in and deeply concerned about the need for us as a society to provide the kinds of programs and services which elderly people need and want.

I have been very pleased at the progress which has been made in this country and here in our State in working toward these objectives.

But as an Iowan of some 28 years, I am particularly concerned that we not simply pay lip service to the elderly or mislead them into believing programs and services will be available, only to have them never reach fruition in reality.

This sort of misleading is already all too prevalent in what I consider the broken promises which strew the path of the medicare program. It concerns the delivery of medical care and the provision of long-term care facilities in adequate numbers and quality to respond to the health care needs of our aging and aged citizens.

Similar remarks might also be made about the hopes engendered in the hearts and minds of the elderly that up-to-date, 1976 housing will be made available to them, only to have time pass with little or nothing actually happening in the way of actual construction of adequate housing for those who need it most.

I was delighted to hear Mr. Sprunger talk about the housing program here in Winterset, and I cannot help but think that many folks may be sitting in the audience wondering why they can't have that kind of housing in their communities. That concerns me, too.

Far too many of our older adults are living below the poverty level with no truly creative plans or programs on the drawing boards to permanently solve this problem.

It is true that we have social security and supplemental security income programs, but neither has been able to keep pace with the inroads of inflation, and neither was designed to permit older people to maintain the standard of living to which they have been accustomed or are deserving.

But these remarks are focused on the elderly in general; in Iowa and in other Midwestern States, in particular, we have a special problem, and that is the rural elderly—those to whom Senator Clark is addressing these hearings this week.

A SPECIAL PROBLEM IN IOWA

Unhappily, so far as I am aware, there is no national or State of Iowa policy regarding the rural elderly. Even a cursory examination of the situation of the rural elderly will suggest that they are all too

often underserved and underrepresented—or not served or represented at all—in Federal and State programs which should be serving them and their basic needs.

What good is it, for example, to provide even inadequate medicare benefits to the rural elderly if there are too few physicians, dentists, nurses, physical therapists, audiologists, and long-term care beds to provide the health care the rural elderly need?

Similar questions might be asked about the various programs and services provided for under the Older Americans Act and other Federal programs for the elderly in the areas of information and referral, legal assistance, housing, senior centers, congregate meals programs, and readily available and convenient transportation services.

In most if not all of these, the rural aging and aged have been overlooked and neglected. Part of this, I am sure, is due to the fact that there was no Federal emphasis on this aspect of the aging problem.

State agencies on aging and, indeed, area agencies on aging found themselves so caught up in the day-to-day business of establishing new programs and services, trying to work out the meaning of State and Federal mandates and directives, seeking adequate funding for desirable programs, and lacking manpower trained in the field of aging, simply were unable to give adequate attention to the special needs of special groups such as the rural elderly.

Designating Problem Areas Within States

As I have reported on previous occasions, it is possible to divide various areas of a State—such as counties or planning and service areas—on the basis of the general weight of the problems such areas face because of the relative dependency needs of the elderly citizens which make up a portion of their population.

It turns out that what I fondly call high-senescity counties—those with a high proportion of older citizens—are essentially in rural areas, while low-senescity counties comprise the urban areas of the State of Iowa.

I was interested, Senator, that among the materials that were distributed this morning was a copy of the Senate hearings you conducted in Washington on April 28, 1975.[1] Those of you who are interested will find in that a description of what I just referred to, high-senescity and low-senescity counties, and a map of Iowa shows where those counties are.

The southern two tiers of counties are our most high-senescity counties.

Senator Clark. Why is that true, if I could just interrupt you 1 second?

Dr. Morris. Well, I believe it is essentially true because people are moving out of these counties, particularly young and middle-aged people, and they are the people of child-bearing age. The end result of all this is that the people who are left tend to be those who are older or very, very young. This leaves a proportion of the population in these counties, which is in the range of 20 percent or more, in the age range of 65 and over.

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[1] Hearing, "The Older Americans Act and the Rural Elderly," U.S. Senate Special Committee on Aging, Washington, D.C., Apr. 28, 1975.

One of the aspects of serving the needs of the elderly in rural areas is related to the density of the population in high-senescity counties in contrast to the population density in low-senescity counties.

Density data are of some interest because, in a gross way, they reflect the relative concentration or dispersion of the people who are entitled to various governmental services. It would be easier, for example, to serve 100 people living within the confines of a single square mile area than it would be to serve 100 people scattered over an area of 50 square miles.

That is all this concept means. The former situation is more characteristic of populated areas such as cities; while the latter are more typical of rural areas.

Relating this to congregate meal sites suggests that it is conceivable that a single nutrition site could easily provide services for 100 elderly people in an urban setting and none would have to travel very far to reach the site.

In the other hand, in a rural setting elderly participants would either have to be transported several miles to reach the site, or more sites would have to be provided so that they would be more accessible to the elderly.

In either case it will be more expensive to mount a satisfactory program in a rural area than it would be in the urban setting. In general, these same factors—senescity, density, and related factors—will operate to effect the establishment of senior centers under title V of the Older Americans Act, just as they are now affecting the congregate meals program under title VII.

Accessibility Is Key Factor

Accessibility to services, then, becomes a key factor which must be taken into consideration if those we wish to serve are to receive the services to which they are entitled and for which the programs were designed.

In this connection, it is obvious that one of the most important variables to be considered is to have—as you heard from the panel repeatedly this morning—a comprehensive transportation system.

In general, it is safe to say that programs now underway have not been designed to take accessibility to services into consideration when funds are allocated either by the Federal Government to the States, or by the State of Iowa to its constituent area agencies.

Furthermore, it will be difficult to do this at this point in our history without making some basic changes in the policy of both Federal and State governments to recognize the special needs of the rural elderly.

It will be difficult because the area agencies have, for a period of years, become accustomed to their portion of the Older Americans Act and other funds as they have been allocated to them. To change the formula now, without adjustments, will mean taking funds away from some areas in order to make them available to the rural area agencies.

Similarly, if corrections are to be made now in the formula allocating Federal funds to the States to take into account the rural features of some States, it will mean taking funds away from the more urban States.

In addition to the two particular programs mentioned earlier, rural areas differ significantly from urban areas in a number of other important ways. Time does not permit me to discuss all of these this morning, but let me just note a few.

They include a higher percentage of families living below the accepted poverty level, greater severity of poverty, lower population density, fewer primary care physicians, lower accessibility to the services of primary care physicians and dentists, and a less desirable relative health status index.

Finally, it seems to me that what is called for is a truly national policy regarding the provision of programs and services to the rural elderly of our Nation. Such a policy would serve to focus attention on the special situations of the rural elderly, their special needs, the requirement that specially devised progams need to be developed to respond to those needs, and that these programs be specially funded so that State units on aging will be able to respond to the grass-roots requests from the area agencies on aging.

Present Data Under Study

Senator Clark, there is much more that needs to be said about the rural elderly. We are beginning to collect relevant data at the University of Iowa and data are available and under study at Iowa State University.

Senator Clark. Thank you very much.

I think you have spoken particularly relevantly to the question of accessibility of services because, after all, it may well be that the Federal Government has the service or that the service exists from some other source, but if one cannot get to it, it really does not make much difference.

As you say, the allocation of funds in the past and at the present have not been made on the basis of how difficult it is to deliver those services.

I wanted to get your judgment on two or three specific programs that are now being funded, how you think they might be improved, or what your assessment is of these programs in rural areas.

First of all, the question of housing. Is it your judgment that we have an enormous way to go yet in our rural areas in providing the kind of housing that we talked about at the Plaza which I saw this morning? Have we begun to meet the need there, or do you think it has not been reasonably met?

Dr. Morris. No, I don't think it is being reasonably met at all. I am delighted that there are programs. I have not seen a recent survey of available housing programs for the elderly in Iowa, and you are going to hear later in this week from Governor Blue who is more expert in the field of housing that I am. He has been interested in this for many years.

I was visiting with Governor Blue just last Friday and one of the things he said to me was, now that he and I are no longer going to be intimately involved on the Commission on Aging, perhaps we and some others could work together toward providing more adequate housing for elderly people throughout the State, with particular emphasis in the smaller towns and cities in the rural areas of the State where housing is, I think, desperately needed.

I think we have a long way to go yet.

Senator CLARK. What about health care in rural areas? What do you see as the greatest need there? What should we be working toward as far as this State is concerned?

Dr. MORRIS. You are going to have an expert in a few minutes. Dr. Fickel will be talking with you about one of the most fascinating programs in the State, and Bruce Brenhold is here from the University of Iowa College of Medicine, and he has been working with Dr. Fickel on these programs.

My personal attitude toward this is that the college of medicine is working in the right direction toward developing an approach toward a solution to some of these health care delivery problems.

BETTER ORGANIZATION STRESSED

The approach is, in essence, to develop units which will provide a demonstration of how a community can organize itself better—particularly the health care community can organize itself better—to provide care throughout the community and the surrounding area.

I think if the college of medicine can continue to work toward the development of such approaches throughout the State, and if other communities will read the story of the development of a program such as the one you will hear about later in Red Oak, the whole State can lift itself up by the bootstraps.

In essence. that is the story of Iowa. You are also going to be conducting a hearing in Ottumwa. Ottumwa is in an area of 10 counties which incorporated and called themselves Tenco. This was designed to do the same thing for that whole area in general—to pull itself up by the bootstraps—by its own efforts.

This is the kind of thing I look forward to. I think this would do the most good in the health care area, the housing area, and a lot of other areas.

Senator CLARK. Good. We thank you very much, Dr. Morris, and we appreciate your coming down from Iowa City to testify.

Our last panel is going to be made up of Joe Pals, Louise Forsyth, and Dr. Jack Fickel, who has just been referred to.

We are asking each panelist to try to limit their remarks to 4 or 5 minutes so we will have plenty of time for questions. I am hoping, too, that we might end soon enough to get some questions from the audience of the panelists or members of the staff of the committee.

First, let's hear from Joe Pals who is the former executive director of MATURA Action Corp. in Orient, Iowa.

STATEMENT OF JOE J. PALS, FORMER EXECUTIVE DIRECTOR OF MATURA ACTION CORP., ORIENT, IOWA

Mr. PALS. Senator Clark, staff, and friends, I have heard it said that if you are getting a lot of static, you are not tuned in to the right wavelength. So I hope you keep me on the right wavelength this morning.

I am suposed to talk to you this morning about some of the programs that we had at MATURA—winterization and services or programs for elderly, and the future of CSA.

CSA is the national name. MATURA began in Creston, Iowa, April 25, 1966, representing six counties: Madison, Adams, Taylor, Union,

Ringgold, and Adair. At that time we were known as OEO—Office of Economic Opportunity—better known as the poverty program. The words "poverty program," I think, is one of the things that took us out, because it was more or less downgrading, or I have always thought so at least. About a year ago, our name was changed from the Office of Economic Opportunity to Community Services Administration. CSA are the initials we use.

Our primary function or mission is to help people help themselves, by referral to other agencies or into other programs or jobs. Our philosophy from the very beginning was that of cooperation with other agencies, rather than competing. Having worked in public works a good many years before I came with MATURA, it was my thinking that the only way we could accomplish anything was to work with other agencies rather than to try to compete. A new agency coming into the community, I think, probably made some of the other agencies wonder. "What are they going to do? Are they going to be taking part in what we are doing?" There were some agencies that were somewhat apprehensive about what part we would play within the community.

It has been a long road. How did we build it? I am going to talk a little about linkages for just a moment. What do we mean by linkage and linking the programs together? For example, at the Corning Center, the county board of supervisors and the AAA—the area agency on aging—bought an old school bus. We at MATURA furnished the money for the gas and oil and the part-time driver to operate the bus. So you see, you have three various entities there. You have three agencies operating together or working together to provide a service within that community.

Then what was the service for? The service was for transportation. Again we have transportation coming up, and I am sure, from what all the others have said, that we are pointing out the need here for transportation. We served approximately 45 people from towns like Carbon, Mount Etna, Brooks, Nodaway, and Prescott. These people were picked up in the rural areas and brought into different towns to buy groceries, to see the doctor, or whatever services they might need.

Besides that, there were approximately 35 people picked up within the town of Corning that were taken to the meal site within Corning itself by this same bus. MATURA also furnishes a driver and pays mileage for the car that the driver uses. The driver—in this case it happens to be a lady—uses her own personal car. She is paid mileage for this. We have transportation from Bedford and Lennox to take people to Clarinda, Maryville, Grant City, Creston, and Corning.

Few Medical Facilities In Area

This is mainly for medical and dental care. This is pointing out what Dr. Morris said a little bit ago, medical care being what it is now. We are thinking in terms of the number of doctors in the area—there aren't many. In all of these small towns, there are just no medical facilities, so somebody has to see that people get somewhere so that they can be taken care of.

Again, we are pointing out that transportation is a very, very vital thing in the area, and so is medical care. As Dr. Morris said, social security is not keeping pace. These people out there are below the poverty line at the present time, and they are underserved; some are not served at all. I think that was a statement that was very well put.

Now some of the other things that we have done, we had $18,000 of CSA money that was "one-shot" money. By that we mean it was money that was given to us that we could do with what we saw fit. About the time that we received this money, some of the meal sites were being set up in the six-county area but they didn't have funds to purchase equipment for the meal sites. Many of the programs were financed for the meals, or part of them, but they didn't have funds to buy stoves or refrigerators and that sort of thing.

Sometimes you can get used equipment. But when do you give a refrigerator away? Usually when it is worn out, sometimes not. You don't have the type of stove, usually, that they need for that. That $18,000 was distributed among the sites so that they could buy equipment, so the sites could get started, so they could have meals in various areas.

Then another $5,000 that we received from CSA was emergency food money and was supposed to be used for emergency food in some manner or other. We felt, if we called in the social service directors within the six-county area and talked to them and asked them perhaps what would be the best way, that they might have suggestions. So we called in the social service directors and talked to them. We said, "Now we have $5,000; do you have any need or can you use it or dispense with it in any way?" They said, "Yes, we can use emergency money." There are times when people come in and have to have emergency money for food and we don't always have that.

The upshot of all that was this: We gave five counties $800 each—one county $1,000. They allocated the money and sent the bills to us. We made the check out to them. That is the way it was handled.

Then we have the center systems, of which there are five. We don't happen to have one at Bedford, but they are in the backbone of our total system. You are looking at one of the centers right here—you are sitting in one of them. Louise Forsyth, sitting right next to me, will be talking about that a lot more later.

I am not going to go into any more of the organization or any more linkages of the programs, or that sort of thing. We will go into the winterization program. I think, perhaps, this is one of the best programs that we have had in a long, long time. It is one of the programs that has gotten a lot of good for a lot of people. Within this program, the original grant amounted to $26,150 Federal money and the State of Iowa allocated $3,495.

The Winterization Program

Whenever money of any kind, Federal or State, is allocated, there are always guidelines that you have to follow. Federal dollars were for all age groups, but 90 percent of the homes that we worked on were elderly occupied and, again, this was because of the need. The guidelines for the elderly poor—we could go 25 percent above poverty guidelines for winterization. State dollars were earmarked for 62 years and over. In other words, for people 62 years and older, we could use State money.

The work schedule or accomplishment: What did we do or what have we gotten done within that program? First of all, under Federal regulation we could not exceed $250 per home.

Senator Clark. You could not spend more than $250 on a home for winterization?

Mr. PALS. That is correct.

We planned to work in 185 homes. I will explain this a little more clearly. Actually, we worked on 302 homes. Now there are different phases within this project. For example, we started out, first, with what we call protecting the home from air infiltration by using plastic and caulking the home, doing the best we could. We get those that have the greatest need.

We finally decided perhaps a storm window might be a better route because plastic would not last that long, and maybe there was a better way. So we started with storm windows and we did quite a bit. We started doing that and we had 40 homes that had permanent storm windows, which was better. Then we went to ceiling insulation, and we have done 57 homes so far. So you see, we have various homes in various phases—not all complete, but in various phases. We will go back and do more next year.

Besides this, we have put in vents in the roof, vents in the side walls, and this sort of thing. We traded off 55 tons of old paper, enough to do 20 attics. We are the only agency in the State of Iowa to have done this and we have to give credit to the center people and you people who brought in old papers. This was trucked to Des Moines and traded in on insulation. We got enough by trading in to do 20 attics free; this is what it amounted to.

Then we generated 1,160 hours of volunteer time. We picked up 1,000 old storm windows. We put on plastic, and used windows where possible. Those that didn't fit right into the old windows were screwed on to the outside. We could not use all of them.

It would not have been possible to do all this without the help of our center supervisors—our CETA people. What are we talking about? We are talking about CETA people—the Comprehensive Employment Training Act.

MATURA is, or was, using five carpenters provided by CETA under titles II and VII. All of them are under a title II contract, presently, because of the funding within the two programs. The title VII funding ran out within the area, so it was all transferred to title II, and presently they are on that. As I understand, that is to run out on January 1, and I am hoping that that will continue, Senator.

Senator CLARK. We are going to be voting on that, as a matter of fact, in about 7 or 8 days, so we are hopeful that it will.

CETA FUNDS NECESSARY

Mr. PALS. It is indeed fortunate that MATURA could avail themselves of the CETA contracts, as it would have been impossible to have accomplished what we did because neither our own budget nor the winterization budget had allowed for this kind of needed manpower. Without CETA, MATURA would need at least an additional $30,000 to $35,000 to continue a program of this kind another year.

Now, as to the future of CSA—it has been kind of up and down, as you all know, and my guess is that is true of any new program. I will read what I have here on the future of CSA. I hope I keep within my time.

For those working within an organization like MATURA, especially those who have any tenure at all, realize the many frustrations we have gone through; we have never been quite sure each year if we

would be funded. When President Nixon's order came out to dismantle the total organization, this was very disheartening to CAP people. All agencies seemed to lose ground and, again, when it looked like President Ford might transfer us to HEW, it seemed almost as bad. After 10 years of dedicated work, it seems as if we are still struggling up a fairly steep incline, whereas we should be on a plateau progressing forward with less concern about annual funding as well as how much funding we will receive. MATURA has had the same funding level for the last 5 or 6 years. With cost-of-living increases—increases in rent, utilities, telephone, et cetera—there is only one answer, and by now you've guessed it.

Thank you.

[A poverty guideline table submitted by Mr. Pals follows:]

CSA POVERTY GUIDELINES FOR ALL STATES EXCEPT ALASKA AND HAWAII

	Nonfarm family	Winterization	Farm family	Winterization
Family size:				
1	$2,800	$3,500	$2,400	$3,000
2	3,700	4,625	3,160	3,950
3	4,600	5,750	3,920	4,900
4	5,500	6,875	4,680	5,850
5	6,400	8,000	5,440	6,800
6	7,300	9,125	6,200	7,750

Note: For family units with more than 6 members, add $900 for each additonal member in a nonfarm family and $760 for each additional member in a farm family.

Senator CLARK. Thank you very much. You may be on the incline, but it looks like you have accomplished a great deal; in particular, the winterization program which is the kind of program that, it seems to me, can have a lot of practical effect with a fairly small amount of money expended. We compliment you on that.

I just want to point out that Congressman Tom Harkin on my immediate right, as you know, is also sitting in on the hearings.

We are going to go ahead with the panel and then, Tom, if you have anything you would like to say at that point, we would be happy to hear you.

Representative HARKIN. Thank you.

Senator CLARK. We are going to hear now from our next witness who is, in fact, the director of this center, Mrs. Forsyth. I want to start, Louise, by saying we are very, very grateful to you for making the arrangements here and allowing us to use your center.

STATEMENT OF LOUISE FORSYTH, DIRECTOR, MADISON COUNTY MULTIPURPOSE CENTER, WINTERSET, IOWA

Mrs. FORSYTH. We are most happy to have you, and we are glad to do it. Welcome to everyone who is here. I am extremely pleased to see such a large turnout and so many strange faces. This means there are people from without our area.

My roots are planted quite firmly in Madison County. I was born and raised in Lincoln Township and have lived in Madison County all my life, except for 9 months spent in California in 1955–56. My great grandfather was a country doctor in that neighborhood in the late 1800's and early 1900's.

My personal association with Madison County Multipurpose Center was on January 16, 1974, when I began work as assistant director on a part-time basis. I did not know at that time that I would become the director, as I have in a short 2½ years. The center staff at that time consisted of the director, Mr. Herb Flint; a part-time outreach worker; and myself.

I knew relatively little about CAP agencies—their purpose, operation, or funding. When I started work, the funding for future operation was very shaky, and remained that way for quite some time. The first experience I had in dealing with public officials and others outside of the CAP agencies was when we compiled a report on center activities and services, presenting them to the mayor and city council and enlisting the support of the Madison County Board of Supervisors just in case we were not funded again through the OEO program.

When I came on board, the title VII nutrition program was operating in four sites: Earlham, Truro, St. Charles, and Winterset. The meals for Winterset participants were served 5 days a week at the multipurpose center and the associate director for the program had—and still has—her office at the center.

Countywide Transportation System

In the summer of 1974 we—the area agency on aging staff, Madison County Board of Supervisors, center people, and other interested people in the community—began putting together plans for a countywide transportation system for our senior citizens who could not provide their own and needed such a service in order to remain in their own homes. Mrs. Stroeber has told you this started off on February 3, and she and Mrs. Carter from Macksburg were the first riders.

As we worked on this plan, Glenda Knight, a planner with the area agency on aging, began to think of expanding the use of the transportation service by multifunding. This could be done by setting up a contract for purchasing services with the Department of Social Services, thereby making it possible to provide transportation to the blind, the handicapped, and the disabled, as well as those over 60 years of age.

I think, probably, if I had known how much bookwork, extra hours, headaches, hassles, et cetera, were involved, I probably would have opted out of any involvement with the program. Nevertheless, I am not sorry I didn't know, and I feel it has worked out very well. We are in our second year of operation and are gaining friends and participants every month.

One project leads to another. In the spring of 1974, the nutrition program in Winterset, particularly, was not gaining—people were not participating. With some funds that MATURA had available, they purchased a used car—a 1968 Bel-Air Chevrolet four-door—and provided a driver and gas for 6 months as an experiment to see if transportation lack was part of the reason for the low numbers participating. On about May 1, 1974, the car was put in service.

We were also aware that there was considerable misinformation circulating in regard to the program. The area agency decided to use some funds allocated for supportive service to provide an outreach worker to work exclusively at contacting people over 60 and explaining the program and its purpose.

In the 10 weeks this outreach person worked, meal participation in Winterset doubled, and also increased in the other sites. The transportation provided by the center car was a factor that could not be taken lightly. If my memory serves me correctly, I think that 60 percent or more of the people availing themselves of the use of the car were coming to the meals; this percentage has continued.

We still are operating this 1968 Chevy. We have not received any Federal, State, or county funds since the end of the first 6 months. This operates exclusively within the city limits of Winterset. The donations of the participants, the community, and the city keep it going from day to day. Sometimes it gets a little shaky but, so far, faith, the community, and the people that use the car have kept it going.

The only other public transportation in the town of Winterset is one taxi and the county van, when it is in town and which is not available 5 days a week for the people in Winterset to use. Neither the car nor the van operate on weekends, so this means that people are without transportation unless they have their own.

On February 10, 1975, Therese Brittain, associate nutrition director, and I attended a town meeting called to discuss community needs. Except for a group interested in finding a solution to the problem of inadequate sewers, we were the only ones attending. A representative from the Central Iowa Regional Association of Local Governments gave a brief résumé of the Federal Housing and Community Development Act of 1974 and the related community block grant program.

Certain city activities were eligible for funds under these programs. The one that caught our attention was acquisition, construction, and reconstruction of senior citizens' centers. Now we knew why we had attended the meeting.

Needed: A Kitchen

By this time it was becoming apparent that any congregate meal program, particularly in a small community, could operate more economically if the food was prepared at the serving site. The kitchen facilities in our center were inadequate to prepare a full meal, so we submitted plans and estimates to the city council to build a kitchen in another room of the center—the room occupied by the kitchen to be converted to office space.

Our plans were made part of the application sent to HUD for approval. On Friday, August 1, 1975, confirmation of the approval by the Department of Housing and Urban Development of the grant for $293,000—$285,000 for sewer improvement and $7,500 for the center kitchen—was received by the city mayor. Then came a long period of frustration of planning and estimating, waiting on approval, et cetera, and, in the meantime, everything had gone up in price.

Finally, all the adjustments, deletions, and changes were made and a contract to get the work started was let the first of June 1976. The kitchen is practically completed. We still lack a garbage disposal and the booster heater on the dishwasher. Today we are initiating it and will soon be preparing meals for our elderly.

I think we have proved that, with the cooperation of the community, a goal can be achieved that would have been impossible for one segment alone.

In each of the projects that have been initiated and brought to a successful completion, I think that a number of people that did not know anything about the multipurpose center or what a community service agency is supposed to do, except that we existed in what used to be the "old creamery building," now know what we are, what we do, and why we do it. I sincerely hope that such joint efforts will bring many more projects to help our fellow man to successful completions in coming years.

One of the biggest hurdles for any people program, particularly those involving people in rural areas, is reaching those people with accurate, unimbellished information about the program and its aims. I feel that personal eyeball-to-eyeball contact by an adequately trained and informed outreach person is the only answer.

Outreach Allocation Should Be Updated

Every program written and implemented should allocate enough money for this outreach. CSA centers are operating on the same allocation that they were 10 years ago so therefore cannot provide the outreach personnel necessary to reach the number of people that need to hear the news. Their expertise could be used to train and supervise the people needed to reach the prospective participants in these programs and to assess the value of the programs.

I would like to infringe on, maybe, a little bit of extra time to express my appreciation and thanks to the following people:

Herb Flint, director of the multipurpose center from its beginning in 1966 until January 1975 and under whom I started to work; H. W. Callison, Reese Bridenstine, Harvey Davis, and Joe Pals for their confidence and backing when I became acting director of the center and later as director. I could not have made it without them. To the mayors, past and present, of Winterset; the city council members, past and present; the Madison County Board of Supervisors; the area agency on aging, particularly Kay Samec, Vada Babcock, Glenda Knight, Rhonda Varnum, and Vance Baird: Les Goeldner, chairman of the area agency on aging advisory board; and the Central Iowa Regional Association of Local Governments, that is, Gary Pryor, Jerry Franke, Judy, and Joe. And for the efforts and help above and beyond the call of duty in getting things ready and in shape for this hearing today: Yvette Wilson, transportation secretary and all-round handyperson: Betty Berry, outreach worker; Fred Vierling, Dan Rater, Helen Grandfield, Lillie Moore, Florence McCauley, and Wilma Barker; Roscoe Tyer, general contractor for our kitchen; and his personnel and subcontractors.

Finally, I would like to introduce my mother, Mrs. Neva McKibban, a member of the Hillbilly Band and an active participant in center activities.

Senator Clark. Yes. Stand up, please. We need the drummer.

Mrs. Forsyth. And I would like to say a special "thank you" to her and my father, now deceased, for raising me in a home where love, thoughtfulness, and concern for others was a daily part of life.

Senator Clark. Thank you very much for an excellent statement. We appreciate it very much. We can see why people are doing so many excellent things around here.

Mrs. Forsyth. Thank you.

[A prepared statement of Mrs. Forsyth follows:]

PREPARED STATEMENT OF LOUISE FORSYTH[1]

The Madison County Multipurpose Center, located in Winterset, Madison County, Iowa, was opened in 1966, in a building that had been used to house a creamery (some of the vats and other equipment were still there and had to be removed), cream-buying business, and hatchery. There were no ceilings—just unadorned beams and hollow tile walls.

The reason for the opening and continued existence of any CSA (prior to 1974 CAP) Center was, and is, to provide help for people, particularly those with low incomes, the handicapped, blind, disabled, and/or disadvantaged.

We feel that over the past 10 years we have helped to coordinate programs that have provided help in many areas and have generated other needed programs.

From the beginning the center people have worked a great deal with the elderly and the handicapped. The center was instrumental in starting, and continues to work with, seven senior citizens' groups in the county. The center serves as the meeting place for four of these groups.

The center conducts, and has since shortly after opening, a class for adult handicapped people; most of these people reside at Horton's Custodial Home just north of Winterset. This class consists of a craft project and refreshments. The help in teaching the craft lesson and providing refreshments is all volunteers—most of whom are senior citizens.

Two very important things, or benefits, to the participants in this class have been self-discipline (learning to complete a task) and a sense of accomplishment.

It was through the center staff's concern and interest in these handicapped people that an effort was launched to start a challenge center as a satellite of the Southwest Iowa Sheltered Workshop, located at Afton, Iowa. This challenge center began operation early in 1975.

A class is still held at the center one afternoon a week for those handicapped people who are unable to attend the challenge center.

In past years the center director and others directly involved with center have worked with the health planning council to encourage doctors to come to our county and in getting new nursing homes (4) and a custodial home in operation. They also have been active on the board of the home-health agency (Earlham CARE program) and in recruiting home-health aides.

Our center has operated a rent-a-kid, or busy kid as it is now known, service for the past 5 or 6 years. We also keep in close touch with the Job Service of Iowa and make referrals to them and to the EDS Manpower Office.

Head Start, Neighborhood Youth Corps, GYOP, and many other self-help agencies received our full support and cooperation.

GED certification classes, classes in sign language for those wishing or needing to communicate to the deaf, classes in needlecraft and ceramics are held regularly at the center.

We maintain a close contact with various health agencies: i.e., the Commission for the Blind, Easter Seal Society, the Cancer Society, Crippled Children of Iowa, and Planned Parenthood.

One of our greatest areas of influence has been in alerting the community to the need for coordinated volunteer activities. Over the years a great number of women (over 200) have been involved in: (1) a clothing room (used clothing donated for use by those who need them); (2) personal shopping service to three nursing homes; (3) library service for nursing home residents; (4) friendly visitors; and (5) handicapped class once a week.

Other activities and services that came from the center's efforts are the hospital guild; Madison County Title VII Nutrition program; a car that provides transportation for people over 60 within the city limits of Winterset; the Madison County Title III Transportation System; a HUD block grant to build a kitchen at the center so that the congregate (Title VII Nutrition) meals could be prepared on site in Winterset; 51 homes weatherized (attic insulation, caulking of windows and cracks, storms and screens put on); a summer recreation (1976) program for youngsters from low-income families, ages 8 through 13—50 enrolled; approximately 400 homes reached with direct (one-to-one) information on SSI; property tax relief; rent reimbursement; countywide transportation; nutrition meals (since September 1975); and a kitchen.

As the months and years fly past, it is our hope and aim to continue to serve the people in need in our county to the best of our abilities and to continue to

[1] See also appendix 1, item 2, p. 43.

seek and enlist the help of whatever agency or individual that is needed to provide this service.

The real challenge for community centers is to be foresighted enough to recognize the changing needs of the community and be prepared to meet these needs.

Senator CLARK. I would like, Dr. Fickel, to call on Congressman Harkin. I know he has office hours downtown starting about 10 minutes ago.

Representative HARKIN. That is right.

Senator CLARK. We will take your statement now, then we are going to have Dr. Fickel's, and we will be closing.

Go right ahead.

STATEMENT OF HON. THOMAS R. HARKIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Representative HARKIN. Thank you very much, Senator Clark.

Dr. Fickel, I appreciate your indulgence.

I had previously scheduled office hours in a mobile office starting at 11:30. I am a little late.

I deeply appreciate the opportunity to be here. I am no stranger to this place, as you all know. I was just invited to stay for lunch, but I guess I am going to have to miss it.

Senator CLARK. I will eat for both of us.

Representative HARKIN. I appreciate your coming out here and having these hearings. It seems that whenever Congress holds hearings on anything about rural affairs, especially on the elderly, they usually do it in Washington, D.C., where people can't get to the hearings. So I think we ought to be thankful to Senator Clark for bringing his committee out here to where the problems really are. If there is one thing that I discovered in just a year and a half in Congress, it is that you know the answers are not in Washington—the answers are out here where the problems are. So by bringing the committee out here for the hearings, I think they will gain a very good insight into where the problems are that the rural elderly face.

Rural America in the past few years is becoming less visible in terms of priority in our Federal programs. This is so because, let's face it, those of us who represent rural areas are becoming fewer and fewer in Congress. The district that I represent is one of the most rural in America. Out of 435 congressional districts, this is the eighth most rural.

Now if I had been elected to Congress about 25 years ago, there would have been about 125 Members of Congress from areas about like this. Now there are only about 25 of us. As rural America becomes less and less visible in terms of the Federal Government, the elderly who are becoming less visible all around the country have become even less visible in the rural areas.

RURAL ELDERLY SUFFER MORE

As bad as things have been for the elderly in the cities, their problems have doubled and quadrupled in the rural areas because of the low visibility. These older persons become isolated. The poor health standards in the rural areas are something that has recently come to our attention in Washington. Also, problems with housing, and especially transportation.

Recently I just read in the *Congressional Record* the "Bicentennial Charter for Older Americans" prepared by the Federal Council on Aging. I don't know if anyone brought it up here yet to see, but it outlines a "bill of rights" for the elderly in our society which I think ought to be adopted by our Government:

(1) The right to freedom, independence, and the free exercise of individual initiative;

(2) The right to an income in retirement which would provide an adequate standard of living;

(3) The right to an opportunity for employment, free from discriminatory practices because of age;

(4) The right to an opportunity to participate in the widest range of meaningful civic, educational, recreational, and cultural activities;

(5) The right to suitable housing;

(6) The right to the best level of physical and mental health services needed;

(7) The right to ready access to effective social services;

(8) The right to appropriate institutional care when required; and

(9) The right to a life and death with dignity.

While all older Americans have had many of these basic human rights denied to them, those living in rural areas have suffered most of all. For example, in 1973, the Department of Health, Education, and Welfare spent only $7 million out of $175 million on health services delivery in rural areas, although statistics show that approximately 140 rural counties in the Nation do not have a physician and that they have very limited auxiliary health services. In the Congress we have passed legislation designed to encourage health service professionals to practice in rural areas. But it is just a step, and there is much more that needs to be done.

We do have some of the minivans now. They have been very good but, as we all know, there is not enough of them and they only service a very small fraction of the people that really need them. The Labor-HEW appropriations bill which Congress has enacted provides more funding for senior citizens and more than requested by the administration. Title III of the Older Americans Act has been increased quite a bit. The nutrition program, which provides for the congregate meals, has also been increased. One provision that I was especially pleased to see finally get funded was title V, the multipurpose senior citizens program, which has not before been funded. I suppose we have just touched on this.

Senator CLARK. This kind of center.

MUCH REMAINS TO BE DONE

Representative HARKIN. Yes. This now is being funded for the first time. Again, while we have made some progress, there is a lot more to be done. I believe that I am well represented on the Committees on Aging by Senator Clark from the Senate and Congressman Blouin from the Second District in the House of Representatives.

I am sure that it comes as no surprise to all of you here that Florida has, as I understand it, the most percentage of its people who are elderly, and second to Florida is Iowa. So I think it is very mandatory that we have someone on the Committees on Aging like Senator Clark and Mike Blouin.

Let me just wrap up by talking about money. We are all concerned about inflation. We are all concerned about the fact that those of you who are on fixed incomes see a real decline in your purchasing power because of inflation. We want it stopped, and we are trying to do everything we can to bring our Government spending under control. I hope that we can bring our budget into balance in the next few years and bring our inflation down to a reasonable level of maybe 1, 2, or 3 percent per year, but that means we are going to have to change some priorities.

You know we only have so much money and we are going to have to decide where that money is going to be spent and how it is going to be spent—that is where we need your input. No longer can we continue to go to the Federal Government to fund this and fund that, no matter how well-meaning a program may sound. So we have got to decide on our priorities.

Just let me mention one thing. The House of Representatives this year lost by 17 votes—17 votes—in an effort to stop funding for the B–1 bomber. Let me just tell you what that B–1 bomber is going to cost. I was a pilot; I flew for 8 years in the Navy, and my brother was an Air Force pilot. I can tell you the B–1 bomber is the biggest boondoggle that has ever been foisted upon us. To build a fleet of B–1 bombers and service them over a lifespan of about 20 years is going to cost this country somewhere in the neighborhood of $60 billion.

Now I just see here from the memorandum from your committee, Dick, that the Senate just approved $480 million for the Older Americans Act for the entire United States. Let's just round it out and say that is $500 million. For the cost of the B–1 bomber, we could fund the Older Americans Act at its present level—actually a little more than its present level—for 120 years. Now you tell me where your priorities are. I know where mine are, and they are with the Older Americans Act.

Thank you very much.

Senator CLARK. Thank you very much, Tom. [Applause.]

Representative HARKIN. I just want to say, again, thank you. I have to go to my office hours.

Senator CLARK. We are going to hear now from Dr. Fickel who, I think, is in a position to talk with you about a program in Red Oak that has been one of the most successful and one of the most exciting programs in terms of rural health care in America, and certainly leading the way in showing the rest of the country how this kind of program can work. So we are very, very pleased, Dr. Fickel, that you are here to talk with us about your program. Please proceed in any way you think appropriate.

STATEMENT OF DR. JACK FICKEL, MEDICAL DIRECTOR, FAMILY CARE CENTER, RED OAK, IOWA

Dr. FICKEL. Thank you, Senator Clark.

I think I will read this in the interest of brevity because I tend to wander if I speak extemporaneously. I tend to get off on another subject.

I would like first to thank you for this opportunity to present testimony to your committee. Any serious effort to consider problems of the rural elderly must, early on, deal with their health and the health care delivery system available to them.

In this brief presentation I will not attempt to define the specific health problem of the aged. It is well documented, however, that the elderly do have an incidence of chronic illness, debilitating disease, and other medical conditions requiring nursing, medical, and paramedical care which exceeds that of the general population.

Compounding the problems of the rural elderly is their decreased and decreasing access to health care facilities and personnel. They share poverty with their urban counterparts, although at a significantly higher rate. In Iowa 11.6 percent of the State's total population had an income less than the poverty level of 1969; of those over age 65, 29 percent had an income less than the poverty level. Of the urban elderly, 30.9 percent were below the income poverty level while the rural elderly, who did not derive the majority of their income from farming, had a staggering 40.6 percent. Four out of ten rural elderly were below the poverty level.

Iowa's system of indigent care at the university hospitals in Iowa City and the advent of medicare and medicaid has measurably eased the barrier poverty imposed on access to health care in those services covered by these programs. One serious problem for the elderly in their utilization of the medicare programs is the paper storm with which they are deluged by the computers after a claim is filed.

Keep in mind that many of these recipients have loss of vision, often are somewhat confused, live alone, and are totally unaccustomed to business forms and computer correspondence. Further most really do not comprehend the concept of usual and customary fees, the ever-changing level of deductibles and percentage payment of allowable charges and the variability in the percentage of payment for similar services when provided as a hospital inpatient, outpatient, or in the doctor's office.

With this in mind, then, imagine the confusion created in the mind of the poor recipients when they receive a form which gives them the detailed results of these policies, regulations, and calculations. The fact that all of the forms have the words "This is not a bill" printed in large letters is little comfort when the reader has no idea just what in the world it actually is. This problem has turned off elderly from applying for benefits under medicare; it also has caused them confusion and they have thrown away checks for the benefits. Simpler forms with less detail would aid the patients. More detailed information could always be obtained for those interested in obtaining it.

Lack of Accessibility to Health Care

The greatest problem facing health care in the rural elderly is their lack of physical accessibility to the health care delivery system. In larger urban centers, hospital outpatient facilities, public health departments, increased physician-patient ratio, and the availability of public transportation greatly facilitates the patient's entry into the system.

In rural areas, however, there is little or no public transit. Farms and small towns are remote from physicians and hospitals. Public health services in rural counties often consist of only one nurse in the entire county, and some counties have none at all. In several rural counties with a public health nurse the supervisors have been quoted as saying that they will have public health nurses in their counties

only so long as they have Federal funds to pay for them. Public health programs in the rural Midwest, if left to local government initiative and funding, will remain inadequate at best and too often will be nonexistent.

Despite efforts by the University of Iowa College of Medicine to retain primary care physicians in Iowa, the supply of doctors in rural areas continues to fall. The proportion of elderly physicians in rural counties sometimes exceeds the percentage of elderly in the country's general population. This affects both the availability and the quality of care.

In Red Oak we have initiated a program which we believe will reverse the worsening of the physician-patient ratio, improve the quality and availability of rural health care, initiate community health programs, teach medical students and family practice residents in a rural setting, and provide a model replicable in other communities who desire to achieve the same goals in their areas.

Ours is a private practice assisted by community effort and aided in the teaching and model aspects of the program by funds from the Kellogg Foundation. Two of us in private, solo general practices joined in establishing a group family practice. We adopted problem oriented medical records and relocated in a new medical office building adjacent to the local hospital. We established a satellite office in Malvern with a population of 1,200 20 miles away. We employed a family nurse practitioner who worked both in the central office and the satellite. The community actively recruited board certified family practitioners to join our group.

Within 1 year we had employed three such physicians. Red Oak had been unsuccessful in attracting any new young family practitioners since I came there in 1953. One of the new doctors joined us in July 1975 and the other two in July 1976. Our family nurse practitioner has since retired from practice for personal reasons and we are actively recruiting another physician extender at the present time. While she was in our employment we were dismayed to find that the Federal Government was imposing a major obstacle to the use of physician extenders.

Reimbursement Disallowed

Medicare refused to allow reimbursement for physician extenders' services provided in the absence of direct supervision—that is, the physical presence—of the employing physician. This makes it impossible to utilize either a physician's assistant or a nurse practitioner in an efficient and meaningful way to improve the availability of health care in rural areas.

Senator, I am aware of your efforts to direct this problem, at least in relation to the family nurse practitioner. Iowa's medicaid-medicare carrier has successfully induced HEW to include at least some of the 40 or so physician extenders employed in the State in a Social Security Administration contract study with the University of Southern California. When approved those physicians employing the physician extenders as part of the experimental study program may be reimbursed. Approval has been extremely slow and, as of my latest information, none were yet receiving reimbursement unless it was stated that the physician was present at the time of service. If the Federal

Government is truly interested in finding ways to improve the availability of quality health care in rural America, reimbursement should be available when State license and practice standards are met.

Although our program in Red Oak is in its infancy, we are encouraged by its acceptance in the community. Our successes and failures will serve as guideposts to other communities in their efforts to provide better health care. Evaluation studies are being developed to measure the impact it has on the health and well-being of the citizens it serves. Because of the age distribution of our area's population, a significant percentage of them will be among the rural elderly.

Senator CLARK. Thank you very much. I know that this program that you are developing there has been a particularly enlightening one and we enjoyed hearing about it. If you have any additional information, details, or material that ought to be made a part of the record about the center, we would be very, very pleased to have those as well.

Dr. FICKEL. I would appreciate the opportunity to submit a written report [1] in the next few weeks, Senator.

Senator CLARK. Good.

What can be done, Dr. Fickel, to promote the physician-extender concept around the State? Should the Federal or the State help? Could they be of some help by giving training, or is that not practical? In other words, what can be done to extend or to encourage physician extenders to go to the very rural areas? Are there any circuit-riding programs, or the like? Do you have any ideas about what might be done?

RESULTS MUST BE DEMONSTRATED

Dr. FICKEL. I think that to demonstrate that it works is probably the greatest tonic. As you know, six Iowa nurses went through a program at the University of North Dakota. I was preceptor for one of them. They have come back to Iowa to practice in the employment of physicians here. In Iowa, under State law, any physician extender must be employed by a physician, which I think is quite proper to provide quality health care. But proving that these will work and that they can provide service without sacrificing quality, I really think is the answer. Then we are going to have a need for funds in training large numbers of them, because I think there is a definite need and we believe that it is a very sound concept.

Senator CLARK. Thank you very much.

I notice that the hour of 12 o'clock has arrived and I know that they want to use this room to serve lunch. Thank you very much for coming and I particularly thank the witnesses that have testified. I am very pleased to have George Orr here who is the new executive director of the Iowa Commission on Aging. I thought we got a good bit of information from the panels that was very valuable to the committee.

I thought in particular the testimony in the first panel, the two ladies that talked about transportation—talked about some other problems, too, but particularly transportation—was helpful, as well as Mr. Willis Sprunger who spoke particularly about the Plaza—the housing area—and what that has meant to people who live there. Mr. Goeldner spoke about the very excellent example that we see in Earlham where they started, I guess, about 12 or 14 years ago to really

[1] Not received at time of publication.

begin to work in homes with homemaking, home health care nursing visits, transportation, meals-on-wheels—or I should say congregate meals in this case—all of the programs that they were able to develop in this kind of rural community.

We also, of course, were very pleased to have Woody Morris here who knows so very much about these programs and hear his point, particularly about the necessity for these Federal programs to deal with accessibility—not just the fact that we have got the programs, but whether or not anybody can get to them or whether they can get to the people one way or the other.

Then, also, this last panel. I particularly enjoyed Mr. Pals' talk about what you can do with a small amount of money in terms of the winterization program—the number of homes—300 some, I think you said—you were really able to help with a fairly small amount of money. Then Mrs. Forsyth, whom you have just heard, and the things that they have done here in the development, not only of a multipurpose center for so many things, but now also the development of this kitchen so that meals can be prepared right here. We also appreciate your testimony as well, Dr. Fickel. It has been very valuable to us.

We are going to go on over and hold hearings this afternoon in Ottumwa starting about 1:30 or 2 o'clock. So we are going to continue to hear various views. I think we are hearing that the major problem still seems to be lack of funds; that is to say, financial. I am speaking about an individual having enough money. The figures that you gave, and particularly Dr. Fickel, show that about 40 percent of the rural elderly are living below the level of poverty, and that is a distinguishing figure.

I think the accessibility of medical care which Dr. Fickel talked about still is obviously a problem in rural areas. We have seen the success of nutrition programs—the kind of program that we are going to take advantage of here, if I quit talking—and transportation which seems to mean so very much in rural areas, the housing, and the community center. We have started on all these things and they are very, very important, but we have got a long way to go.

Thank you very much for coming.

[Whereupon, at 12:12 p.m., the hearing was recessed.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. MAGAZINE ARTICLE AND BROCHURE SUBMITTED BY L. R. GOELDNER[1]

[From *Aging*, U.S. Department of Health, Education, and Welfare publication, dated November 1963]

A SMALL TOWN ORGANIZES BASIC SERVICES FOR ITS AGING

Earlham, Iowa, 30 miles west of Des Moines, is a farming community with a small central business district surrounded by pleasant homes in wide lawns. Earlham boasts a bank, one restaurant, an automobile dealer, a clinic, a school with a fine new addition, a weekly newspaper, and a farmers cooperative. The farmland around the town is rich and productive, except where the farms have been displaced by three gravel quarries.

Earlham is a pleasant place to live, and the people of Earlham are forward-looking and interested in improving their community. But Earlham is a small town. Only 800 people live there, only 2,000 in the entire school district, and 15 to 17 percent of these people are elderly. As in rural communities across the Nation, the percentage of the older population is higher than in most cities.

Many small American communities have thought of doing something for their older people, but most of them have felt too small or too poor. But Earlham went ahead with its plans and, in doing so, it made itself a model for community action.

As *Aging* goes to press, the Earlham Care program, initiated July 1, 1963, has already started the following activities: (1) Homemaker service; (2) Handyman service; (3) Activity center; (4) Counseling service; (5) Transportation within the community; and (6) Meals-on-wheels.

Care is planning to start friendly visiting and a telephone service this fall, and it has a visiting nurse available.

FIRST STEPS IN COMMUNITY ACTION

A group of Earlham citizens, calling themselves the Earlham Community Development Committee, started meeting informally to discuss the town's future. Earlham, they felt strongly, was a good place to live and they could build on this asset by making it an even better place. Among the things mentioned were greater services for the older people in the community.

In the spring of 1962, two members of the committee contacted the town's ministerial association with the request that the ministers secure the backing of the nine churches in town for a nursing home project. By fall, the association had decided on a thorough investigation and appointed a committee of three ministers to make a study of nursing homes and to report with definite recommendations.

By the end of 1962, the three ministers were almost ready to make their report and to recommend that funds be raised for a 25-bed, nonprofit nursing home. But, at that point, they contacted the State Department of Welfare in Des Moines. There they received suggestions on other services which might be of benefit to the elderly, and they were urged to talk to Amelia Wahl, Kansas City Regional Representative on Aging for the U.S. Office of Aging.

[1] See statement, p. 7.

DEFINITION OF NEEDS

In early January 1963, Miss Wahl and Mrs. Virgie Love of the Madison County Welfare Department met with members of the development committee and the ministerial association. At this meeting, they discussed such basic services as homemaking and home nursing care, and made plans for a survey to learn what services the elderly population needed and wanted.

By March, Earlham had a survey form ready. It asked such questions as: Do you like living in Earlham? Would you participate in an activity center if one were made available? Do you feel a nursing home is needed in Earlham?

Many of the questions were preceded by a statement explaining a particular service, for example: "Some communities provide services to help persons stay in their own homes as long as possible. They have available persons who do part-time meal preparation, grocery shopping, and some housekeeping. These programs are called homemaker services. Do you feel this kind of program is needed in Earlham?"

Thus, the survey not only produced usable information but also began the community education that was necessary before the program would be accepted. The local weekly helped by carrying stories on the survey and its purpose, and it was the weekly that called for volunteers to conduct the survey.

On March 28, the 41 people who had volunteered to act as interviewers met at the Methodist Church for a short training session conducted by Miss Wahl. During the following week, 331 people in the district who were 60 years of age or older were interviewed and their responses recorded.

APPLICATION FOR GRANT

Earlham now had the information it needed to develop a realistic program for its older people. The idea of eventually building a nursing home in the town was not abandoned, but the concept had changed slightly. When the nursing home is built, it will probably be in conjunction with the Earlham Activity Center and, possibly, with housing for senior citizens.

With the data from the survey and the help of people at the State and regional level, a proposal was developed for an Earlham home care program and submitted to the Iowa State Department of Health. The proposal included a statement of objectives, a description of the way the program will be administered, the resources available, and the services proposed. The proposal stated that the "program was being set up on a demonstration basis for an anticipated 5 years dependent upon the availability of funds to support it." It also mentions the plans for a nursing and custodial facility which will become the headquarters for both the home care program and the activity center.

Fortunately for Earlham, not all of the State formula grant funds had been committed in Iowa. These funds are allotted to all States by the Division of Chronic Diseases of the Public Health Service, U.S. Department of Health, Education, and Welfare, to be used for just such local programs. A sum of $21,000 from the Iowa funds was approved for the Earlham program.

EARLHAM CARE PROGRAM

Shortly after Earlham was notified that the proposal had been approved at the State level, the Earlham care program was incorporated and a program director was elected by the board of four officers and five members. Final approval of the project by the regional office of the Public Health Service in Kansas City was received on July 1 and the program started to operate in a temporary office next to the bank. By the time the permanent office and the community activity center were ready for occupancy, several services were already in existence.

In late August, a short institute was held to train future homemakers for the program, with speakers from the Polk County Home Care-Homemakers Service, the Des Moines Health Center, the Iowa State Department of Health, the Public Health Nursing Association, and the Iowa Heart Association. Six housewives had volunteered to do this work and three were employed almost immediately.

The elderly people using the homemakers services are billed by the care program which, in turn, pays the homemakers. The program operates as a clearinghouse, receiving requests and referring them to qualified people.

A handyman service, operated on the same basis, has proved very popular. Although one handyman is available—and two boys who mow lawns—the Care office has received so many requests it could use another man. The handyman replaces lightbulbs, makes small repairs, and is available to put up storm windows before winter comes.

One of the members of the Care board is a graduate nurse, and she is on call to visit the homes of elderly invalids.

Arrangements have been made with the local retirement home to provide meals-on-wheels.

The Care office has already been helpful in counseling elderly people on financial problems, and it also serves as an employment service, receiving requests for part-time help and helping those who desire jobs to find employment.

Earlham is off the regular route for buses going into Des Moines and efforts are being made to remedy this situation. In the meantime, an arrangement has been made with an elderly retired man, who owns a car, to furnish transportation within the town.

On Sunday, September 15, Care held an open house at the new office and activity center. A total of 135 attended the function and many others dropped in during the following week. The center will provide space for parties, programs, and table games.

A shuffleboard court has been constructed across the street, and many of the elderly men of Earlham are busy each day from 9 to 12 and from 2 to 5 playing shuffleboard, with time out in the middle of the day for lunch and a rest.

FUTURE PLANS

The future of the Earlham Care program depends on Earlham. The county welfare department is happy to see such programs as home care, homemakers service, and meals-on-wheels underway in the community. It is cheaper to pay fees for these services for recipients of old-age assistance and medical assistance for the aged, than it is to pay for nursing home services. Sooner or later Earlham may also initiate foster home care.

This fall, again with the help of the ministers, the Care program will begin a friendly visiting program. Plans are also being made for a telephone service or some other communication system for keeping in touch with those among the elderly who are ill or unusually frail. Regular contact with these people, especially if they live on isolated farms, can often prevent a tragedy. When there is no answer to a regular call, someone will investigate at once.

MODEL FOR OTHERS

Any demonstration project is designed to show how something will work. The Earlham Care program had already demonstrated one thing even before it started operating on July 1—the importance of community planning and the steps to be taken in introducing such a program. On a small scale, Earlham's program is a model for community planning.

Earlham's effort can make other communities realize that they, too, can do more than they have, that they have available resources of their own, as well as resources at the State and even Federal level, which are still untapped. But other communities may not be so fortunate as to find that, at almost the end of the fiscal year, the State department still has uncommitted funds. People in these communities should start working now toward their goals and contact their State health department as soon as they have an understanding of their needs and a plan for meeting them.

Furthermore, in many States, welfare departments may also, under the 1962 public welfare amendments to the Social Security Act, obtain demonstration funds for local programs.

For information on how these funds may be used, write to your State health or welfare departments or to your State commission on aging. For further information on the Earlham Care program, write to John R. Carson, program director, Earlham, Iowa.

[1966 brochure]

EARLHAM HOME CARE PROGRAM

(A pilot project for Earlham and Dexter communities)

What is the Care Program?

The Care program is a concerted effort of the community to extend a helping hand to the aged and chronically ill residing within Earlham, Dexter, and the surrounding communities.

Existing Services:

1. Homemaker service.
2. Visiting nurse service.
3. Handyman service.
4. Transportational system.
5. Friendly visitation and telephone visitation.
6. Meals-on-wheels.
7. Employment and counseling service.
8. Intercommunication system.
9. Community center.

Who Are the Homemakers?

Each homemaker is a mature, competent woman, carefully chosen for good health, dependability, and homemaking ability. She has had a professional training course.

Responsibilities of a Homemaker:

Homemakers shall assist the family in maintaining a cheerful, relaxed home environment enabling them to live in their own homes as long as possible.

The homemaker will perform household tasks such as light routine cleaning, preparing meals, caring for patients, marketing, and other similar tasks.

Visiting Nurse Service:

A visiting registered nurse acting under the supervision of one's own physician will make home calls as prescribed by their doctor.

Handyman Service:

Handymen put on storms, screens, rake or mow yards, etc. Fee based on type of work and time involved. This has proved to be of invaluable assistance for people within the community.

Transportation Service:

Transportation in town is 25¢ one way or 7¢ a mile out of town.

Friendly Visitation and Telephone Visitation:

This volunteer service by individuals or church groups within the communities helps shut-ins realize someone cares.

Meals-on-Wheels:

Balanced and/or special diets are available through meals-on-wheels.

Employment and Counseling Service:

As a courtesy service to the community, the office assists employers secure personnel, and job-seekers to find employment.

The office is happy to assist in counseling such subjects as insurance, social security, financing, etc. Your problems are confidential to this office.

Intercommunication Service:

An intercommunication system is available upon request.

Community Center:

Citizens are invited to visit and enjoy the facilities available in the community center located within the main office building. Please feel free to enjoy its comforts.

Requests for Service and Who Pays?

Earlham is proud to welcome the Dexter community in their program effective April 1, 1966.

Home care services are available to all senior citizens and the chronically ill.

Earlham, Dexter, and their communities may request services through their physicians, nurses, social and health agencies, and individuals by personal contact or by dialing 4341, Earlham, Iowa, or after office hours, 4711 or 2471.

All personnel are paid by the care office. No money is to be exchanged between the personnel and the patient.

All financial arrangements are made prior to commencement of services. If funds are not available, efforts to obtain assistance will be made by the office.

All charges are billed to the responsible parties monthly. All payments are to be made to the care office.

Hours Available:

Except for emergency situations, when special rules will apply, the general homemaker services will be available 5 days a week, 10 hours a day, Monday through Friday. Part time services are also available.

ITEM 2. ADDITIONAL INFORMATION SUBMITTED BY LOUISE FORSYTH[1]

WELCOME TO WINTERSET

(From the staff of the Multipurpose Center, 114 North 2d Street, Winterset, Iowa)

Through the courtesy of the Welcome Wagon, we would like to tell you about some of our activities and invite you to enjoy them with us.

We have activities for most age groups and hope to get more going soon. Most of our activities are for the senior citizens—those over 60.

To give you an idea of what we are all about, here is a list of things going on at the center regularly:

The ceramics class meets on Tuesday afternoon at 1:30 p.m. (The regular ceramics class is limited to those over 60. There are a few that are interested in cold ceramics and we have a gal in town who is willing to give some instruction. This group will be open to all ages.)

The kitchen band is one of our most active projects. It is under the direction of Gertrude Shoemaker. They practice at the center and entertain at the nursing homes, at the covered bridge festival every fall, and anywhere else they are invited to entertain as long as it is within a reasonable distance.

On the second and fourth Tuesdays of each month, the social security representative is at the center from 9 a.m. until noon.

Wednesday: A representative from the Care office at Earlham, Iowa, is here at the center from 9 a.m. until 12 noon. Care provides homemaker/home health aides for the aged and infirm in their own homes; the acute and chronically ill, the disabled and lonely, children, and entire families at times of illness in the home. This service is available countrywide.

On Wednesday afternoon the class for the handicapped meets at 1:30 p.m. Mrs. Pearl Flint is in charge of the planning end of this class and oversees the volunteers in executing the program. She is always in need of people to volunteer their help with this activity—one of becoming involved and acquainted in a new community.

Thursday: The needlecraft class meets at 1:30 p.m. Our teacher, Mrs. Peggy Taylor, can teach you a new skill or help with an individual problem.

Friday: On the first and third Friday afternoons of each month the Young-in-Heart Card Club meets to play pitch. Anyone over 60 that enjoys playing cards is welcome to come and join the fun.

On the second Friday of each month the Golden Years Club meet for a potluck meal and a program. In the winter, they meet at 12:30 p.m.; during the rest of the year, they meet in the evening.

On the fourth Monday of each month the Sixty-Plus Club meets at 1:30 p.m. for an afternoon program, bingo, and refreshments under the direction of Mrs. George Montross and Beulah Mundell.

On Monday evening and Tuesday evening from 4 to 5 p.m. we are having a needlework and craft class for fifth and sixth graders. They will be learning to knit and crochet first and other skills and crafts later as time goes on. These classes going on now have mostly girls enrolled but we will be setting up some classes for boys if there is enough interest.

Other services originating from the center are the shopping carts and bookmobile to the nursing homes. Every Tuesday and Friday mornings the clothing room is open. There is a variety of good, usable clothing available just for coming in. We also appreciate donations of good, used clothing.

We provide an information and referral service to the community as far as our knowledge and time will allow.

The staff at the center would like to again say "Welcome to Winterset." We will be happy to assist you in solving any problems that come within our area of service and invite you to come in and take part in any of our activities that interest you.

HERB FLINT,
Director.
LOUISE FORSYTH,
Assistant Director.
BEULAH MUNDELL,
Outreach Worker.

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[1] See statement, p. 27.

NUTRITION MEALS FOR THE ELDERLY

A nutrition program for persons 60 years of age and older, and their spouse, started in Madison County, Iowa, in November, 1973. A good, hot, nutritious meal is provided at the multipurpose center in Winterset at 11:30 a.m. Monday through Friday. Cost of the meal is on a sliding scale—pay what the meal is worth to you. Reservations should be made in advance, either with Esta Bishop (462-1620) or the multipurpose center (462-4704).

Here is a sample of some of the menus served recently:

Creamed chicken on biscuits, mashed potatoes, buttered corn, cole slaw, and peaches.

Fish with tartar sauce, mashed potatoes and gravy, buttered peas, lettuce salad, and vanilla pudding.

Minishrimp, mashed potatoes and gravy, buttered peas, bean salad, and fruit cocktail.

Coffee, milk, and juice and bread and butter are served with each meal.

The meal is served by the site coordinator, Esta Bishop, and at least two volunteer helpers here at the center. Come and enjoy a good meal and companionship. Make new friends.

For further information, contact Terese Brittain, project director, at the multipurpose center (462-4704).

Madison County, Iowa, has a total population of 11,558. Out of this number we have the largest percentage of people over 60 of any county in the State. There are 2,631 persons aged 60 and over in the county; 1,329 of these people have incomes below the poverty level.

If we stay in existence, we hope to take some kind of count right here in Winterset to determine approximately how many people living here are over 60 years of age.

The following is a partial copy of facts taken from our quarterly report to Matura for the months from December 1, 1973 through January 31, 1974:

Volunteers (number of people and total hours worked):

Nutrition program—18 women working a total of 445½ hours (this is not counting the women and hours worked from the other sites in the county serving nutrition meals (Earlham, Truro, and St. Charles).

	People	*Hours*
Shopping carts to nursing homes	29	260
Clothing Room (2 mornings a week)	18	272
Bookmobile	10	32
Kitchen band	27	432
60 Plus Club	44	176
Golden Years Club	18	54
Young-in-Heart Card Club	24	24
"500" Card Club	6	6
Friendly Visitor	1	36

Nutrition meals (average attendance per week) 68.3

Other projects and meetings and estimated attendance:

GED—80 people have gotten diplomas in the past 4 years.

Needlecraft Classes (12 meetings) average attendance 6.

Sign Language Class (8 meetings) average attendance 17.

Ceramics Class (7 meetings) average attendance 6.

Estimated number of people attending other meetings such as Boy Scouts and Cub Scouts, Hospital Guild, card clubs, etc., 309.

Total number using some facility of the center or attending a meeting here—1,363.

Total number of volunteers in all programs	219
Total number of volunteer hours	1,923

113 different families or individuals visited the clothing room—some more than once for a total of 246 visits in the three month period. Each of these times those people came in they found some item or items of clothing that they could use. All the clothing is donated.

Madison County title III transportation costs from February 3, 1975 through August 31, 1975, and other interesting data. Number of people served during this period:

18 Madison County handicapped.

15 Polk County handicapped—residing at Horton's Custodial Home or a foster home in Winterset.

1 Wapello County handicapped—residing at Horton's Custodial or a foster home in Winterset.
3 Dallas County handicapped—residing at Horton's Custodial or a foster home in Winterset.
167 other individuals.

Total number of miles driven from February 3 to August 31, 1975, is 12,830. The van is averaging 10 miles per gallon of gas.

ACTIVITIES BY AND FOR THE AGING THROUGH THE MULTIPURPOSE CENTER IN WINTERSET, IOWA

(1) Sixty-Plus Club—average attendance 120.
(2) Golden Years Club—average attendance 50.
(3) "Young-in-Heart" Card Party—average attendance 30.
(4) "500" Card Club—average attendance 12 to 15.
(5) Truro "Guys & Gals" Club—average attendance 25.
(6) St. Charles Seniors—average attendance 25.

AARP meets at the center once a month (has a membership of over 125 Madison County people). Center director assisted with organizing group and occasionally assists with programs.

(7) Earlham Care Homemaker Service: A representative is at the center every Wednesday morning and they hold their training classes at the center.
(8) Earlham Sixty-Plus Club: We work with this group.
(9) Ceramics classes and workshop (the kiln is owned by the center).
(10) Needlecraft of all types.
(11) Employment Service: The ISES representative is no longer here every week but we make referrals when we can and received job lists from the ISES office in Des Moines.
(12) Rockhound Club: No longer meets at the center but they began under the center's wings.
(13) Clothing room is maintained at the center and staffed by volunteers two mornings a week. (The volunteers are recruited and schedules made up by Betty Berry, outreach worker for the center.)
(14) Shopping cart to nursing homes.
(15) Bookmobile cart in nursing homes. (Items 14 and 15 are also staffed by volunteers recruited and scheduled by Mrs. Berry.)
(16) Big print songbooks.
(17) Big print Scriptures.
(18) Talking book machines.
(19) Big print books.
(20) Monumental park project.
(21) Senior citizens festival.
(22) Toys-for-tots.
(23) Friendly visitors.
(24) Antique show at covered bridge festival.
(25) Antique sale at covered bridge festival.
(26) Hobby show at covered bridge festival.
(27) The center is open for use as a comfort station both days of the covered bridge festival—coffee and cookies are on tap and interesting wood carvings are on exhibit.
(28) Trips to points of interest—art center, science center, Perry Conservation Park, Red Rock Dam, State fair every year, hobo day at Britt, Iowa, and many more.
(29) Programs and demonstrations on clothing and food for the elderly.
(30) Bread project—this project was discontinued with the closing of the Goode Bakery but is worthy of note. Mr. Goode bakes small loaves of bread—just the right size for a person alone.
(31) Campaigned for low-rent housing for the elderly—successfully. We now have 43 units operating as North Ward Plaza.
(32) Programs for and in nursing homes.
(33) Golden voice choir.
(34) Kitchen band (men and women) average two performances a month (25–30 senior citizens—most of whom are past 70 years). Hillbilly Band. All senior citizens.
(35) Attempted to cooperate with every agency, both governmental and voluntary, that can aid the elderly of our county.

(36) Meals-on-wheels—meals are prepared by the hospital and delivered by volunteers coordinated by Mrs. Lee (Peggy) Taylor.
(37) Nutrition meals (title VII)—these are meals served each weekday at the center. Anyone over 60 may participate, regardless of income.
(38) Classes in sign language and lip reading—have had three classes (all ages included).
(39) Transportation—we are working with CIRALG and any other agencies available to see what we can accomplish.
(40) Entries in arts festival.
(41) High school equivalancy classes—we have had 6 classes with 20 per class. Also one basic education class where four people completed the course that could not read or write.
(42) Class of handicapped people (from Horton's Custodial Home and others in the county).
(43) Young mothers group.
(44) Boy Scout Troop No. 114. Cub Scout Pack No. 114 meet at the center at this time. When there was a Webelos Pack, it met here.
(45) Lending library (mainly paperbacks)—extensively used.
(46) Administered the N.Y.C. program, Head Start, and GYOP and summer recreation program for 8 to 12 year olds.
(47) Helped dropouts.
(48) Started (helped) hospital guild—they still have an occasional meeting and their bazaar here.
(49) Representative from WINN is here every week.
(50) Recruiters for the Army and Air Force are here every week.
(51) Polling place.
(52) Groups who meet regularly at the center:
(a) M.C.A.R.C.
(b) Red Cross.
(c) American Cancer Society.
(d) N.F.O.
(e) Farm Bureau ladies' guest day.
(f) Health planning council.
(g) Girls softball meeting.
(h) Republican caucuses and meetings.
(i) Democrat caucuses and meetings.
(j) Goodwill pickup station.
(k) Classes for knitting and crocheting (for fifth and sixth graders).
(l) Showers, receptions, reunions, parties (December is already book-full for reunions and family dinners).

In the future:

(1) To acquaint more of the people living and working in Madison County of the center (for both young and the elderly) and also some of the problems of our area as concerns the elderly/particularly.
(2) Transportation—increased use in the city of Winterset and countywide.
(3) Workshop for the arthritic, elderly, and handicapped in cooperation with the extension office.
(4) Get more things going for the youngsters in the way of crafts, sewing, etc.

The equipment to operate the center and equipment materials effectively is all here: tables, chairs, the public address system (which was designed especially for the building by Fred Kuntz), game tables, and equipment.

Greater involvement by the youth of the community in recognizing and meeting its needs.

SUMMARY OF CAR RECORDS, NOVEMBER 29, 1974, THROUGH DECEMBER 30, 1975

Receipts:	
Donations from clubs, churches, and service organizations	$864.00
Participants (people who ride) donations	852.71
Trash and treasure sales and food sales	196.11
City of Winterset	1,025.00
Total	2,937.82

Expenses:		
Driver		2,225.50
Gas and repairs		541.75
Miscellaneous		25.00
Total expenses		2,792.25
Balance		145.57
Grand total		2,937.82
Unduplicated people that rode in car		140
Unduplicated handicapped people that rode in car		24
Total number of trips (one-way)		2,773
To congregate meals	1,012	(37 percent)
For shopping	280	(10 percent)
Doctor or dentist	111	(4 percent)
Recreation	232	(8 percent)
Center class and challenge center	233	(8 percent)
Other, miscellaneous	259	(9 percent)
Trips of pickup congregate meals	550	(20 percent)
Errands for senior citizens	95	(4 percent)
Trips relating directly to congregate meals		(57 percent)
Miles driven from November 29, 1974, through December 30, 1975 (according to my figures, this is about 53 cents per mile, or about $1 per person)		4,956

This car is a 1968 Bel Air Chevrolet which was purchased in May 29, 1974, to be used to provide support for the nutrition program. Since this car was purchased, it has been driven 9,474 miles. Practically all of them within the city limits of Winterset.

Appendix 2

LETTERS FROM U.S. DEPARTMENTS AND AGENCIES

ITEM 1. LETTER FROM WILLIAM B. PRENDERGAST, ASSISTANT, DIRECTOR FOR CONGRESSIONAL AFFAIRS, ACTION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED JULY 27, 1976

DEAR SENATOR CLARK: Thank you for your June 21, 1976 letter that advised ACTION of the intent of the Senate Special Committee on Aging to conduct field hearings in Iowa, Nebraska, and South Dakota in August. We welcome this opportunity for the committee to see firsthand some of the results of the Older Americans Volunteer Programs and other ACTION programs in the communities where the volunteers serve.

For ease of reference the questions contained in your letter are answered below in the same order as received:

Question (1). What is the official definition of a rural area in your agency?

Answer. ACTION is guided by the definition used by the Bureau of Census, with the result that communities with fewer than 2,500 inhabitants are regarded as rural.

Question (2). Do you agree with the designation—as in Administration on Aging programs—that an "older American" is of age 60 or over?

Answer. In our three older American programs, we accept as volunteers only those aged 60 or over. This standard has been set by Congress in P.L. 93–113, the Domestic Volunteer Service Act, which provides the statutory authorization for these programs. None of these programs has the statutory requirement that the recipients of services be older Americans; however, we try to maintain this as the principal thrust of the Senior Companion Program.

Question (3). How many Foster Grandparent, RSVP and Senior Companion programs are currently operating in each of the three States mentioned above; what are the locations and sponsoring agencies for each; how long has each project been in operation; what is the total volunteer enrollment for each; and what are the current total program obligations of Federal funds provided through ACTION for each project?

Answer. Note: Current Federal funding is for 1-year budget period unless otherwise indicated.

Project sponsor and location	Project beginning date	Volunteers (as of July 1, 1976)	Current Federal funding
IOWA			
FGP:			
Iowa Commission on Aging—Des Moines	June 1972	97	$183,752
Department of Social Services—Glenwood	Feb. 1972	71	152,279
Dubuque Area Project Concern for Elderly and Retired, Inc.	June 1976	32	98,083
Rock Valley Rotary Club	June 1974	50	109,281
City of Fort Dodge	June 1973	47	105,823
Total	do	297	649,218
RSVP:			
Southwest Iowa Learning Resources Center—Red Oak	June 1973	141	13,603
Clinton Senior Citizens, Services, Inc	do	115	16,115
Northeast Iowa Council on Aging—Waterloo	do	338	27,902
Chariton Rotary Club	do	139	15,000
Four County Benevolent Non-Profit Corp.—Belle Plaine.	June 1974	210	15,346
Department of Planning and Development—Burlington	June 1973	164	19,450
Senior Citizens, Inc.—Webster City	do	121	13,926
Story City Senior Citizens, Inc	do	280	21,000
Dubuque Area Project Concern for Elderly	June 1972	431	22,366
Newton "Y" Community Center	June 1973	156	15,215
United Way of Greater Des Moines	June 1972	735	43,862
Hope, Inc.—Fort Dodge	June 1973	175	17,654
Region XII Council of Governments—Carroll	June 1974	118	14,586
Northern Iowa Area Community College—Mason City	do	105	20,189
Ottumwa Area Chamber of Commerce	June 1972	218	15,527
Winneshiek County Crosslines Council—Decorah	June 1974	154	18,000
Total	do	3,600	309,741
Grand total	do	3,897	958,959
NEBRASKA			
FGP:			
Volunteer Action Center—Gering/Scottsbluff	June 1974	55	[1] 202,925
Nebraska Department of Public Institutions—Lincoln/Beatrice.	June 1972	74	[1] 239,986
Eastern Nebraska Human Services Agency—Omaha	June 1976	19	[2] 145,700
Senior Citizens Industries—Grand Island	June 1973	64	124,520
Total		212	713,111
RSVP:			
City of North Platte—North Platte	do	154	16,038
Crawford Cultural Center—Crawford	do	98	14,633
Lincoln/Lancaster County Commission on Aging—Lincoln.	do	300	[3] 15,063
Dawes County Commissioners—Chadron	do	101	16,289
Housing Authority of Falls City	do	160	[4] 19,946
City of Ogallala	June 1974	97	17,290
City of Grand Island	Dec. 1972	166	20,670
Nebraska Indian Inter-Tribal Development Corp.—Winnebago.	June 1973	175	17,576
Good Samaritan Village—Hastings	March 1973	191	19,279
Eastern Nebraska Human Services Agency—Omaha	June 1972	420	43,661
City of Alliance	June 1973	159	13,118
Mayor's Office—Henderson	Dec. 1972	50	8,019
Sheridan County Commissioners—Rushville	June 1974	97	19,256
Total	do	2,168	240,923
Grand total	do	2,380	954,039
SOUTH DAKOTA			
FGP:			
Aberdeen Area Senior Center—Aberdeen	June 1972	50	125,865
Pine Ridge Indian Reservation—Pine Ridge	do	40	99,211
Total		90	225,076
RSVP:			
Brown County Council on Aging—Aberdeen	June 1974	150	26,790
City of Canton—Canton	June 1973	160	17,240
Huron Senior Center—Huron	do	180	17,525
Dakota Wesleyan University—Mitchell	May 1973	180	15,000
City of Rapid City—Rapid City	June 1974	200	22,500
Senior Citizens Services—Sioux Falls	do	180	22,924
N.E.S.D. CAP—Sisseton	June 1973	177	21,004
Spearfish Senior Servire Center—Spearfish	do	192	15,000
Meade County Senior Citizens Center—Sturgis	do	150	14,700
Total	do	1,569	172,683
Grand total	do	1,659	397,759

[1] 19 mo. [2] 13 mo. [3] 6 mo. [4] 18 mo.

Question (*4*). Are there any VISTA projects or special volunteer projects serving the rural elderly in each of these three States? If so, can you provide a description of project activities and goals; sponsoring agency and location; number of elderly served; and current total Federal program obligations for each?

Answer. Note: In Fiscal Year 1976, the average Federal cost in direct payment to each VISTA volunteer was $4,470. This figure should be added for each volunteer in addition to the other support costs indicated.

Sponsoring agency and location	Number of elderly served and description of project	Current total Federal program obligations
IOWA		
VISTA:		
Commission on Aging, Des Moines.	4 VISTA's serving 600 rural elderly (with potential to 1,500)—increase awareness programs for the elderly to improve nutrition and health and raise income.	
Voluntary Action Center, Cedar Rapids.	1 VISTA serving 300 rural elderly—food stamp program awareness and Telecare.	$1,200 for volunteer transportation.
Iowa Western Community College, Council Bluffs.	4 VISTA's serving 3,500 rural elderly—identify health needs of senior citizens in 8 counties for health education and related courses.	$2,400 for volunteer transportation.
Mid-Sioux Opportunities, Inc., Remsen.	1 VISTA serving 1,500 rural elderly working with Meals on Wheels; transportation for the elderly and Telecare.	$500 for transportation contract on GSA car.
Volunteer Bureau, Waterloo	1 VISTA serving 30 rural elderly encouraging them to participate more fully in their communities through voluntarism.	$1,410 for volunteer transportation.
Minigrant: Mid-Sioux Opportunities, Inc., Remsen.	Coordinate volunteer opportunities for 15,995 persons over age 60 in 5 counties.	$2,275.
NEBRASKA		
VISTA:		
Center for Rural Affairs, Walthill.	4 VISTA's serving 180 rural elderly—establish Co-op food stores and provide information on agricultural issues.	$6,112 for volunteer transportation.
Nebraska Indian Inter-Tribal Development Corp., Winnebago.	2 VISTA's serving 120 rural elderly providing legal assistance to Indians.	$11,136 for volunteer transportation. $19,686 for volunteer supervision (both for 16 mo).
SOUTH DAKOTA		
VISTA: Northeast South Dakota CAP, Sisseton.	1,300 elderly low income in rural areas in fields of consumer education, health and nutrition, transportation, arts, crafts, referrals.	$3,000 for volunteer supervision and $2,000 for volunteer transportation.

Question (*5*). In addition to the information requested above for the Senior Companion program, can you supply the committee with a description of the volunteer settings and the number of elderly served by each of the Senior Companion programs in these three States?

Answer. As indicated above, there currently are no operating Senior Companion projects in the three States where the initial field hearings are to be held. It is contemplated that one Senior Companion project each will be funded in Iowa and Nebraska in the near future.

Question (*6*). Has your agency been unable to fund any grant applications from these three States for RSVP, Senior Companion, or Foster Grandparent programs during the last two years, and if so, how many?

Answer:

IOWA

Foster grandparents:
Cedar Rapids.
Clinton.
Ottumwa.
Senior Companions: Council Bluffs.

NEBRASKA

RSVP:
Columbus.
Kearney.
Loop City.
Seward.
Foster grandparents:
Kearney.
Loop City.

SOUTH DAKOTA

RSVP: Yankton.
Senior companions: Sioux Falls.

It is hoped that this information will be beneficial to the hearings. Please let us know if we can be of further assistance.

Sincerely,

WILLIAM B. PRENDERGAST.

ITEM 2. LETTER FROM FRANK B. ELLIOTT, ADMINISTRATOR, FARMERS HOME ADMINISTRATION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: This will reply to your letter concerning Federal programs for the elderly. You specifically requested information about the rural housing program of the Farmers Home Administration (FmHA) to be used at the Special Committee on Aging hearings which will be conducted in Iowa, Nebraska, and South Dakota.

We will answer the questions you asked in the order they were presented:

(1) Rural areas. Because of the nature of some of the FmHA programs, we have more than one definition for a rural area. They are as follows:

(*a*) The official designation of a "rural area" as it relates to the rural housing program follows:

> Section 520 of the Housing Act of 1949, as amended, states, "As used in this title, the term 'rural' and 'rural area' mean any open country, or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000, and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary of Agriculture and the Secretary of HUD." Attachment 1* is a copy of the definition of rural areas as it apears in FmHA Instruction 444.1.

(*b*) The official definition of a rural area under the business and industrial loan program is that " 'rural' and 'rural area' may include all territory of a State, the Commonwealth of Puerto and the Virgin Islands, that is not within the outer boundary of any city having a population of 50,000 or more and its immediately adjacent urbanized and urbanizing areas with a population density of more than one hundred persons per square mile, as determined by the Secretary of Agriculture according to the latest decennial census of the United States: *Provided*, that special consideration for such loans and grants shall be given to areas other than cities having a population of more than twenty-five thousand." This definition is also applicable to industrial grants of the community programs.

(*c*) As it relates to community programs, with the exception of "industrial grants" to the terms "rural" and "rural area" shall not include any area in any city or town having a population in excess of 10,000 inhabitants according to the latest decennial census of the United States.

(2) For rural housing loan purposes, we define a senior citizen as an individual who is 62 years of age or older. This is in accordance with the provisions of section 501(b)(3) of title V of the Housing Act of 1949.

(3) Section 504 Rural Housing Repair Loans:

(a) From fiscal year 1965 through fiscal year 1975, we made 309 of these loans in Iowa; 54 in Nebraska and 99 in South Dakota.

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*Retained in committee files.

(b) We do not have cumulative statistics on the number of these loans made to the elderly. Most section 504 rural housing loans, however, are made to elderly persons as an eligible borrower must be a owner-occupant with a very low income. Elderly persons use the loans to repair their homes.

(c) The outreach activities of the agency for the section 504 loan program include group information talks, agency representation at conventions and meetings with interested groups, such as church groups, issuance of information pamphlets, advertising the program through the local media, and publicity by other Federal agencies. The FmHA's delivery system, however, consists of approximately 1,760 county offices located primarily in county seat towns where housing loans are processed. This means that the local representative of the FmHA is located not too far from most rural residents.

(d) Reactivation of the grant portion of the 504 program would definitely make it more accessible to senior citizens. Many of those who would like to repair their homes do not have the resources and cannot afford to repay a housing loan.

(4) From fiscal year 1965 through fiscal year 1975 we made 791,305 section 502 rural housing loans, of which 33,415 were for senior citizens.

(5) Statistics on rental units provided for the elderly by rural rental loans, are only available for fiscal years 1972 through 1975. During that period, 2,675 out of 3,261 units in Iowa, 76 out of 292 units in Nebraska, and 685 out of 1,812 units in South Dakota were made available for senior citizens.

(6) Owner occupied and substandard housing:

(a) Information obtained from the 1970 Census of Housing shows that there are 279,296 owner occupied housing units in the rural area in Iowa, 131,307 units in Nebraska, and 83,655 units in South Dakota.

(b) We have no figures on the number of senior citizens living in substandard homes in Iowa, Nebraska, and South Dakota. The 1970 Census of Housing shows, however, that of the owner-occupied units in these three States, 39,671 homes in Iowa, 19,179 homes in Nebraska, and 22,879 homes in South Dakota lack some or all plumbing facilities.

(c) We have not defined substandard housing in our regulations, however, we consider homes without bath and plumbing facilities and overcrowded dwellings as being substandard. We have established the standards for an adequate but modest home and the requirements are contained in the following publications: HUD Minimum Property Standards (MPS) 4900–SFH; 4910.1 MFH; 4920.1 Care Type Housing, and; 4930.1 Manual of Acceptable Practices. The requirements contained therein, define the minimum level of quality acceptable in each specific condition. This, in addition to the appropriateness of the building site and the neighborhood, other minor considerations, and the acceptability of the property as a whole, determine an adequate home for loans from FmHA.

(7) A memorandum of understanding (see attachment 2*) on the use of section 8 of the U.S. Housing Act of 1937 and section 515 of the Housing Act of 1949 was signed by the Secretary of Agriculture and the Secretary of Housing and Urban Development (HUD) on June 23, 1976. In order to implement the program in compliance with the memorandum of understanding, both the FmHA and HUD must publish the required regulations to the field office; however, present instructions exist outlining the method for obtaining the combination of section 8 rental assistance payment program and section 515 loans in tandem.

The FmHA requires, in accordance with HUD minimum property standards, that FmHA financed rental projects as well as single family housing designed for senior citizens, include certain special architectural features to assist the elderly such as handrails for bathtubs, special lighting, minimum width halls to accommodate wheelchairs, nonabrasive walls and maximum gradient of 5 percent for driveways. FmHA housing regulations require that the location of rural rental projects designed for senior citizens be convenient to stores, medical services, churches and other facilities needed regularly by the occupants.

We appreciate your interest in our housing program and hope we have provided the information you requested.

Sincerely,

FRANK B. ELLIOTT.

*Retained in committee files.

ITEM 3. LETTER AND ENCLOSURE FROM WILLIAM. H. WALKER III, ASSISTANT SECRETARY, DEPARTMENT OF AGRICULTURE; TO SENATOR DICK CLARK, DATED AUGUST 3, 1976

DEAR SENATOR CLARK: This will reply to your letter concerning planned hearings to examine the effectiveness of certain Federal programs which serve older Americans in rural areas. While I am responsible, in the Department, for the operations of the Farmers Home Administration, the Rural Development Service and the Rural Electrification Administration, I believe, from the questions you asked as they relate to the FmHA's business and industry program, the Farmers Home Administration. The attachments provide answers to the questions you asked as they relate to the FmHA's business and industry program, the community programs and the rural housing programs.

We appreciate your interest in the Department's rural development activities.

Sincerely,

WILLIAM H. WALKER III.

[Enclosure]

RURAL HOUSING PROGRAMS

Questions answered in order asked:

(1) The official definition of a "rural area," as it relates to the rural housing program is as follows:

Section 520 of the Housing Act of 1949, as amended, states, "As used in this title, the term 'rural' and 'rural area' mean any open country or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000, and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary and the Secretary of Housing and Urban Development."

Farmers Home Administration (FmHA) instructions, in defining rural area, basically repeat, in modified form, the above section 520 of the Housing Act of 1949, as amended. The FmHA instructions, based primarily on legislative history and other factors, also provides additional guidelines to the FMHA field staffs for making the necessary determination as to those areas which are rural and nonrural.

(2) All rural housing programs are available to Iowa, Nebraska, and South Dakota. Following is a list of the housing programs currently operating with the corresponding obligations, as of June 3, 1976, for fiscal year 1976. The rural housing programs are authorized in the Housing Act of 1949, as amended.

State and program	Number of loans	Funds obligated
Iowa—Sec. 502 (homeownership)	3,125	$56,937,980
Iowa—Sec. 504 (low-income home repair loans)	52	60,070
Iowa—Sec. 515 (rural rental housing)	113	14,441,120
Nebraska—Sec. 502 (homeownership)	1,534	32,306,600
Nebraska—Sec. 504 (low-income home repair loans)	4	6,830
Nebraska—Sec. 515 (rural rental housing)	3	307,950
South Dakota—Sec. 502 (homeownership)	1,342	24,393,890
South Dakota—Sec. 504 (low-income home repair loans)	12	30,250
South Dakota—Sec. 515 (rural rental housing)	52	6,411,440

(3) While there is no strong disagreement with the designation that an "older American" is of age 60 or older, the FmHA housing programs consider the "elderly" to be 62 years of age or older. This age designation goes back to the "Senior Citizens Housing Act of 1962" which specifically states the term "elderly persons" means persons who are "62 years of age or over." Furthermore, we believe the Social Security Administration and others have, for several years, used 62 years of age as the time a person becomes a senior citizen. We recommend that the age of 62 be used by all agencies as the time a person is considered to be elderly.

(4) All rural housing programs are available to the elderly. However, the three programs most widely used by that age group are the section 502 home ownership loans, the section 504 rural housing repair loans, and the section 515 rural rental housing loans. Following is a brief description of these housing programs.

OUTLINE OF RURAL HOUSING PROGRAMS—FARMERS HOME ADMINISTRATION

Type of assistance	Purpose	Terms	Who may qualify
Sec. 502—Rural housing loans (adequate housing).	To buy, build or improve or relocate homes and related facilities. To buy minimum adequate building sites. Also to refinance debts under certain conditions when necessary to help a family retain ownership of its home.	8½ percent interest for low- to moderate-income families. Eligible families may receive interest credits which may reduce the effective interest rates on the loan to as low as 1 percent. Up to 33 years to repay.	Low- and moderate-income families who lack adequate housing and related facilities and who will become the owner-occupants of a home in a rural area after the loan is closed; or a farmowner without decent, safe, and sanitary housing for his own use or for the use of his tenants, sharecroppers, farm laborers, or farm managers. Housing must be located in rural areas, i.e., any place which is not part of or associated with a nonrural area, is rural in character and has a population not in excess of 20,000.
Sec. 504—Rural housing loan.	To make minor repairs to homes to make them safe and remove health hazards to the family or the community.	1 percent interest and up to 20 years to repay. $5,000 limit.	Very low-income owner-occupants who do not have enough income to qualify for sec. 502 assistance. Applicant must be able to repay the loan.
Rural rental housing and cooperatively owned housing loans (secs. 515 and 521).	To build, improve, repair or buy rental or cooperatively owned houses or apartments that are economically designed and constructed for independent living. Eligible occupants must be low- to moderate-income families or senior citizens.	9 percent. Up to 40 yrs. except that projects for senior citizens may be up to 50 yrs. Loans to private nonprofit corporations, consumer cooperatives, State or local public agencies, and other nonprofit organizations will be limited to the development cost or the security value of each project, whichever is less. Loans to other applicants will be limited to 95 percent of the development cost or the security value of each project, whichever is less.	Private nonprofit corporations, consumer cooperatives, and State or local public agencies. Individuals or organizations operating on a profit basis, including those that agree to operate on a limited profit basis. Cooperatives owned, occupied and managed by eligible low- to moderate-income families or senior citizens.

(5) We are unable to keep a running account of the number of elderly persons under our housing programs. Data is not compiled to show the number of elderly people who satisfy their housing loans by payment in full or other methods and thereby graduate from the housing programs.

(6) The FmHA and HUD work together in many ways in an effort to provide housing for the elderly and others. Following is a list of some joint endeavors:

(*a*) On June 23, 1976, the Secretary of HUD and the Secretary of Agriculture signed a memorandum of understanding covering the combining of the FmHA section 515 rental housing loan and the HUD section 8 program. This is a way to provide subsidized rental housing in rural areas.

(*b*) The FmHA and HUD use the same minimum property standards (MPS). They work together, as needed in developing these standards.

(*c*) The FmHA utilizes and is a party to HUD's contracts with credit reporting agencies for the obtaining of credit reports.

(*d*) The FmHA and the Federal Insurance Administration of HUD worked together in the implementing of the Flood Insurance Protection Act of 1973.

(*e*) The FmHA and the Flood Disaster Assistance Administration (FDAA) of HUD have a memorandum of understanding permitting the FDAA to use FmHA inventory housing for disaster victims.

(7) We know of no way to accurately measure the current needs of the elderly for programs the Department administers in Iowa, Nebraska, and South Dakota. There is always a need for jobs, services, and better housing but statistical data is not available to enable us to answer this question in a responsible way.

COMMUNITY PROGRAM LOANS

Questions answered in order asked:

(1) FmHA is authorized to make loans for facilities for public use in rural areas and towns of up to 10,000 in population.

(2) See the following table:

	Iowa	Nebraska	South Dakota
Water and waste disposal loans	$91,773,103	$17,400,440	$28,820,990
Water and waste disposal grants	14,153,515	5,560,850	6,922,200
Community facility loans	3,868,000	1,500,000	2,566,000
Industrial development grants	784,900	368,000	423,800

(3) FmHA does not distinguish between elderly and nonelderly in administering its programs. However, we have no objection to the definition stated by the Administration on Aging.

(4) Funds may be used to construct, enlarge, extend or improve water, sewer and solid waste disposal systems, fire stations, libraries, hospitals, nursing homes, clinics, community buildings, recreation facilities, industrial parks and other community facilities that provide essential services to rural residents.

(5) FmHA does not distinguish between elderly and nonelderly in administering its programs. However, several nursing home projects have been funded in the three States mentioned.

(6) Not applicable.

(7) FmHA does not distinguish between elderly and nonelderly in administering its programs and has no specific information regarding the needs of the elderly.

BUSINESS AND INDUSTRIAL LOANS

The official definition of a rural area under the business and industrial loan program is that " 'rural' and 'rural area' may include all territory of a State, the Commonwealth of Puerto Rico and the Virgin Islands, that is not within the outer boundary of any city having a population of fifty thousand or more and its immediately adjacent urbanized and urbanizing areas with a population density of more than one hundred persons per square mile, as determined by the Secretary of Agriculture according to the latest decennial census of the United States: *Provided,* That special consideration for such loans and grants shall be given to areas other than cities having a population of more than twenty-five thousand."

Records indicate that under the business and industrial loan program, the following activity in each of the states from inception through June 30, 1976:

IOWA

Twenty-four loans amounting to $18,888,500 have been obligated. The projects that would provide services for the elderly that funds have been obligated for are one hospital and two nursing homes. The State Office is in the process of evaluating an additional nursing home application at the present time.

SOUTH DAKOTA

Twenty-two loans in the amount of $5,955,500 have been obligated. No specific projects that cater to the elderly have been financed. The community programs division has been able to fill this State's needs for the elderly for hospitals and nursing homes.

NEBRASKA

Six loans amounting to $4,740,000 have been obligated. The community programs division has been able to fill this State's needs for the elderly for hospitals and nursing homes.

We are unable to forecast the need for additional hospitals and nursing homes and do not have any data on the number of elderly in Iowa, Nebraska, and South Dakota.

ITEM 4. LETTER FROM SAMUEL R. MARTINEZ, DIRECTOR, COMMUNITY SERVICES ADMINISTRATION, WASHINGTON, D.C.; TO SENATOR DICK CLARK, DATED AUGUST 10, 1976

DEAR SENATOR CLARK: Thank you for your recent letter concerning the field hearings on the rural elderly that you plan to conduct during August in Iowa, Nebraska and South Dakota.

We are pleased to provide you with the information you requested from the Community Services Administration. Our Headquarters response is being coordinated with the CSA Region VII and VIII Offices that administer programs

in Iowa, Nebraska and South Dakota, respectively. Our answers have been provided in the same sequence as your questions.

(1) CSA defines a rural Community Action Agency (CAA) as one that serves an area in which the household population is 50 percent or more "rural," based on the definition of the Bureau of the Census. If an area is less than 50 percent "rural" and contains no place with a household population of 10,000 or more, it is classified by CSA as "rural," too.

(2) CSA's legislation defines an "elderly poor American" as one who is 60 years of age or older, except in one section of the Headstart, Economic Opportunity, and Community Partnership Act of 1974. Section 223 of that Act uses age fifty-five (55) years and older for employment purposes and employment opportunity "as regular, part-time and short term staff in all component programs."

(3) The CSA funds 18 CAA's in Iowa, 9 CAA's in Nebraska and one statewide CAA in South Dakota. The geographical areas covered by each CAA or delegate agencies and the number of agencies having elderly service components are being provided to your office by the CSA Region VII and VIII offices.

(4) The description of services being provided to the elderly poor by the CAA's in the aforenamed States, the number of elderly served, and the level of funding in fiscal years 1975 and 1976 are also being provided to your office by our regional offices. Additionally, descriptions of information and referral and outreach services which assist the elderly in the more rural areas are being included in the regional reports.

(5 and 6) The answers to these two questions will be reports provided by our regional offices.

(7) The CSA and the Congress have long recognized that the needs and the provision of services to assist the elderly poor cannot be met alone by the CAA's and SOS projects with their limited resources. Instead, CSA sees as its mission and function at the local, State, and Federal levels to be a catalytic agent which generates and mobilizes other sources of funding and to be of assistance in the formation of coalitions of agencies and joint funding efforts which meet the growing and unmet needs of our Nation's elderly poor. The Congress of Seniors Organizations located in South Dakota, is a good example of how we see the CSA best using our limited funding resources to assist the elderly poor.

(8) The President's budget for fiscal year 1977, included a request for the SOS program in the amount of $10 million. In the light of both the administration and the congressional budgetary ceilings, it does not seem practical at the present time to support a higher congressional appropriation for the SOS program. To a certain extent all of the programs funded and administered by CSA benefit older poor citizens, for our goal is to enhance the opportunities and lives of all the poor. However, because of the increasing and special needs of the elderly poor, CSA is supporting a number of research and action projects which we hope through their implementation and replication will diminish the impact of poverty on their lives.

(9) As you know, the CAA programs are designed exclusively for the poor as a whole, whereas the SOS programs focus on the elderly poor. Basically speaking, SOS programs provide the elderly poor with another means of obtaining information and assistance. While AoA's congressional mandate is to be responsible for programs for all the elderly poor in the Nation, CSA uses the SOS program through its CAA network to provide service delivery programs to the elderly poor. For example, in cases of emergencies or national disasters, SOS programs provide the means to meet the personal and special needs of the stricken elderly poor.

(10) We believe the ultimate value of our SOS program has been to improve the quality of life for individual elderly poor men and women, and we thank you for giving CSA an opportunity to express our effort to help them.

Sincerely,

SAMUEL R. MARTINEZ.

ITEM 5. LETTER AND ENCLOSURE FROM FAYE G. ABDELLAH, SPECIAL ASSISTANT TO THE UNDER SECRETARY, HEW; TO SENATOR DICK CLARK, DATED JULY 16, 1976

DEAR SENATOR CLARK: The enclosed report is in response to your request that our office assist the Special Committee on Aging in preparing for field hearings on the status of rural, older Americans in Iowa, Nebraska, and South Dakota by providing information on several federally funded programs in those States. The report was formulated with the collaboration of Mrs. Helen Lazenby and

Mr. Bruce Edemy of the Social Security Administration and Dr. Jerry Solon of the National Institute on Aging.

I trust that this information is sufficient for your current needs. Please do not hesitate to contact this office in your future preparations for hearings in other States.

Sincerely yours,

FAYE G. ABDELLAH.

[Enclosure]

(1) *Question.* What is the official definition of a rural area in your agency?

Answer. For purposes of classifying the older population by place of residence, this office accepts the definition of a rural area as utilized by the Public Health Services' National Center for Health Statistics (NCHS) in its 1971 National Health Survey. The NCHS definition geographically separated the population into persons residing in urban areas, inside a standard metropolitan statistical area (SMSA), and persons residing in rural areas, outside a SMSA. The U.S. Office of Management and Budget considered two primary steps of factors in establishing the boundaries and titles of SMSA's: First, a city or cities of specified population which constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with contiguous counties which are metropolitan in character.

(2) *Question.* Do you agree with the designation—as in Administration on Aging programs—that an "older American" is of age 60 or older?

Answer. Depending upon the program area involved, we believe the answer to this question may be either yes or no. In service administration or benefit programs, such as the Administration on Aging, the Social and Rehabilitative Services, and the Social Security Administration, it may become necessary to select an age at which eligibility for services or benefits begin. When, for example, legislative or administrative authority dictates that services are to be made available only to a population, specifically defined by age, the operating agency must accept and adhere to a prescribed definition. In the research and policy development areas, however, a greater flexibility in formulating concepts about age is permissible and desirable. Thus, in the latter areas, a sensitivity to the invalidity of choosing one time at which old age begins is important, and the term "older American" may take on a functional definition in which the individual is defined with reference to physical, physiological or mental capacities.

(3) (a) *Question.* How many persons in these three States are receiving long-term care services under the Medicare program?

Answer. Information was obtained on the number of admissions to skilled nursing facilities (SNF's) under the Medicare program during 1974 and 1975. Since Medicare for long-term care patients covers only services in a SNF and coverage may not be extended past 100 days for any one admission, we believe the following information presents a fairly accurate picture of the actual numbers of persons in long-term care facilities in the three States who received Medicare reimbursement.

State	Total number medicare enrollees	SNF admissions
1974:		
Iowa	362,613	3,934
Nebraska	191,170	2,239
South Dakota	84,407	815
1975:		
Iowa	365,076	3,943
Nebraska	192,971	2,219
South Dakota	85,294	679

(3) (b) *Question.* How many persons are receiving reimbursable home health services under the Medicare program in these States?

Answer. Since 1971 the Social Security Administration (SSA) has not tabulated information on the numbers of persons receiving reimbursable home health services under the Medicare program. The most relevant information attainable from SSA, in response to your question, pertains to the total number of bills paid for home health services under title XVIII, part A, hospital insurance, and part B, medical insurance, during 1974 and 1975 and to the number of bills paid for every thousand Medicare enrollees. This information does not reflect the actual number of persons receiving home health services, since one individual may have been responsible for more than one bill. The following statistics were provided:

State	Total aged enrollees	Total home health service (bills paid)	Home health services per 1,000 enrollees (bills paid)
1974 HOSPITAL INSURANCE (PART A)			
Iowa	362,613	29,653	82
Nebraska	191,170	18,428	96
South Dakota	84,407	5,505	65
1974 MEDICAL INSURANCE (PART B)			
Iowa	357,458	17,570	49
Nebraska	187,042	13,048	69
South Dakota	82,688	3,578	43
1975 HOSPITAL INSURANCE (PART A)			
Iowa	365,076	41,701	114
Nebraska	192,971	27,593	143
South Dakota	85,294	6,425	75
1975 MEDICAL INSURANCE (PART B)			
Iowa	360,405	22,903	64
Nebraska	189,940	14,483	76
South Dakota	83,723	3,405	41

(3)(c) *Question.* Can your office provide the Committee with a listing of home health agencies and day care centers for the elderly in these States, particularly those serving rural areas?

Answer. A list* of the home health agencies in Iowa, Nebraska, and South Dakota is attached. However, the Department of Health, Education, and Welfare's only responsibility, to date, for funding day care centers has been through Section 222(b) of P.L. 92-603 which authorized expenditures of monies for demonstration projects, none of which is located in Iowa, Nebraska, or South Dakota.

ITEM 6. LETTER AND ENCLOSURE FROM ARTHUR S. FLEMMING, COMMISSIONER ON AGING, HEW; TO SENATOR DICK CLARK, DATED JULY 17, 1976

DEAR SENATOR CLARK: This is in response to your inquiry of June 22, 1976 in which you asked me to prepare a summary on rural areas and the effectiveness of certain Federal Programs for the States of South Dakota, Iowa, and Nebraska.

To answer your first question concerning the official definition of a rural area, the Administration on Aging issued IM-73-28, April 16, 1973 to the State agencies on aging as a guideline to determine a sparsely populated rural area. This guideline said in part:

"If the project area of an award has boundaries essentially coterminous with those of any community (city, town, borough, village, etc.), whether incorporated or unincorporated, that has a population of less than 2,500 such project area may be considered a sparsely populated rural area. However, if an award is made to an area larger than such community and the average population density of the whole project area is less than 100 persons per square mile, then such project area may also be considered a sparsely populated rural area. However, if such larger project area contains one or more communities having a population greater than 2,500, then, the elderly outside of those communities must be served at least in proportion to their numbers within the entire project area."

The responses to the remaining questions are contained in the attached chart. If I can be of any further assistance please do not hesitate to contact me.

Very sincerely and cordially yours,

ARTHUR S. FLEMMING.

[Enclosure]

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*Retained in committee files.

RURAL AREA AGENCIES, TITLE VII AND MODEL PROJECTS

Questions	South Dakota	Iowa	Nebraska
1. Percent of area agencies located in rural areas	Single PSA [1]	50 percent	66 percent.
2. Geographical area these area agencies are mandated to serve	Total State	59 percent (58 counties)	29 percent (27 countries).
3. Elderly served by these agencies in rural areas	66,007	225,000	61,000.
4. Areas within State not served by area agency	The total State is covered because it is a single planning and service area.	No rural areas are denied coverage.	The complete State is considered rural and at present do not cover 43 percent of the elderly.
5. Total number of nutrition projects located in rural areas	12	6	7.
6. Total sites operated by rural nutrition projects	24	81	46.
7. Total number of elderly served by these sites	2,166	26,461	6,943.
8. Percentage of meals served by these sites which are home delivered	18 percent	9 percent	14 percent.
9. Number of projects which allow food stamps for congregate or home delivered meals	H.D.—7; Cong.—7	H.D.—6; Cong.—7	H.D.—7; Cong.—7.
10. Number of rural areas within the State which have requested a nutrition project, but denied because of lack of funding	None	None	None.
11. Number of AOA model projects funded	None	1	1.
12. Special outreach and/or information and referral operations	80 percent of elderly have access to I. & R.	100 percent of elderly have access to I. & R.	65 percent of elderly have access to I. & R.
13. State programs related or coordinated with Older Americans Act	Transportation, title XX.	Transportation	Transportation.
14. The effectiveness of South Dakota as a single planning and service area	It is not feasible at this time to ascertain the effectiveness of the single agency operation in meeting the needs of older persons in rural areas. An adequate response to this question would require an extension evaluative study. It is, however, the experience of the Administration on Aging that the effective administration of programs under the Older Americans Act in a State designated as a single planning and service area is dependent upon the characteristics of the State and its older population. Serving older persons in rural areas is emphasized both in States that are designated as a single planning and service areas and in those where there are planning and service areas with area agencies on aging. Therefore, each request by a State for designation as a single planning and service area must be reviewed on its individual merits. Primary consideration is given to the size of the State, its topography, the size and distribution of elderly population as well as to capacity of the State agency to administer the program. This latter factor, State agency capacity, is often a major consideration when assessing the effectiveness of one structure versus the other. All these factors and their interrelationship are weighed when considering whether the single planning and service areas with area agencies on aging is the most effective means of meeting the needs of the older persons in the State. The framework for this perspective is based upon sec. 301 of the act and on the intent of Congress as explicated in the reports of the Senate Committee on Labor and Public Welfare and the House Committee on Education and labor.		

[1] Single planning and service area has 1 area agency which has responsibility for the complete State.

Note: Special significance to rural elderly. Iowa—Project provides a means of part-time employment for the 60-plus person. Nebraska—Project provides for the winterizing of homes.

ITEM 7. LETTER AND ENCLOSURE FROM M. KEITH WEIKEL, COMMISSIONER, SOCIAL AND REHABILITATION SERVICE, HEW; TO SENATOR DICK CLARK, DATED JULY 27, 1976

DEAR SENATOR CLARK: I was pleased to learn in your June 23 letter about the forthcoming hearings scheduled for August by the Special Committee on Aging in Iowa, Nebraska, and South Dakota.

In your letter you requested specific information concerning the Medicaid programs in these States as they might affect the rural elderly population. Each of these questions is addressed in detail below.

What is the official definition of a rural area in your agency?

Although Social and Rehabilitation Service/Medical Services Administration has not officially adopted a definition of rural areas *per se*, we are essentially in agreement with that developed by the Office of Rural Health Initiatives (HEW/HSA). This office defines rural areas as those geographical areas which are not included within a standard metropolitan statistical area, i.e., under 50,000 persons or are not listed as an urbanized area or as unincorporated places in the current *County and City Data Book*, tables 4 and 5 (U.S. Department of Commerce).

Do you agree with the Administration on Aging (AoA) designation that an "older American" is of age 60 or older?

Congress has mandated that for a person to be eligible for Medicaid, he must be 65 or over and either be receiving "old-age cash assistance" or, in those States having medically needy programs such as Nebraska, fall within a financial range not to exceed 133 percent of the States welfare income limits. Age 60 or older as the basis for dispensing AoA grants in no way conflicts with these requirements.

How many persons in each of these States are eligible for Medicaid? How many of these are elderly? How many in rural areas? Could the committee be provided with descriptions of each State's Medicaid plans?

Current Medicaid eligibility data is not routinely available from the States although figures collected for a recent special study by the HEW regional office indicate that in fiscal year 1976 the total number of eligible in Iowa and Nebraska were 138,776 and 56,437, respectively. Of these the number of aged eligibles in Iowa was 6,695 and in Nebraska, 12,293. The most reliable figures for South Dakota is an unduplicated *recipient* count for fiscal year 1975 which totaled 41,966 persons with 11,540 of these elderly.

No information is presently available on the number of Medicaid elderly living in rural areas of these States. Enclosed is a current summary of Medicaid services by State which describes in general the scope of benefits offered in each State.

I hope this information is useful to you during the hearings and if we can be of additional support as they progress, please feel free to contact me.

Sincerely yours,

M. KEITH WEIKEL.

[Enclosure]

MEDICAID SERVICES STATE BY STATE, JUNE 1, 1976 1/

*BASIC REQUIRED MEDICAID SERVICES. Every State Medicaid program must cover at least these services for at least ... inpatient hospital services; outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physician services. Federal ... States ... to expand their Medicaid programs by covering additional services and/or by ... people eligible for medical but not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicare ... screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● offered for people receiving federally supported financial assistance

+ offered also for people in public assistance 2/ and SSI 3/ categories who are financially eligible for medical but not for financial assistance

Additional services for which Federal financial participation is available to States under Medicaid:

FMAP 4/	BASIC* REQUIRED MEDICAID SERVICES (SEE ABOVE)	State	Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive and rehabilitative services	Emergency hospital services	Skilled nursing facility services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Care for patients under 21 in psychiatric hospitals	Institutional services in intermediate care facilities	
74	●	Alabama		●		●	●				●	●	●				●		● 5/	AL
50	●	Alaska					●				●	●	●			●		●	● 5/	AK
60		Arizona																		AZ
75	+	Arkansas	+	+	+	+					+	+			+	+	+	+	● 5/	AR
50	+	California	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+ 5/	CA
56	●	Colorado		●		●			●		●	●		●		●		●	● 5/	CO
50	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+		+	+ 5/	CT
50	●	Delaware	●	●					●					●		●	●		●	DE
50	+	D.C.	+	+		+	+		+	+	+	+	+	+		+	+	+	+ 5/	DC
57	●	Florida		●							●					●	●		● 5/	FL
66	●	Georgia	●	●		●				●		●		●		●	●		● 5/	GA
50	+	Guam	+	+	+	+	+		+		+	+	+							GU
50	+	Hawaii	+	+	+	+	+		+	+	+	+	+						+	HI
68	●	Idaho	●	●							●	●	●	●	●				● 5/	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	IL
57	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●	IN
67	●	Iowa		●	●	●	●		●		●	●	●	●	●				● 5/	IA
54	+	Kansas	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+ 5/	KS
71	+	Kentucky	+	+	+	+			+		+	+				+	+	+	+ 5/	KY
72	●	Louisiana	●	●		●				●	●	●			●	●	●	●	● 5/	LA
71	+	Maine	●	+		+			+	+	●	+		+	+	+		+	● 5/	ME
50	+	Maryland	+	+		+	+				+		+			+	+		+ 5/	MD
50	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+		+	+		+ 5/	MA
50	+	Michigan	+	+		+				+	+	+		+	+	+	+	+	+ 5/	MI
57	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	MN
78	●	Mississippi		●	●							●				●	●		● 5/	MS
59	●	Missouri		●	●						●		●			●	●		● 5/	MO
63	+	Montana	+	+	+	+	+	+	+	+	+	+	+	+		+		+	+ 5/	MT
56	+	Nebraska	+	+	+	+	+	+	+		+	+	+	+	+	+	+		+ 5/	NB
50	●	Nevada	●	●	●	●	●	●	●		●	●	●	●	●	●			● 5/	NV
60	+	New Hampshire	+	+		+	+	+	+	+	+	+	+	+	+	+			● 5/	NH
50	●	New Jersey	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	NJ
73	●	New Mexico	●	●	●	●	●	●	●		●	●	●	●					● 5/	NM
50	+	New York	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	NY
68	+	North Carolina	+	+	+		+			+		+	+	+	+	+	+	+	+ 5/	NC
58	+	North Dakota	+	+	+	+	+	+	+	+	+	+	+	+	+			+	+	[illegible]
54	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	● 5/	OH
67	+	Oklahoma		●	+									+		+		+	+ 5/	OK
59	●	Oregon	●	●	●	●	●	●			●	●	●	●	●	●	●	●	● 5/	OR
55	+	Pennsylvania	+	●	●	●	+				+	+	+	●	+	+		+	+ 5/	PA
50	+	Puerto Rico	+	+	+				+	+	+						+			PR
57	+	Rhode Island		+	+	+	+						+	+		+			● 5/	RI
74	●	South Carolina	●	●	●	●	●		●		●	●	●		●	●	●	●	● 5/	SC
67	●	South Dakota	●	●		●	●		●		●	●	●	●	●				● 5/	SD
70	+	Tennessee	+	+		+					+					+	+	+	+ 5/	TN
64	●	Texas		●	●		●				●		●	●			●		● 5/	TX
70	+	Utah	+	+	+	+	+	+	+		+	+	+	+	+	+		+	+ 5/	UT
70	+	Vermont	+	+		+					+	+		+		+		+	+ 5/	VT
50	+	Virgin Islands	+	+	+	+	+													VI
58	+	Virginia	+	+			+		+		+	+	+	+		+	+		+ 5/	VA
54	+	Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	WA
72	+	West Virginia	+	+	+	+	+	+	+			+	+	+	+	+	+		+	WV
60	+	Wisconsin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	WI
61	●	Wyoming										●	●						●	WY
●	21	●	13	21	12	14	12	6	10	5	18	18	15	14	10	14	11	8	25	
+	32	+	29	30	22	27	24	14	22	17	25	25	23	23	18	27	19	21	25	
	53	Total	42	51	34	41	36	19	32	22	43	43	38	37	28	41	30	29	50	

Intermediate Care Facilities (ICF): P.L. 92-223 transferred the ICF program to Medicaid (Title XIX) as an optional service, effective 1-1-72. States may at their option include institutions for the mentally retarded, both public and private. See footnote five.

1/ Data from Regional Office reports of characteristics to State programs and State plan amendments.
2/ People qualifying as members of families with dependent children (usually families with at least one parent absent or incapacitated).
3/ People qualifying as aged, blind, or disabled under the Supplemental Security Income program.
4/ FMAP - Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from July 1, 1975, through June 30, 1977, are rounded.
5/ Including ICF services in institutions for the mentally retarded.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Social and Rehabilitation Service — Medical Services Administration

Division of Program Monitoring

(SRS)-76-24901*

ITEM 8. LETTER FROM ROBERT FULTON, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, HEW; TO SENATOR DICK CLARK, DATED JULY 28, 1976

Dear Senator Clark: Thank you for your letter of June 22 on behalf of the Special Committee on Aging requesting information about Federal programs for older Americans in rural areas. Please accept my apology for the delay in responding.

You ask specific questions concerning programs in Iowa, Nebraska, and South Dakota. In response to your first question, this agency has no official definition of a "rural area." Since title XX is a Federal-State program that is State administered or supervised, States decide what services will be offered in the dif-

ferent political subdivisions according to the specific needs in those areas. In other words, rural areas reflect rural interests, urban areas reflect urban interests.

Contrary to the Administration on Aging, this agency, under the titles of the Social Security Act, classifies an "older American" as one who is age 65 or older.

States are not required to accumulate and report precise data on age breakdowns of social service recipients. However, for your upcoming committee hearings, I requested staff in the Social and Rehabilitation Service Denver and Kansas City Regional Offices, to compute rough estimates regarding the percentage of title XX funds that are used for social services for the aged. In Nebraska, approximately 16 percent of the title XX funds are used for services to the aged; in South Dakota, 11 percent and in Iowa, 15 to 20 percent.

All three States provide the following title XX services to Supplemental Security Income recipients: health related programs, home management services, meal programs, and transportation services. Nebraska also provides adult day care services.

Title XX programs are coordinated with programs under the Older Americans Act through joint working agreements between the State title XX agencies and the State commissions on aging. This allows the agencies to work closely together when determining the needs of the aged and the programs that will be provided. In South Dakota, the State Office on Aging is under the umbrella of the State title XX agency. Therefore, South Dakota sees no reason to sign a joint working agreement.

Revisions to section 228.61 of the title XX regulations allow the States to establish any method or methods, including income declaration without documentation, when determining title XX eligibility. Nebraska and South Dakota require income documentation while Iowa requires only declaration of income.

I trust this information is helpful to your committee. Please let me know if I may be of further assistance.

Sincerely,

ROBERT FULTON.

ITEM 9. LETTER FROM LOUIS M. HELLMAN, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, HEW; TO SENATOR DICK CLARK, DATED AUGUST 11, 1976

DEAR SENATOR CLARK: This is in further response to your letter of June 22 requesting information about the Health Services Administration's (HSA) role in serving the elderly in rural areas.

Within HSA there are several programs which serve rural areas, including the health maintenance organization (HMO), the emergency medical services (EMS), the community health centers (CHC), the migrant health, the national health service corps (NHSC), the health underserved rural areas, and the home health programs. Health service delivery programs for rural areas are coordinated through the Public Health Service's (PHS) rural health initiative (RHI) under the guidance of a PHS-wide rural health coordinating committee. The RHI is an administrative effort combining existing health resources of the Department to improve the delivery of health care to health underserved rural areas.

We shall respond to the specific questions you asked in the order presented to us in your June 22 letter.

(1) HSA has explored and is using several definitions of "rural." The RHI initially defined rural as nonstandard metropolitan statistical area (non-SMSA) counties. Data subsequently received from the Department of Agriculture indicates that approximately 38 percent of the rural population live in SMSA counties. Accordingly, we reviewed the definition we used for rural, i.e., non-SMSA, and found that it would be more appropriate to define rural as non-SMSA *or* those areas not listed as urbanized areas *or* unincorporated places (places having 25,000 or more inhabitants) in the *County and City Data Book 1972*, tables 4 and 5, U.S. Department of Commerce, Bureau of the Census, Social and Economic Statistics Administration, Washington, D.C. 1973.

HMO regulations published in the *Federal Register*, October 18, 1974, defines a rural area as any area not listed as a place having a population of 2,500 or more in Document #PC (1)–A, "Number of Inhabitants," table VI, "Population of Places," and not listed as an urbanized area in table XI, "Population of Urbanized Areas" of the same document (1970 Census, Bureau of the Census, U.S. Department of Commerce).

The EMS program defines rural areas as those areas other than urbanized areas as defined by the Bureau of the Census.

Enclosed for your information is a copy of a paper* prepared by HSA in September 1974 which examined several other definitions of rural in use.

(2) The Older Americans' Act title VII (nutrition program) requires that beneficiaries be "60 and over." Title III of the same act, however, requires that for the purposes of planning, each State should determine the age of an older person in accordance with a thorough needs assessment. Our position is that each State should determine the age in accordance with need. Farm area residents have higher incidences of chronic disability conditions, therefore, if by lowering the age (e.g., 55) individuals would have better access to health care through transportation systems, sponsored by the Administration on Aging (AoA), we would support that action. By intervening at the beginning stages of a chronic disability there is both a cost savings and slower development of disease progression. Nebraska has determined that an older person is "55" because of certain disabling conditions and is eligible to participate in a transportation system to health facilities authorized by the State AoA agencies.

(3) The NHSC assigns health professionals to critical health manpower shortage areas (CHMSA's) rather than to medically underserved areas (MUA's). Designations of CHMSA's for the States of Iowa, Nebraska, and South Dakota are enclosed. Also enclosed are lists of areas designated as MUA's. These designations are used by the CHC and HMO programs.

The PHS NHSC scholarship program was established in 1974 and the first recipients eligible for placement were assigned this year. Twenty-two scholarship recipients have been available for placement nationally through the NHSC. The remainder of the scholarship recipients who have completed their training have been assigned through the Bureau of Health Manpower and the Indian Health Service. One scholarship recipient has been placed in Faulk County, S.Dak., through the NHSC. It is estimated that 149 scholarship recipients will be available in 1977 for placement in NHSC designated CHMSA's, and this number will continue to grow as more of the recipients complete their education. The NHSC's placement of health professionals is not limited to recipients of scholarships. In addition to the physician placed through scholarship obligations in South Dakota, three M.D.s and one nurse practitioner (N.P.) were recruited and assigned to South Dakota. Also, five M.D.s and one physician extender (P.E.) were recruited and assigned to shortage areas in Iowa. The NHSC has only the one nurse practitioner serving within the three States at the present time. She is assigned to Onida (Sully County), South Dakota, and is working with a NHSC physician. Many nurse practitioners are employed by communities, however, we do not have any statistics available on such paraprofessionals. The NHSC assignees are as follows:

Iowa: 1 M.D. in Eldora County, 1 M.D. in Lyon County, 1 P.E. in Lyon County, and 3 M.D.s in Tama County.

South Dakota: 2 M.D.s in Faulk County (includes the scholarship assignee), 1 M.D. in Sully County, 1 N.P. in Sully County, and 1 M.D. in Roberts County.

(4) Iowa received $45,000 for a planning grant in fiscal year 1975 under section 1202 of P.L. 93–154 (the Emergency Medical Services Systems Act of 1973). This planning project covered a population of 339,000 (253,000 rural and 86,000 urban) in the northwestern part of the State. The 1976 appropriations for P.L. 93–154 stated that if a State and/or locale had not received monies in fiscal year 1975 under either section 1203 or section 1204 those locales were ineligible for fiscal year 1976 implementation monies. The lack of funding under these sections in 1975 precluded the operational funding of this region in fiscal year 1976. It is estimated that 42,000 or 12.4 percent of the population in this region are age 65 and over.

Nebraska has received 2 years' funding for grants under section 1203 of P.L. 93–154, fiscal year 1975, $1,236,836 and fiscal year 1976, $1,547,391. These grants cover EMS regions comprising 80 percent of the State's population and 60 percent of its land area. Of the land area covered, 80 percent of the area is rural to wilderness. The rural population in this federally funded EMS region totals 443,030 of which 65,952 (14.9 percent) are over 65. Current data being obtained from EMS facilities in Nebraska reflects only time-patient loading characteristics. Age is not now being collected for usage, but a standard ambulance form will be introduced this year which will report age of utilizing patients.

*Retained in committee files.

South Dakota received $90,000 for planning grants in fiscal year 1974 under section 1202 of P.L. 93–154. Two additional grants under section 1203 have been awarded, fiscal year 1975, $556,484 and fiscal year 1976, $714,519. These two operational grants cover 100 percent of the State and its population. Ninety-two percent of the State is estimated to be rural, 21.1 percent of the population are over 65, 55 percent of the population is classified as rural and 18 percent of the population actually live on farms. It is estimated that 42,000 rural elderly have access to the Federal service programs.

(5) At the present time the names and locations of operational or developmental HMO's in the three States mentioned are:

Iowa: None.

Nebraska: Community Health Care Association, Lincoln; Missouri Valley Group Health, Inc., Omaha.

South Dakota: Health Care, Inc., Mitchell; Rosebud Sioux Tribe, Rosebud; Western South Dakota, Rapid City.

(6) HSA has not conducted a total health needs assessment for the elderly, however, our home health program has made an assessment as to those counties within your investigation area that *do not* have home health services. It is the intention of the Under Secretary to hold regional public meetings on the status of home health care in five cities (New York, Atlanta, Chicago, Dallas, and Los Angeles) as to the needs of the chronically disabled and the elderly.

We have also enclosed for your information a list of health service delivery projects presently being supported by programs administered by the Bureau of Community Health Services, HSA.

Copies of this correspondence are being forwarded to Holman R. Wherritt, M.D., Regional Health Administrator in our Kansas City Regional Office, and to Hilary H. Connor, M.D., Regional Health Administrator in our Denver Regional Office, so they will be aware of your interest. If they can be of further assistance to you in your field hearings, their addresses are: Holman R. Wherritt, M.D., Regional Health Administrator, Department of Health, Education, and Welfare Region VII, 601 East 12th Street, Kansas City, Mo. 64106, 816–374–3291; Hilary H. Connor, M.D., Regional Health Administrator, Department of Health, Education, and Welfare, Region VIII, 19th and Stout Streets, Denver, Colo. 80202, 303–837–4461.

If we can be of further assistance, please let us know.

Sincerely yours,

LOUIS M. HELLMAN.

ITEM 10. LETTER AND ENCLOSURES FROM JAMES B. CARDWELL, COMMISSIONER OF SOCIAL SECURITY; TO SENATOR DICK CLARK, DATED AUGUST 27, 1976

DEAR SENATOR CLARK: With further reference to your inquiry of June 23, I am enclosing some material relevant to the questions which you posed in your letter.

(1) While the Social Security Administration does not officially define an area as urban or rural, we can indicate the rural status of counties by using census data (see table C). Residents of less populated areas are served by contact stations on specified days of the month. Toll-free lines are also available and district offices have a liberal policy on accepting collect telephone calls.

(2) Information for items 2(a), 2(b), and 2(c) are shown in the enclosed tables C, D, and E, respectively. While we do not know the number of beneficiaries residing in rural areas, we show in table C a breakdown of the number of beneficiaries by the rural status of the counties in which they reside. (For detailed county data on beneficiaries, see enclosed tables A and B for Iowa, Nebraska, and South Dakota.)

(3) Information for items 3(a), 3(b), 3(c), and 3(d) is shown in the enclosed table F, which summarizes information shown in the enclosed table 4, the research and statistics note No. 8, and the advance release of supplemental security income (SSI) data—March 1976. We do not have information with respect to item 3(e). We are referring your letter to the Social and Rehabilitation Service of the Department of Health, Education, and Welfare for any information which they may have with regards to this item.

(4) Information with respect to the medicare program is as follows:

(*a*) Tables 4.a.1–4.a4 show enrollment and utilization data for both the hospital insurance (part A) and the supplementary medical insurance (part

B) programs, and by aged (65 and over) and disabled. Data on enrollment are shown, as of January 1, 1975, in table 4.a.1. Table 4.a.2 shows the number of part A admissions to inpatient hospitals and skilled nursing facilities (SNF's) in fiscal year 1975, with a separate breakout for persons with chronic renal disease (CRD) who are under 65 years old but are not qualified as disabled under medicare. (These people are covered under medicare on the basis of their chronic renal disease only.) The number of admissions may be greater than the number of persons served since a person may have more than one admission to a health care facility. Table 4.a.3 shows the number of home health agency (HHA) visits for fiscal year 1975. Table 4.a.4 gives the approximate number of persons aged 65 and over using all types of part B services for calendar year 1974 by metropolitan and nonmetropolitan area of residence. (Such a breakdown is not available for disabled persons.)

(*b*) With reference to your question on physician assignment rates under medicare, the physician decides on a case-by-case basis whether or not to accept assignment. He may submit assigned claims for one type of service and not another, for one patient and not another, or for a patient or service on one occasion and not on another. The percentage of physicians who accept assignment is unknown. However, the percentage of claims assigned is shown below. Assignment rate data is available only on a part B carrier basis. (A carrier is a health plan administering medicare part B on local level.) In the case of the three States in question, one carrier serves each State in its entirety (Iowa-Blue Shield, Nebraska-Mutual of Omaha, and South Dakota-Blue Shield). The available data do not permit a rural-urban breakdown.

Percent of claims assigned	Iowa	Nebraska	South Dakota
Total	41.0	41.8	38.8
Net [1]	34.9	37.6	32.6

[1] Excludes claims made by hospital-based physicians and group prepayment plans (GPPP's).

(*c*) Currently there is no reliable data on payments made to paramedical personnel (physician extenders). These people work under the direct supervision of a physician who submits claims for medicare reimbursement on their behalf. The physician is under no obligation to identify them or how much of his total reimbursement they are receiving. A program experiment, not as yet fully operational, has begun, whereby physicians who agree to participate in the experiment will begin identifying their physician extenders, the services they render, and the amount they are reimbursed by him. All claims for medicare payments will still be made by the supervising physician under his identification number. As of April 1976, there were 10 physicians' practices in Iowa which have shown interest in the experiment, 3 in Nebraska, and 5 in South Dakota.

(*d*) As of December 1975, data regarding the number of health care facilities participating in medicare for the three States are as follows:

	Iowa	Nebraska	South Dakota
Part A:			
Inpatient hospitals	173	123	60
Beds	17,293	9,828	3,511
SNF's	32	16	10
Beds	921	1,014	326
HHA's	64	12	21
Independent labs	14	7	6
Outpatient physical therapy	1	.....	.....
Part B.—Groups, clinics: [1]			
General practice groups	53	1	31
Clinics [2]	32	1	2
Group practice prepayment plans	.....	.....	.....

[1] Number of groups is approximate since a group may have more than 1 identification number. (These numbers are assigned by carriers.) For example, a group or clinic with more than 1 office or branch may have a separate ID number for each location. Also, the figures here represent only those groups or clinics which have received medicare reimbursement.

[2] A clinic is a group of physicians with at last 2 specialties.

We are unable to provide you with separate data on health care facilities in "medically underserved" areas. However, you may wish to contact Dr. Daniel F. Whiteside, Director, Bureau of Health Manpower, Public Health Service, for any information that he may have available. His address is: National Institutes of Health, Room 5C02, 900 Rockville Pike, Bethesda, Md. 20014.

You may also be interested in several publications which contain data on health resources availability. These are:

(1) *Health Resources Statistics—1975*, Public Health Service, Health Re-Sources Administration, National Center for Health Statistics, Rockville, Md. 20852.

(2) *Distribution of Physicians in the United States, 1973*, vol. 1, region, State, county; vol. 2, metropolitan areas; American Medical Association, Center for Health Services Research and Development, 535 N. Dearborn Street, Chicago, Ill. 60610. (This publication includes data on counties with no active physician in patient care.)

I hope this information will help to satisfy your needs.

Sincerely yours,

JAMES B. CARDWELL,
Commissioner of Social Security.

[Enclosures]

TABLE C.—ALL BENEFICIARIES AND THOSE AGED 65 AND OVER FOR IOWA, NEBRASKA, AND SOUTH DAKOTA, BY RURAL STATUS OF COUNTY OF RESIDENCE, END OF 1975

Rural status of county of residence [1]	All beneficiaries	Those aged 65 and over
Iowa:		
All counties	470,003	341,195
Counties which are:		
100 percent rural	47,001	35,822
50 percent or more rural but not 100 percent	180,753	134,699
Under 50 percent rural	242,249	170,674
Nebraska:		
All counties	241,168	178,058
Counties which are:		
100 percent rural	49,104	38,410
50 percent or more rural but not 100 percent	55,380	42,387
Under 50 percent rural	136,684	97,261
South Dakota:		
All counties	113,364	80,344
Counties which are:		
100 percent rural	39,055	28,640
50 percent or more rural but not 100 percent	13,704	9,531
Under 50 percent rural	60,605	42,173

[1] Based on Census Bureau classification.

TABLE D.—SOCIAL SECURITY OFFICES IN IOWA, NEBRASKA, AND SOUTH DAKOTA, 1976

	Iowa	Nebraska	South Dakota
District or branch offices	21	10	6
Contact stations [1]	99	67	68
Institutional contact stations [1]	8	4	0
Enterprise toll free lines [2]	22	10	0
WATS lines	0	1	0

[1] A contact station is a space in some local government or other office which serves as a social security office on a prearranged number of days during the month.

[2] All offices have a liberal policy on accepting collect telephone calls.

TABLE E.—ESTIMATED AVERAGE MONTHLY BENEFIT AMOUNTS FOR SPECIFIED BENEFICIARY GROUPS IN IOWA, NEBRASKA, AND SOUTH DAKOTA

Beneficiary group	December 1975	June 1976
Iowa:		
Retired worker without dependents	$197	$212
Aged couples	345	370
Aged widow	197	212
Nebraska:		
Retired worker without dependents	194	208
Aged couples	335	360
Aged widow	194	208
South Dakota:		
Retired worker without dependents	184	198
Aged couples	314	338
Aged widow	187	201

TABLE F.—SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENT DATA

	Iowa	Nebraska	South Dakota
Recipients of federally administered SSI payments, June 1976:			
Total	28,943	15,823	8,803
Aged	15,807	8,193	5,332
Monthly amount of State supplementation:			
Individuals	$55.20	[1]	[1]
Couples	$54.20	[1]	[1]
Living arrangements of aged recipients, March 1976 (percent):			
Owns households	80.1	80.0	82.2
Another person's household	9.2	7.3	8.3
Medicaid institution	10.7	12.7	9.5
Recipients receiving concurrent OASDI benefits, December 1975:			
Total	17,400	8,800	5,100
Aged	12,500	6,200	3,900
Recipients living in nonmetropolitan areas, December 1974 (percent):			
Total	NA	NA	NA
Aged	74.6	72.8	91.3

[1] No State supplementation.

TABLE 4A–1.—ENROLLMENT AS OF JAN. 1, 1975

	Iowa	Nebraska	South Dakota
HI and/or SMI:			
Total	389,220	204,392	91,288
Aged	366,680	193,673	85,766
Disabled	22,540	10,719	5,522
HI:			
Total	387,060	203,128	90,601
Aged	364,520	192,409	85,079
Disabled	22,540	10,719	5,522
SMI:			
Total	379,794	198,534	88,295
Aged	359,142	188,896	83,293
Disabled	20,652	9,638	5,002

TABLE 4A–2.—NUMBER OF HI (PART A) ADMISSIONS, FISCAL YEAR 1975

	Iowa	Nebraska	South Dakota
Inpatient hospital:			
Total	147,060	82,500	37,352
Aged	136,737	77,381	35,207
Disabled	10,077	4,941	2,124
CRD only [1]	246	178	21
SNF:			
Total	3,954	2,172	773
Aged	3,802	2,124	751
Disabled	151	48	21
CRD only [1]	1	0	1

[1] Under 65 but not qualified as disabled under medicare—coverage is on the basis of chronic renal disease only (no other disabling conditions).

TABLE 4A–3.—NUMBER OF HHA VISITS, FISCAL YEAR 1975

	Iowa	Nebraska	South Dakota
HI and SMI:			
Total	59,368	40,761	10,265
Aged	54,211	38,544	9,665
Disabled	5,148	2,218	600
HI:			
Total	37,148	25,525	6,160
Aged	34,161	24,273	5,870
Disabled	2,988	1,253	290
SMI:			
Total	22,220	15,236	4,105
Aged	20,060	14,271	3,795
Disabled	2,160	965	310

TABLE 4A-4.—APPROXIMATE NUMBER OF PERSONS 65 AND OVER RECEIVING ANY TYPE OF SMI (PART B) SERVICE, CALENDAR YEAR 1974

	Iowa	Nebraska	South Dakota
Total	282,948	143,956	59,568
Metropolitan areas	147,379	74,982	31,027
Nonmetropolitan areas	135,569	68,974	28,541

ITEM 11. LETTER FROM JAMES L. YOUNG, ASSISTANT SECRETARY, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT; TO SENATOR DICK CLARK, DATED JULY 13, 1976

DEAR SENATOR CLARK: Secretary Hills has asked me to acknowledge your letter of June 23, 1976, and coordinate the Department's response to your request for certain information dealing with older Americans in rural areas.

With respect to your first question, this Department does not have an official definition of rural area, since, by and large, our programs are available to all eligible users regardless of the type of location. Section 520 of the Housing Act of 1949 does define rural area for the purposes of eligibility for Farmers Home Administration programs.* We have in the past occasionally used this definition for statistical purposes, but changes in this definition have made it less useful, particularly as a result of the addition of part (3) to section 520 in 1974, which expanded the definition to include places between 10,000 to 20,000 population if they are determined to have a "serious lack of mortgage credit."

For the purposes of providing the information requested in items 3 through 6, where appropriate, we intend to provide such data for non-metropolitan areas which we define as being outside of Standard Metropolitan Statistical Areas (SMSAs) rather than "rural." Data maintained within the Department is normally identifiable on an SMSA basis, whereas identifying the specific location of a project and then determining the population of the community in which it is located would require an extensive effort. I am informed that we would have considerable difficulty in obtaining much of the desired data by July 15, 1976, if it were necessary to utilize any other area of definition.

With respect to your second question, our housing legislation consistently defines elderly as one who is 62 years of age or more. The Department believes that there remains substantial unmet needs among those currently defined as elderly, and that an expansion of elderly housing demand through a reduction in the age standard is not warranted.

Please be assured that we will make every effort to supply you with the remaining information requested within the July 15, 1976, date you indicated.

We are pleased to be of assistance in your efforts in examining Federal activities in these areas and will be glad to be of further assistance in other hearings you are planning.

Sincerely,

JAMES L. YOUNG.

ITEM 12. LETTER AND ENCLOSURES FROM JAMES L. YOUNG, ASSISTANT SECRETARY, HUD; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: This is in further reply to your letter of June 23, 1976, requesting certain data concerning older Americans in rural areas.

The following responds to questions 3 through 6, which were not addressed in our initial response:

3. (*a*) How many persons in these States are receiving section 8 rental assistance?

*Section 520 reads as follows: ". . . the terms 'rural' and 'rural area' mean any open country, or any place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000 and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit, as determined by the Secretary and the Secretary of Housing and Urban Development."

(*b*) How many of these could be classified as rural elderly?

The following represents actual occupancy through June 1976, as reported by the respective HUD Field Offices in a telephone survey done for this purpose:

State	Total number of households receiving sec. 8 assistance	Number considered elderly outside SMSA's [1]
South Dakota	65	20
Iowa	567	85
Nebraska	345	0

[1] Standard metropolitan statistical areas.

(*c*) What offices are responsible for administering the section 8 program in these States?

The Omaha, Nebr., area office has responsibility for administering the section 8 program in Nebraska, and the Des Moines, Iowa, insuring office administers the program in that State. The Denver regional office is responsible for administering the program in South Dakota. I have enclosed a listing of the full address of these offices for your information.

(*d*) Does the Department work jointly with Farmers Home Administration in meeting rural needs?

The Department and the Farmers Home Administration (FmHA) have executed a memorandum of understanding to encourage and facilitate the greater use of section 8 housing assistance for families in newly constructed projects financed under the FmHA Section 515 Rural Rental Housing program. We are drafting regulations for a joint program to implement this memorandum. A central aspect of the program is that owners will deal only with FmHA in developing projects and FmHA will certify to HUD that the proposed project is in compliance with the program requirements. We have agreed that we will set aside not less than 4,000 units for FmHA through September 30 and, subject to congressional authorization, not less than 10,000 units in subsequent fiscal years.

A copy of this memorandum of understanding signed by Secretary Butz and Secretary Hills is enclosed for your information.[1]

4. (*a*) How many units of public housing are located in each of these States?

(*b*) How many of these units are located in rural areas, and how many of these rural units are occupied by elderly persons?

PUBLIC HOUSING UNITS IN IOWA, NEBRASKA, AND SOUTH DAKOTA AS OF JULY 1975

State	Total units		Units located outside SMSA's			
	Programed	Under management	Under management	Occupied	Elderly occupied	Percent elderly
Iowa	3,890	2,927	1,730	1,718	1,505	88
Nebraska	9,436	8,609	3,473	3,312	3,110	91
South Dakota	4,998	3,713	2,368	2,234	778	35

5. What other Federally subsidized or assisted housing (i.e., 202, 221, 231, 236) for the rural elderly is available in these States. May we have a listing of rural projects in each State?

Enclosed is a detailed listing of multifamily subsidized housing available for elderly occupancy under HUD programs in nonmetropolitan areas in the three States.

6. What is the need for rural housing for the elderly as assessed in the housing assistance plans of the communities in these States?

I have enclosed a complete listing of the estimated number of elderly households in need of housing assistance as reported in the housing assistance plans submitted to HUD by the nonmetropolitan communities in the three States.

I hope you find this information useful in your coming hearings. If you require more detail on the information provided or further information, please do not hesitate to contact me.

Sincerely,

JAMES L. YOUNG.

[Enclosures]

[1] Retained in committee files.

ADDRESSES OF HUD FIELD OFFICES HAVING JURISDICTION OVER SECTION 8 PROGRAM IN IOWA, NEBRASKA, AND SOUTH DAKOTA

Iowa: Mr. Nate Ruben, Director, Department of Housing and Urban Development, 210 Walnut Street, Des Moines, Iowa 50309. Telephone (515) 284–4512.

Nebraska: Mr. Guy J. Birch, Area Director, Department of Housing and Urban Development, Univac Building, 7100 West Center Road, Omaha, Nebr. 68106. Telephone (402) 221–9301.

South Dakota: Mr. Robert C. Rosenheim, Regional Administrator, Department of Housing and Urban Development, Federal Building, 1961 Stout Street, Denver, Colorado 80202. Telephone (303) 837–4881.

SUBSIDIZED HOUSING AVAILABLE FOR THE ELDERLY UNDER HUD INSURED OR DIRECT LOAN PROGRAMS OUTSIDE SMSA'S IN IOWA, NEBRASKA, AND SOUTH DAKOTA, AS OF DEC. 31, 1975

State and project name	Place	County	Amount	Units
IOWA				
Sec. 202:				
Eventide Lutheran Home for the Aged	Denison	Crawford	367,000	51
Rotary Club	Eagle Grove	Wright	398,000	43
Prairie View Home	Garner	Hancock	885,000	76
Good Shepherd Retirement Apartments	Mason City	Cerro Gordo	1,374,000	93
Golden Buckle Home	Rockwell City	Calhoun	345,000	42
Do	do	do	140,000	12
Sunset Retirement Home	Spencer	Clay	515,000	51
Sec. 202/236: Golden Buckle	Rockwell City	Calhoun	583,300	48
Sec. 221 MR rent supplement:				
Jans Manor	Indianola	Toma	701,600	60
Courtview Apartments	Carroll	Carroll	575,500	56
Suncrest Village	Newton	Jasper	679,200	60
Sec. 236:				
McBurney Apartments	Belmond	Wright	372,200	32
Bluff Towers	Council Bluffs	Pottawamie	1,137,000	70
United Manor	De Witt	Clinton	560,200	48
Franken Manor	Sioux Center	Sioux	404,700	31
SOUTH DAKOTA				
Sec. 202:				
Morningside Manor	Alcester	Union	518,169	52
Wesley Acres, Inc	Mitchell	Davison	400,000	45
Do	do	do	494,000	38
Pioneer Memorial Manor	Spearfish	Lawrence	274,000	23
Sec. 221 MR rent supplement:				
Pierre Senior Citizens Home	Pierre	Hughes	450,500	40
Carver House	Wagner	Charles Mix	132,000	12
Sec. 236: Village Green	Yankton	Yankton	394,000	32
NEBRASKA				
Sec. 202: North Platte Odd Fellow Housing	North Platte	Lincoln	1,515,000	120
Sec. 202/236: Norfolk Housing Inc	Norfolk	Madison	1,635,000	92
Sec. 221 MR rent supplement: Valentine Housing	Valentine	Cherry	248,800	24
Sec. 236:				
Home Creek Manor	Gering	Scotts Bluff	685,400	40
Good Samaritan Society	Hastings	Adams	1,699,400	106
Tabitha Village	Lincoln	Lancaster	1,923,900	128

Elderly households in need of housing assistance as reported in 1975 housing assistance plans

Iowa:	*Number*
Akron	46
Albia	225
Ames	672
Arnold Park, Okoboji, W. Okoboji, Milford	49
Auburn	16
Bloomfield-Davis Counties	270
Burlington	435
Calumet	11
Carroll	29
Centerville	303
Charles City	266
Clinton	1238
Colfax	37
Fairfield	352
Fort Madison	420
Ft. Dodge	355

Grinnell	155
Iowa City	660
Iowa Falls	626
Jewell Junction	3
Keokuk	114
Leon	38
Mason City	1302
Missouri Valley	55
Moravia	55
Muscatine	715
Oelwein	102
Onawa	156
Oskaloosa	305
Ottumwa	408
Villisca	35
Winterset	171
Woodburn	43
Nebraska:	
Atkinson	35
Cedar Rapids	34
Crofton	41
Elgin	15
Fairbury	100
Falls City	120
Franklin	74
Grand Island	236
Hartington	35
Hastings	3820
Kearney	157
Loup City	85
Norfolk	494
North Platte	762
Omaha Indian Reservation	13
Scottsbluff	80
Talmage	11
Verdigre	20
Wilber	15
South Dakota:	
Astoria	7
Cheyenne River Reservation	50
Crow Creek Reservation	9
Dallas	17
Ft. Pierce	29
Garden City	23
Henry	8
Lower Brule Reservation	14
Menno	80
Mitchell	15
Monroe	22
Pine Ridge Reservation	300
Rapid City	213
Sinai	5
Sisseton	39
Sisseton Reservation	92
Toronto	3
Waubay	30
Yankton Reservation	24

ITEM 13. LETTER FROM RICHARD W. VELDE, ADMINISTRATOR, LAW ENFORCEMENT ASSISTANCE ADMINISTRATION; TO SENATOR DICK CLARK, DATED JULY 16, 1976

DEAR SENATOR CLARK: This is in response to your letter requesting information for field hearings to be held by the Special Committee on Aging.

I will respond to your questions in the same numerical sequence in which they were presented in your letter.

(1) The Law Enforcement Assistance Administration does not have an official definition of a rural area, and would use the definition of the Bureau of Census in developing any surveys.

(2) Inasmuch as the Administration on Aging is the agency with the expertise on this subject, we would be inclined to agree with their definition that an "older American" is of age 60 or older.

(3) Although studies have been conducted which show the crime rate on the basis of age, there have been no studies conducted comparing crime rates between rural and urban elderly residents.

(4) At present there are no programs in the three States which deal exclusively or to a large degree with the crime problem affecting rural, elderly residents.

Based on provisions of section 303(a) of the Crime Control Act of 1973, funding under LEAA programs gives priority attention to high-population areas rather than small communities or rural areas. Section 303(a) reads as follows:

"No State plan shall be approved as comprehensive unless the Administration finds that the plan provides for the allocation of adequate assistance to deal with law enforcement and criminal justice problems in *areas characterized by both high crime incidence and high law enforcement and criminal justice activity.*" (Emphasis added.)

It should be pointed out, however, that there are several requirements in the Crime Control Act, as amended, which have a favorable impact on smaller towns and rural areas.

Among the requirements of the Crime Control Act of 1973 (P.L. 93-83) are:

Section 203(c) which provides that the state planning agency must make at least 40 percent of planning funds available to units of local governments so that they may participate in the formulation of the comprehensive State plan.

Section 303(a)(2) requires that the State pass Federal action funds through to local units of governments and that the State assist localities in meeting match requirements.

Section 303(a)(3) mandates that every State plan must adequately take into account the needs and requests of the units of general local government in the State and encourage local initiative in program development, in addition, funds must be allocated between the State and localities in a balanced manner.

Section 303(a)(8) provides for a system of review whereby units of general local government can challenge allegedly adverse State decisions.

All of these congressional mandates are reflected in our guidelines and in the administration of the LEAA program.

I have enclosed a copy of the statement of Judge Henry McQuade, LEAA's Deputy Administrator for Policy Development, before the House Subcommittee on Housing and Consumer Interests Select Committee on Aging. A review of the enclosure will indicate that the entire LEAA program benefits older Americans at least indirectly, for its goal is to enhance the safety of all citizens. Mr. McQuade's statement includes a brief description of several research and action projects, supported by LEAA because of the recognition that senior citizens have special needs.

For your further information, I have also enclosed a copy of the latest National Crime Panel Survey Report entitled "Criminal Victimization in the United States, a Comparison of 1973 and 1974 Findings." I trust you will find both enclosures useful and informative.[1]

Your interest in this matter and the programs of the Law Enforcement Assistance Administration is appreciated.

Sincerely,

RICHARD W. VELDE.

ITEM 14. LETTER FROM JEANNA D. TULLY, DIRECTOR, OFFICE OF REVENUE SHARING, DEPARTMENT OF THE TREASURY; TO SENATOR DICK CLARK, DATED JULY 23, 1976

DEAR SENATOR CLARK: Thank you for your letter dated June 21, 1976, requesting information on the use of revenue sharing funds specifically in the categories of health and social services for the poor or aged.

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[1] Retained in committee files.

As a member of my staff discussed with David Harf of your staff, the Office of Revenue Sharing does not collect specific data on the expenditure of revenue sharing funds. As you know, the State and Local Fiscal Assistance Act of 1972 provides that funds allocated to local governments must be spent within several general priority categories. Additionally, these funds must be spent in accordance with local law.

The Office of Revenue Sharing does not have an official definition of rural area. Revenue sharing funds are allocated to general purpose governments as determined by the Bureau of the Census, Department of Commerce. The Office of Revenue Sharing does not specify which individuals fall into the "poor or aged" category for the purpose of spending general revenue funds to benefit that group. The flexibility of the program allows local governments to make those distinctions as necessary.

We are unable to provide a county-by-county breakdown of funds spent in entitlement period 5 or planned for entitlement period 6. We are able, however, to give you aggregate amounts for all counties within each of the states you mentioned. Accordingly, we have prepared an aggregate report for counties by State for actual uses in entitlement period 5 and a breakout by types of government, including counties, for entitlement period 6 planned uses. This data is enclosed.[1]

I am also enclosing for your information informal notes located in our files concerning expenditures for older Americans in Dubuque, Iowa, and Clay County, Iowa.[1] In addition, we believe that general revenue sharing funds may have been used for the benefit of the aged in Sioux Falls and Huron, S. Dak., as these jurisdictions specifically listed social services as a category of expenditures. Please accept this information as unverified inasmuch as the revenue sharing act does not require specific information of this nature.

I hope that the enclosed data will be of interest to you and the committee. Please feel free to call on me if at any time I may be of assistance to you or your constituents.

Sincerely,

JEANNA D. TULLY.

ITEM 15. LETTER FROM ODELL W. VAUGHN, DEPUTY ADMINISTRATOR, VETERANS' ADMINISTRATION; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR MR. CHAIRMAN: This will respond to the request of Senator Clark for answers to nine questions propounded in connection with field hearings to be conducted relative to the care received by older Americans in rural areas. For your convenience, the questions have been repeated, followed by the pertinent answers.

(1) What is the official definition of rural area in your agency?

The Veterans Administration feels that every veteran or beneficiary has the right to equal service; and, therefore, this Agency does not have an official definition of a "rural area". For general working purposes, particularly with regard to our outreach efforts, we have tended to classify anything outside of the Bureau of the Census list of Standard Statistical Metropolitan Areas as a rural area. This has in no way affected our service to beneficiaries in these areas.

(2) Do you agree with the designation—as in Administration on Aging programs—that an "Older American" is of age 60 or older?

Some veterans' benefits have certain provisions in law which refer to age, such as benefits relating to minors or disability pension. However, the figure 60 should not be used as a yardstick age for all items relating to Older Americans. As to health care, the chronological and physical ages may not be the same, e.g., a veteran may need nursing home or domiciliary care at age 50. These activities are considered as Extended Care or health care facilities for the "Older American Veterans."

There should be flexibility enough in the age designation for "Older Americans," so the justifiable need of the individual is taken care of.

(3) Are there any VA supported or affiliated hospitals, nursing home, or home care programs located in the hearing States which serve a significant rural elderly population?

The following VA and VA-supported facilities and programs serve a significant rural elderly population in the States of Iowa, Nebraska, and South Dakota:

[1] Retained in committee files.

	ADPC [1]	Operating beds
IOWA		
VA hospital, Des Moines		362
Community nursing home care program	42	
VA hospital, Iowa City		360
Community nursing home care program	63	
Hospital based home care program	18	
Iowa Veterans Home, Marshalltown:		
Nursing home care	375	
Hospital	24	
Domiciliary	175	
VA Hospital, Knoxville		703
Nursing home care unit		200
Community nursing home care program	6	
NEBRASKA		
VA Hospital, Grand Island		172
Nursing home care unit		42
Community nursing home care program	4	
Nebraska Veterans Home, Grand Island:		
Nursing home	349	
Domiciliary	200	
VA Hospital, Lincoln		207
Community nursing home care program	16	
VA Hospital, Omaha		444
Community nursing home care program	33	
SOUTH DAKOTA		
VA Hospital, Fort Meade		389
Community nursing home care program	9	
VA Center, Hot Springs		232
Domiciliary		511
Community nursing home care program	6	
South Dakota State Veterans Home, Hot Springs:		
Nursing home	30	
Domiciliary	94	
VA Center, Sioux Falls		249
Nursing home care unit		57
Community nursing home care program	16	

[1] Average daily patient census.

(4) What efforts have been made in the hearing States to acquaint the elderly rural veteran with the availability of VA information and referral services?

In the States of Iowa, Nebraska, and South Dakota, several programs are in operation which have been used to inform the elderly rural veteran. Among these are:

VA mobile vans, manned by veteran benefits counselors.—Vans were in Nebraska in June of 1975 and July 1976, in South Dakota in July 1975 and May 1976, and in Iowa in April 1975 and August 1976. The vans are preceded by intensive publicity in local newspapers and on radio stations. They reach into the most remote small towns and have proved to be an effective means of reaching rural veterans.

Toll-free telephone service.—Toll-free (FX and WATS) telephone service is now available to 90 percent of the Nation's veterans. Benefits information and assistance are provided by means of VA telephone units in each regional office. This service is available in all of Iowa and South Dakota and in part of the State of Nebraska. It has proved to be the most effective medium to assist the aged in rural areas.

Vet reps on campus.—There are now almost 1,300 vet reps on college campuses nationwide. While their primary function is to assist veterans who are enrolled in educational programs, they have frequently been used to provide outreach to individual veterans, especially the aged, in areas of the States in which they work and live.

VA information service.—By means of news releases, pamphlets, radio and TV announcements, the VA information service reaches into all areas of the Nation. Many small hometown newspapers regularly carry VA news release items.

In addition, the VA provides itinerant veterans benefits counselors, who go wherever the need arises, VA counselors who visit Federal and State prisons, VA field attorneys working in the guardianship program, and community service specialists in certain selected VA regional offices. The Veterans Administration is grateful to the veterans service organizations, such as the American Legion,

Veterans of Foreign Wars, Disabled American Veterans. American Red Cross, and AMVETS, who have provided much valuable assistance in providing veterans' benefits information to the aged in these States.

The Veterans Administration has also designated representatives of the Department of Medicine and Surgery and the Division of Veterans Assistance to each of the 10 Administration on Aging Regional Committees. The regional committees serve all States in the task of carrying out the VA's information and referral responsibilities as they have been spelled out in the working agreement between the 14 Federal agencies and the Administration on Aging. Part of the VA's commitment is to acquaint all elderly veterans with the availability of VA information and referral services. Also, to see that each information and referral office has access to VA information and referral service, each VA hospital and/or outpatient clinic and the Department of Veterans Benefits, Division of Veterans Assistance Offices have been designated liaison representatives to each Administration on Aging Area Office to serve the information and referral programs under their jurisdiction. (This provides service at the local level where the "Older American Veteran" is.)

(5) Are any VA day treatment mental health facilities serving elderly rural residents of the hearing States?

Medical District No. 23 includes Iowa, South Dakota, and Nebraska. There is one day treatment center in this medical district located at VA hospital, Des Moines, Iowa. The day treatment center sees approximately 60 people per day. This generates about 15,000 outpatient visits per year. Of the 60 patients seen at the day treatment center, 5 can be considered elderly, 1 in his early 80's, 4 are over 60 years of age. None of these patients are living in rural areas.

(6) What VA social work services, including telecare, are directed toward the elderly rural veteran of the hearing States? What are the names of the affiliated hospitals?

Social work service has a long tradition of providing a wide range of services to the older veteran and to his wife and widow. This is due in part to the fact that the veteran population is essentially an aging population and because medical science and technology have made it possible to live longer than ever before. The challenge to social work has been to help older veterans live meaningful and useful lives within the limits of their health problems and their disabilities. The complicating factor in achieving this goal has been the lack of adequate social services and social supports for older veterans in the community, and the need to locate and develop a variety of reseources including income maintenance, ambulatory health services, housekeeping and other personal services, such as meals on wheels, transportation, recreational opportunities, etc.

Social work service provides a full range of services either directly or through referral to community agencies for veterans requiring discharge planning and followup assistance. Services include evaluation and counselling visits to veterans placed in nursing homes, State homes, personal care homes, their own homes or other special living situations. VA social workers are active in the development of community resources and the coordination of services veterans may require in order to achieve a satisfactory adjustment in the community. All VA hospitals have extensive field visitation programs through which social services are provided directly to the veteran in his own home.

Volunteers are being utilized in 3 hospitals to provide Telecare services to veterans with special needs who live in isolated areas. One additional hospital will have a formal Telecare program operational in 6 weeks. All programs are operating under the auspices of social work service.

The following hospitals are affiliated for graduate training in social work: VAH Des Moines, VAH Iowa City, VAH Knoxville, VAH Omaha, VAH Lincoln, VAH Grand Island, VAH Hot Springs, VAH Ft. Meade.

(7) What, if any, of the following programs are operational and serving elderly rural veterans in the hearing States: rehabilitation medical services; dietetic and nutritional programs; nursing service; or voluntary service programs?

All of these programs are operational and serving rural veterans in VA Hospitals and VA Centers in Iowa, Nebraska, and South Dakota.

(8) Have any findings resulted from your GRECC research program which are of significant interest to the rural elderly?

The geriatric research, education, and clinical centers are involved in ongoing research efforts which are of interest to rural elderly. The research is not limited, however, to just elderly people living in rural areas. Some of the early research involvements include:

Three GRECC's are engaged in demographic health needs assessment studies of their surrounding communities. Results from this work enables better long-term planning of health services, particularly for the elderly population.

Controlled research is being conducted comparing the normal and pathological states of the cardiopulmonary system in the elderly.

Research efforts at another GRECC are making possible the early diagnosis of senile dementia.

Research is being conducted in the area of nutritional effects upon development in the aging brain.

Work carried on at another GRECC has resulted in the first successful growth of human arterial smooth muscle cells which revealed significant species differences in lipoprotein uptake between human and rat cells. This finding has implications for future research in cellular aging.

Additional research is being conducted on diseases often associated with the aged: osteoporosis, diabetes, and arthroscerosis.

(9) Can you recommend any alterations in your pension and compensation programs which would enable them to better serve the rural veteran?

We have no specific recommendations on this point. Veterans' benefits are the same for all, regardless of area.

We trust that the above answers are responsive to your inquiries.

Sincerely,

ODELL W. VAUGHN.

Appendix 3

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM JOYCE LEANSE, DIRECTOR, NATIONAL INSTITUTE OF SENIOR CENTERS; TO SENATOR DICK CLARK, DATED JULY 15, 1976

DEAR SENATOR CLARK: I am pleased to be able to assist the Special Committee on Aging with its preparations for field hearings on older Americans living in rural areas. Not all of the questions you addressed to us could be answered with information from the National Institute of Senior Centers Senior Center Research Project, but I hope the enclosed information will be useful.

The attached summary of data relies on two NCOA publications, the 1974 "Directory of Senior Centers and Clubs" and the "Report of Senior Group Programs in America," and on the in-depth survey questionnaires which were used to prepare the report. Pages from both books have been copied and enclosed for use with the summary. If the committee staff would like an additional copy of the directory or the report, please do not hesitate to ask. I have also enclosed copies of materials which describe some innovative programs designed to serve the rural elderly.[1]

If you have any questions about the summary or if you need additional information, please call me or Valinda Jones of the Public Policy Department, who prepared our response. I look forward to the results of your upcoming hearings and to working further with the committee.

Sincerely,

MRS. JOYCE LEANSE.

[Enclosure]

(1) The exact number of senior centers and clubs in the United States or in any particular State cannot be determined from the senior center research project data. Although an extensive effort was made to identify and elicit responses from as many adult group programs as possible (as described on pages 3–6 of the report), 9,448 organizations of the 17,930 on the basic mailing list did not respond to the initial questionnaire. Of the 8,442 responses, only 4,870 of those that wanted to be listed in the directory met the three criteria for inclusion. To be included, an organization had to offer a program directed at older adults, meet on a regular basis at least once a week and provide some form of education, recreation or social activity.

Consequently, the listings in the directory represent the minimum number of senior centers and clubs in a region. The following chart (based on information from the director) shows the total number of listed centers and clubs, the average age membership, the average daily attendance and the range of membership totals for organizations in the three States (see pages 407 and 437 of the directory). Comparable national averages are listed on page ix of the directory.

State	Total listed centers	Average membership	Number responses	Average daily attendance	Number responses	Range of membership
Iowa	62	160.2	46	58.8	45	16–7,023
Nebraska	63	170.9	42	36.2	51	2–8,000
South Dakota	57	116.6	47	35.3	47	10–1,300

The directory lists the centers and clubs alphabetically by towns and cities within each State. That information is also attached (pp. 409–415, Iowa; pp. 429–435, Nebraska; pp. 453–459, South Dakota). A summary of the percent of centers in rural and urban areas can be found on pages 13 and 14 of the report.

[1] Retained in committee files.

(2) The National Institute of Senior Centers Senior Center Research Project did not attempt to determine funding sources for construction or alteration of facilities because, at the time the surveys were conducted (fall 1973–fall 1974), there were no active Federal programs of assistance for such activities. Title V of the Older Americans Act was not funded until this year when $5 million was appropriated for the Fiscal Year 1976 transitional quarter. Title I of the Housing and Community Development Act of 1974 (enacted August 22, 1974) allows grants for construction and alteration of publicly sponsored senior centers, but it was not an active program when the questionnaires were distributed. Pages 17–19 of the report include a general description of facilities.

The initial surveys and the in-depth questionnaires tried to determine general funding sources and the proportion of Federal, State, and local funds used by centers. Unfortunately, many of the centers did not respond completely to the questionnaires, particularly to the questions concerning financing. The proportion of Federal and other funds on the average in each State is noted on pages 408 and 438 of the directory. Pages 14–17 of the directory summarize the detailed funding information on a national basis. Additional information on funding patterns in Iowa, Nebraska, and South Dakota can be obtained from the in-depth questionnaires. The difficulty is that the number of in-depth questionnaires from each of the three States is too small to be statistically reliable (10 from Iowa, 7 from Nebraska, and 11 from South Dakota). However, the data might be useful in making some broad generalizations about funding resources. The combined data show that each program relies on several funding sources—the only exceptions being the smaller clubs that indicated a sole reliance on dues and fees.

According to the ten in-depth questionnaires from programs in Iowa, only three received financial assistance from sources other than dues, fees, or individual contributions (a "kitty" was listed by several). (Most of the respondents to the in-depth questionnaire in that State considered themselves clubs rather than centers which might explain the reliance on membership contributions.) In these three programs, funds from title III of the Older Americans Act (OAA) were listed twice; from the Office of Economic Opportunity (OEO) once; from adult social services, once; and from a city tax levy, once. Local organizations, such as the United Fund, were listed by all three.

In Nebraska, only one program of six responding to that question used Federal funds (OEO) and that also relied on local in-kind support. Of the other five programs, unspecified, state funds were listed as a revenue source once; unspecified local funds, twice; local revenue sharing funds, once; and dues, fees or money-raising projects, such as bake sales, were listed several times.

Five South Dakota programs out of nine responding to the question used Federal money. Four of these used title III OAA funds; one used Department of Labor funds. Local unspecified funds were listed five times and, again, dues, fees, projects and other membership contributions were also listed by most of the respondents.

(3) Pages 25–33 of the report summarize the findings on activities and services nationwide. For each center that provided details, the directory lists types of services and notes how often and when centers meet (see pages 409–415; 429–435; 453–459). A comparison of services and frequency of meetings can be made by States and by regions from the information listed on pages ix, 407, and 437 of the directory. Organizations noted whether they held sessions in the morning, afternoon or evening in the initial survey. The frequency of full-day sessions (mornings and afternoons—evenings were infrequent and so not considered here) in centers in Iowa, Nebraska, and South Dakota is noted below.

State	Total centers	With full-day sessions	Average full-day sessions per week
Iowa	62	22	4.5
Nebraska	63	32	4.4
South Dakota	57	16	4.6

The report suggests two standards by which multipurpose programing can be determined (see p. 25). The first is to count those groups that offer three or more nonspecific services; the other is to count those that offer the so-called three basic services (recreation, education, information, and referral or counseling). The following chart is based on information obtained from directory listings.

State	Total	3 or more	Percent	3 basics	Percent
Iowa	62	46	74	29	47
Nebraska	63	42	67	28	44
South Dakota	57	52	74	20	35

A similar chart, also based on the directory listings, shows the number of centers offering health services and, from these, the number offering health screening.

State	Total	Health services	Health screening
Iowa	62	3	1
Nebraska	63	5	1
South Dakota	57	13	4

Information on outreach programs was sought in the in-depth questionnaires, but responses were sporadic and inconclusive. A major difficulty in obtaining information is that two in-depth forms were used—one for organizations that considered themselves clubs and the other for self-designated senior centers. Only centers were asked about outreach efforts in any detail, so the number of responses is negligible. (The small number of in-depth questionnaires from each State must also be kept in mind.)

In Iowa, three outreach programs were identified from six responses to that question; in Nebraska, two outreach programs from five responses; and in South Dakota, five from eight responses. The data on the number of contacts made per month and the number of outreach workers used are too scanty to be useful. Thirty is a rough average of contacts per month through all three States. When compared with the national averages on page 39 of the report, this figure demonstrates the likelihood that the small number of responses has made the information unreliable.

(4) The senior center research project did not attempt to obtain descriptions of innovative programs and, unfortunately, correspondence to the National Institute of senior centers from Iowa, Nebraska, and South Dakota has not included many descriptions of programs which might be useful to your committee. The few that might be of interest have been copied and attached.[1]

ITEM 2. LETTER AND ENCLOSURE FROM JUDITH ASSMUS RIGGS, DIRECTOR, OFFICE OF GOVERNMENT RELATIONS, LEGAL SERVICES CORP.; TO SENATOR DICK CLARK, DATED JULY 19, 1976

DEAR SENATOR CLARK: This letter is in response to your request for information on legal services for the elderly in the states of Iowa, Nebraska, and South Dakota. It is provided as background for field hearings on the effectiveness of federal programs serving the rural elderly in those three states.

As you know, the Legal Services Corporation is a private nonprofit corporation established by the Legal Services Corporation Act of 1974 (Public Law 93-355) to provide legal assistance in noncriminal matters to persons who cannot afford to employ an attorney. The corporation makes grants to local legal services programs that previously received funds from the Office of Economic Opportunity and its successor agency, the Community Services Administration. From 1971 through 1975, Federal funds for legal services remained at the same level. As a result, there was no expansion of service and, in fact, many programs were forced to cut back services as a result of inflation. Congress has just enacted an appropriations measure for fiscal year 1977 that provides an increase in funding to enable the corporation to begin expansion of services to the vast areas of the country where the poor are still without any legal assistance at all.

Programs in Iowa, Nebraska, and South Dakota that receive grants from the Legal Services Corporation.

The corporation supports four programs serving eight counties in Iowa, three programs serving four counties in Nebraska (and one county in Iowa), and two programs in South Dakota, one that is limited to a single county and one that

[1] Retained in committee files.

serves a largely native American population in a 15-county area in the central part of the State. Several of these programs are in cities of substantial size—Des Moines and Omaha-Council Bluffs, for example—and serve a predominantly urban client population. Others serve a mix of rural and small city clients. Only two programs could be described as principally serving rural populations—Panhandle Legal Services in Scottsbluff, Nebr., and South Dakota Legal Services in Mission, S. Dak.

There is attached to this letter a list of the programs in the three states, the addresses of their main offices, the counties they serve, and their current level of funding from the corporation.

Number of elderly served.

The corporation does not have data on the number of rural poor over age 55 in the three States. According to 1970 census figures available to us, the number of rural poor over age 65 in Iowa is 43,321; in Nebraska, 24,743; and in South Dakota, 14,946. Obviously, we reach only a small fraction of that population.

None of our programs in the three States serve the elderly exclusively. The percentage of clients over age 65 varies from program to program, from as low as 5 percent to as much as 15 to 20 percent. The programs do not keep separate records on the number of clients over age 55, but if the group aged 45 to 64 is included, then the percentage of older clients increases significantly.

In most programs, the percentage of clients who are over age 55 is less than the percentage of the eligible population that is elderly. This is due largely to the transportation difficulties poor elderly people have, especially in rural areas. In addition, the elderly tend to be less aware of the fact that legal services are available and do not understand how the programs could be helpful to them.

Those programs serving a relatively high proportion of elderly clients are the ones that have engaged in aggressive outreach efforts. For example:

The director of the Legal Aid Society of Polk County (Iowa) regularly visits senior citizens centers and speaks during their meal programs. In addition, he lectures to the State welfare agency's adult protective workers around the State on the problems of the elderly.

Black Hills Legal Services, Inc. (South Dakota) has a wide-ranging program for senior citizens, including presentations in senior citizens centers and monthly newsletters published especially for senior citizens.

South Dakota Legal Services uses paralegals as well as attorneys to visit nursing homes and the elderly in their own homes to advise and assist them with their legal problems. For example, the program recently canvassed the elderly, to inform them of a South Dakota law providing special tax rebates and to help them fill out the forms needed to obtain the rebate.

Unfortunately, few of our programs have the additional resources required for adequate outreach and community education activities. Title III of the Older Americans Act is being utilized effectively by some local programs to supplement Corporation funds in order to reach the elderly in need of legal assistance. Those efforts through the Older Americans Act must be continued and expanded.

Nature of the legal problems of the elderly.

Accordingly to program directors in the three States, most of the legal problems of their elderly clients are routine and not all that different from those of other clients. However, these problems are particularly serious for older persons and often affect their very livelihood. This most common set of problems relate to their ability to obtain government benefits and services to which they are entitled—social security, SSI, medicare and medicaid, and food stamps. A second set of problems are health-related, including insurance, medical bills, and nursing home problems. The elderly also come with property and personal tax problems, and for help with wills, conservatorships, and problems associated with the death of a spouse. To a lesser degree than younger clients, they need assistance with housing and consumer problems.

The majority of these problems are resolved without litigation. In many cases, the client simply needs information on benefits available to him or her, and assistance in filling out forms. Many matters can be resolved through negotiation. The following are examples of how legal services programs represent elderly clients:

When property taxes rose as much as 45 percent in Polk County last year, the Legal Aid Society representing 2,300 elderly persons in individual protest hearings. The vast majority of those cases, 1,500 in all, were won and another 300 are on appeal.

In South Dakota, a legal services attorney represented a poor elderly client who needed life-sustaining drugs costing $80 a month. Since the State medicare plan did not include payment for drugs, the elderly had to rely on county relief. The county had set an arbitrary limit of $50 a month on payment for drugs. Negotiations failed, a successful suit was filed, and that limit was removed, providing relief not only for the particular client but for all of the elderly in similar situations.

In Iowa, a legal services attorney represented a 91-year-old woman in an eviction proceeding. Friends agreed that the loss of her home would destroy all that bound her to life. The court delayed the eviction and the attorney was able to persuade the landlord to let the woman remain.

The need for legal services for the elderly.

Evidence of the need for legal services among the elderly poor is overwhelming. In Iowa, when the State's commission on aging set up a WATS line for the elderly, the bulk of the calls were about legal matters. As a result, the commission has awarded a small grant to the Polk County Legal Aid Society and refers calls there. Often, the program can take care of the problems simply by giving the callers information, and sometimes by writing a letter for them. In other situations, they refer them to a local attorney who can help.

In Nebraska, the most recent needs assessment conducted by the State's commission on aging identified legal services as a priority among the rural elderly in three out of the four areas reporting. The Panhandle Community Action Agency in Gering, Nebr., conducted a separate five-county survey of needs of the elderly, which showed that home health services were the greatest need and legal services the second. In each of the counties, more than 70 percent of those responding to the question, "Is there a need for legal services?" said yes. In some counties, the response was as high as 89 percent.

We understand that you will be holding hearings in all three of the States during August. Representatives of legal services programs, including paralegals and the elderly clients themselves, as well as staff attorneys, program directors and board members, could provide useful testimony about the need for legal assistance and the benefits when it is available. Perhaps even more important, since those attorneys and paralegals work directly with elderly persons who find it difficult to obtain services and benefits available under Federal programs, they can offer useful insights into the way those programs are serving senior citizens.

I am enclosing letters[1] some of our programs sent in response to our request for information. If you need any further information, or if we can be helpful in identifying potential witnesses for your hearings, please let us know.

Sincerely,

JUDITH ASSMUS RIGGS.

[Enclosure]

Legal Services Corporation funded programs in Iowa, Nebraska and South Dakota

Program and area served	*Annual funding level*
Iowa:	
Legal Aid Society of Polk County, 102 East Grand Ave., Des Moines, Iowa (515) 282–8375; Polk County	$308,000
Dubuque Area Legal Services Agency, 630 Fischer Bldg., Dubuque, Iowa (319) 588–4655; Dubuque, Delaware, and Jackson Counties	75,900
Hawkeye Legal Aid Society, 114 East Prentiss, Iowa City, Iowa (319) 351–6570; Johnson, Jones, and Washington Counties (on referral from county bar association)	77,880
Black Hawk County Legal Aid Society, 708 First National Bldg., Waterloo, Iowa (319) 235–7003, Black Hawk County	99,000
Total Iowa funding	560,780

[1] Retained in committee files.

Nebraska:	
Legal Aid Society of Lincoln, Inc., 800 Anderson Bldg., 12th and O Sts., Lincoln, Nebr. (403) 435–2161; Lancaster County	90,400
Legal Aid Society of Omaha-Council Bluffs, Inc., 7th floor, Farnam Bldg., 1613 Farnam St., Omaha, Nebr. (402) 348–1051; Sarpy, Douglas Counties, and Pottawattamie County, Iowa	277,700
Panhandle Legal Services, Inc., 701 East Overland, P.O. Box 605, Scottsbluff, Nebr. (308) 632–4734; Scotts Bluff County	66,000
Total Nebraska funding	434,100
South Dakota:	
South Dakota Legal Services, P.O. 727, Mission, S. Dak., (605) 856–4444, 15-county area in central South Dakota	290,758
Black Hills Legal Services, Inc., 714 4th St., Rapid City, S. Dak., (605) 342–7171, Pennington County	74,800
Total South Dakota funding	365,558
Total funding in 3 States	1,360,438

ITEM 3. LETTER FROM HARVEY C. DAVIS, ACTING DIRECTOR, MATURA ACTION CORP.; TO SENATOR DICK CLARK, DATED AUGUST 12, 1976

DEAR SENATOR CLARK: Matura Action Corp. has been working with and is an advocate for the low-income elderly since 1966. In the last 10 years changes have been made in public attitude toward the elderly. More affirmative thought is going into the well-being of the elderly.

Even with this progressive change in the attitude toward the elderly, some more assertive changes need to be incorporated into the programs. For instance, in housing, HUD's low-income housing has been eliminated or cut back so drastically that many of our towns and cities that had hopes of a program have been dropped and the elderly are then forced to find other means of housing. Also in the housing that has been established, the housing authorities are encouraged to keep running in the black so HUD will not have to subsidize the program. When this happens, the really low income elderly are sometimes passed over as residents because their 25 percent payment would make their contribution for the rent a little over $25 per month for the rent—and with very many of these in a housing complex, it runs in the red. HUD encourages them to eliminate running in the deficit.

Transportation for the elderly is another area that has made some progress the past 10 years, especially in Madison County.

In the other counties that Matura Action Corp. is funded, the area agency on aging has used title III of the Older Americans Act to furnish transportation. This has been a help. Matura Action Corp. has submitted a proposal to the State department of transportation for the coordination of transportation systems. This would be a boon to the area, but some of the boards of supervisors are reluctant to enter into the agreement, although they know there is a need, because it might become so popular they might be forced to contribute to the program. It is my belief that rural public transportation is going to have to be subsidized by the State, Federal, and the agencies purchasing services for the program. The elderly would benefit from this coordination of transportation systems.

Matura's network of neighborhood centers have been a home-away-from-home for the elderly. In most of the counties in our area, these need to be kept in existence by Matura and supplemented by moneys made available by the Older Americans Act. Matura was helping the elderly long before the Older Americans Act designated regional AAA. Out of our centers we also sponsor 16 other projects for the elderly in other smaller towns in the areas.

The title VII nutrition program of the Older Americans Act has been a valuable asset to our area. I have some constructive criticism: In some instances, the wealthy tend to monopolize some nutrition sites and the low-income will not attend

because of this; and in other instances, the low-income elderly are patronizing the nutrition program in large percentages and now the middle-income and above have some hesitancy to take advantage of the program.

I do not have a solution for this problem, although I think it was created in the recruiting phase of the program. I am concerned about the low-income elderly participating in the program and will use Matura's outreach and encouragement for the elderly poor to participate.

Thank you.

HARVEY C. DAVIS.

ITEM 4. LETTER AND ENCLOSURES FROM DAVID L. ADAMS, HUMAN AGING COORDINATOR, DRAKE UNIVERSITY, DES MOINES, IOWA; TO SENATOR DICK CLARK, DATED AUGUST 30, 1976

DEAR SENATOR: I was pleased to receive your request of August 11, 1976 for copies of my research on the rural elderly. I regret that I missed the hearings you held in Iowa, but am very pleased that you got to talk with Woody Morris and with Governor Blue.

I am enclosing copies of those articles which seem most directly relevant to your inquiry. Three of these apply specifically to the small town rural elderly of Missouri and have been done in conjunction with Dr. C. T. Pihlblad of Columbia, Mo.[1] We will soon issue another series based on a restudy of his sample done in 1973–74. The fourth was done for the Gerontology Society and applies to the general concept of rural elderly in America. It may be of particular use to you.

If I can be of further assistance to you, please feel free to contact me.

Sincerely,

DAVID L. ADAMS.

[Enclosure]

WHO ARE THE RURAL AGED?[2]

By David L. Adams, Ph. D., Drake University

In accepting the offer to write this paper, the task of defining the rural aged and of setting the pace for contributions which follow seemed fairly easy and straightforward. After all, there have been several studies of rural and small town elderly done in the past 15 years and while publications in this area are not as voluminous as those in urban aging, they at least offer a high degree of consistency in defining the study sample. Basically, the rural elderly are those persons aged 65 and older who reside in areas of less than 2,500 population density.

The assumption which underlies this demographic definition of the rural aged is that the social persons so named rather suddenly came into existence at the age of 65 and in the locations where they are found. Perhaps this is a necessary assumption, for it does underlie most of the gerontological research of the past 30 years. The theories of aging—subculture (Rose, 1962), role (Phillips, 1957), and disengagement (Cummings and Henry, 1961)—all presume that the variables necessary to explain the elderly are to be found in their current environments and social persons. Even the lifestyle theory (Williams and Wirths, 1965) is limited to existing, rather than preexisting styles of life. There is one approach, however, which is concerned with both past and present environments—the life-course frame of reference (Youmans, 1969).

This approach indicates that a full understanding of human aging requires that the cultural expectations and abilities associated with older age be compared with those of earlier stages of life. It also indicates that to function effectively, a given society must provide the means by which a person can move in an orderly fashion from one status position to another, and the society must provide the motivations for individuals to fulfill the roles of each position.

Consider, for example, the individual who has lived a lifetime in a highly urbanized area, who has achieved considerable class, status, and power in a bureaucratic structure, who has maintained a lifestyle and a value system commensurate with this position, and who at the age of 65 leaves this lifestyle for the quiet countryside of the Ozark foothills of Missouri (Oliver, 1971). By the

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[1] Retained in committee files.

[2] Published by the Gerontology Society, November 1975.

demographic definition, he would be considered rural aged and there would be nothing to distinguish him from the successful store owner who has spent a lifetime in the region—but surely they cannot be considered "rural" aged in the same qualitative sense of the term. Without the earlier environmental history of the respective individuals, we would be lacking valuable information for explaining much of the variance in their current values and life styles.

The "aged" portion of this definition is also subject to qualitative inconsistencies. For instance, the successful grocery store owner mentioned above might be 75 years old, but still puts in 10 hours a day, 6 days a week at the store. He is still treated and greeted by his customers and friends as he has always been. He has come to be defined in terms of functional age, as ageless. His urban counterpart, while 10 years younger, is structurally defined as a retired old man. Consequently, while the store owner is rural, he is not aged—and his younger counterpart while aged, is not rural.

These examples illustrate the weakness of considering only the current characteristics and environments of the rural aged and emphasize the necessity of further inquiry into the past history of the rural aged and their social worlds. Central to this life-course approach are the dual concepts of social role and socialization. The roles provide for the orderly movement through the life cycle as mentioned by Youmans. Socialization provides the continuing motivations to assume these roles. As used here, socialization is considered a lifetime process of modifying adaptive mechanisms, but its foundation is in childhood socialization—the language, values, expectations, and other patterns of environmental adaptation acquired during the younger years. With respect to the current generation of rural aged, their basic socialization occurred in a period which preceeded the instantaneous communication and value exchanges made possible by automobiles, radios, telephones and television. Consequently, change in their social world was slower and social roles were less abstract or ambiguous than is the case today.

In 1942, a role theory approach to understanding adjustment to present and future roles was proposed which included the following requirements for successful adjustment (Cottrell, 1942):

(1) The clarity of such future roles.
(2) Emotionally intimate contact with persons in such roles.
(3) Practice of the role through play or other activity.
(4) The completeness of the shift in responses and expectations of others to the individual in his new role.

All of these factors were more evident in rural America of 1920 than they are today. Consequently, the rural aged were socialized not only to a different society, but also to a different pattern of socialization and speed of expected social change. They were raised to expect that future roles would remain relatively clear and unchanged during their lifetimes and that societal response to them would be towards the total individual (functional worth) rather than towards some social characteristic of the individual (structural definition).

The difference in orientation to one's social world which such a role expectation affords is vividly described by Parsons:

> . . . the (urban) father does not work in the home and his son is not able to observe his work or to participate in it from an early age. Furthermore, many of the masculine functions are of a relatively abstract and intangible character such that their meaning must remain almost wholly inaccessible to a child. This leaves the boy without a tangible meaningful model to emulate and without the possibility of a gradual initiation into the activities of the adult male role. An important verification of this analysis could be provided through the study in our own society of the rural situation. It is my impression that farm boys tend to be "good" in a sense in which that is not typical of their urban brothers. (Parsons, 1942)

If we substitute for the word "good" other descriptive adjectives—such as neighborly, family oriented, independent, etc., the relationship or comparison remains basically the same. The rural environment of the early 1900's produced a social animal well equipped for survival in a society which existed at that time, but less well prepared for a society which was to change quite drastically during the lifetime of that social animal. The remainder of this discussion represents an inquiry into the nature of this change—especially that directly related to "rural" and to "agedness." It is based on the assumption that the rural aged of contemporary America are not simply old people who happen to live in rural places—they are rural people who have aged while their environments have become progressively less rural.

One of the easier methods of tracing changes in the rural scene is through the U.S. census information—not simply the enumerations, but also the changes in definitions over time. For instance, in 1900 the census definition of rural was basically all places of less than 4,000 population density. By 1910 this definition had been changed to 2,500 population. Thus something about the nature of human social environments had changed sufficiently to cause the Census Bureau to question the validity of the earlier indicator and to reduce the size of the place necessary to be considered "rural." The definition of rural was further subdivided in 1930 with the introduction of the concept of rural-nonfarm. In other words, not only the size of a place but also the occupational structure was considered a useful component of the definition. This subdivision suggested two types of rural people—the farmers and the small towners—with the latter being less rural than the former. The most recent development in this changing definition of rural environs occurred in 1960 with the concept of the metropolitan rural areas. Basically, such areas are those which would otherwise be considered rural, but which are located within the county boundaries of a standard metropolitan statistical area. The significance of this change is that an individual could now be a fully occupied agricultural producer, yet not be considered truly rural due to the proximity of a high population density. The rural areas became relegated to those farms which were at some distance from all major and many minor urban areas.

Each succeeding redefinition of rural served to maintain a degree of isolation or segregation of rural persons from those considered urban. The isolation is a product of both geographic distance and of social difference. The social difference is maintained by the occupational homogeneity of rural peoples who are conceived as agricultural producers for urban consumers. Thus the image of old age as consummatory phase of life (Parsons, 1963) which fits the urban aged may not be so applicable to the rural environments. As will be seen in later papers, this social difference accounts for considerable variance in the social environments and expectations of rural and urban aged.

Another major impact of the redefinitions has been the maintenance of a constant rural population size for the past 70 years—those years during which the rural aged gained their status as the aged. This constant population size is often ignored in the presence of the more frequently cited declining proportion of the rural population. During the period 1920 to 1970, the population of the United States increased by 97 million from 106 to 203 million. But during the same time period, the rural population (farm and nonfarm) remained almost unchanged with 52 million and 54 million respectively.

To correct for the slight error due to changing census definitions during this time, the data has been standardized according to the 1960 definition of nonmetropolitan rural (Robinson, 1965). This information is provided in table 1 and figure 1 and indicates that the constancy of rural population remains. Practically all of the population growth in this country in the past seventy years has taken place in the urban areas and their suburbs—the metropolitan rural areas. In fact, the nonmetropolitan rural population peaked in 1940 and has declined since then to a level below that of 1900. This suggests that as the rural aged leave the farms, they are not being taken over by younger generations, but seem to be passing into the conglomerates of agribusiness. Thus even in nonmetropolitan rural America, the impact of urban styles and values of life are being felt.

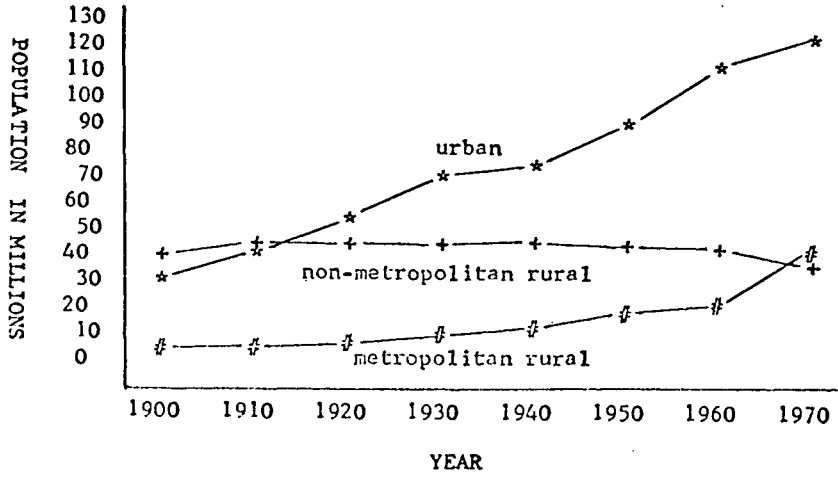
TABLE 1.– RURAL POPULATION OF THE COTERMINOUS UNITED STATES BY METROPOLITAN AND NONMETROPOLITAN STATUS, 1900–70 [1]

[In millions]

Year	Population				Percentages		
	Total	Urban	Metropolitan	Nonmetropolitan	Urban	Metropolitan	Nonmetropolitan
1900	75.7	30.4	5.4	40.5	39.5	7.1	53.4
1910	91.6	42.3	6.7	43.3	45.5	7.3	47.2
1920	105.3	54.5	8.2	43.3	51.1	7.8	41.1
1930	122.3	69.4	10.7	43.2	56.0	8.7	35.3
1940	131.0	74.9	13.0	44.3	56.3	9.9	33.8
1950	149.9	90.4	17.9	43.1	59.4	11.9	28.7
1960	177.7	113.4	24.7	41.2	62.9	13.9	23.2
1970 [2]	203.2	123.0	42.7	37.5	60.6	21.0	18.4

[1] Source: Warren C. Robinson, 1965.
[2] Source: 1970 Census of the United States, U.S. Bureau of the Census.

CHART 1. URBAN AND RURAL POPULATION OF THE COTERMINOUS UNITED STATES BY METROPOLITAN AND NONMETROPOLITAN STATUS, 1900–70



AGE AND SEX ENVIRONMENTS

The rural environment is only half of our consideration here—the other half deals with the aging environment of the American character. That is, not only have the rural aged gained their present status by growing older in the past 70 years, but also the structure of the American population has grown older. Further, the differential impact of mortality on men and women is sufficiently great to cause us to consider rural aged men and rural aged women separately in this section.

Given the phenomena of the migration of youth from rural to urban environs, plus the above cited fact of the stable rural farm population during the past 50 years, it would seem logical to conclude that the rural population has "aged" more rapidly than the urban segments of the population. In fact, it might seem that the 50 million in rural areas today are the same 50 million who were there a half century ago—and consequently are all rural aged. However, the census data supports such a proposition only partially.

It is a well known fact that he "aged" proportion of the American population has increased from about 4 percent in 1900 to about 10 percent today. If the above stated hypothesis were correct, then the rural population would be expected to account for more of this increase than the urban population. However, the data in table 2 indicate that both urban areas and rural farm areas have increased at about the same rate from 1930 to the present.

TABLE 2.– PERCENTAGE OF UNITED STATES POPULATION OVER AGE 65 BY RURAL AND URBAN STATUS, AND BY SEX, 1930–70

1970 distribution and location of aged	Census year				
	1930	1940	1950	1960	1970
Males:					
4 percent rural nonfarm	6.3	7.2	7.8	11.2	11.7
26 percent rural farm	5.7	7.1	8.2	8.8	9.2
68 percent urban	4.8	6.3	7.6	8.2	8.1
Females:					
5 percent rural nonfarm	6.6	7.4	8.3	13.1	15.3
20 percent rural farm	4.5	5.9	7.0	9.0	10.0
75 percent urban	5.4	7.3	9.0	10.1	11.3

Source: U.S. Bureau of the Census, 1930–70.

In each of the census years, there have been about 1 percent more males over age 65 in rural farm areas than in the cities while the reverse was true for females—a higher proportion in the cities than on the farms. For both sexes, how-

ever, the proportion over 65 in the rural nonfarm areas has grown much more rapidly than either rural farm or urban areas. For males, 12 percent of the rural nonfarm population is over age 65 compared with 8 percent and 9 percent in urban and rural areas. For females, the figures are 15 percent, 11 percent and 10 percent respectively. Our first inclination would be to interpret this higher rural nonfarm figure as supportive of the thesis that the rural population has aged faster than the urban population. However, when we realize that only 5 percent of all aged reside in rural nonfarm areas, compared to one-fourth in rural farm and 70 percent in urban areas, then the impact of this higher proportion is seen to be relatively small.

There are three possible explanations why the static population of rural areas, even with its outmigration of youth, has not "aged" faster than the more dynamic and growing urban areas. First, the rural families tend to be larger thereby holding down the proportion over age 65. The rural aged will differ from the urban aged because of this family differential in ways described later by Powers. Second, the life expectancy of rural people has traditionally been lower, thus reducing the number of people reaching the status of rural aged. This is considered in later papers by Oliver and Taietz. Finally, there has surely been some rural to urban migration by the elderly—if not from the farm to the cities, then at least from rural farm to rural nonfarm or small town environments. This is discussed in the following paper by Pihlblad.[1]

It was mentioned above that mortality, and therefore aging, has had a differential impact on rural aged men and women. For the country as a whole, the sex ratio has declined from 104 men per 100 women in 1920 to only 95 m/w in 1970. This information is presented by age and place of residence in table 3 and clearly illustrates that the decline has been the greatest in farm areas, going from 139 in 1930 to only 93 in 1970 for persons aged 65 and over. In other words, there has been a drastic change in the sex composition of the rural aged during the lifetime of the current generation. While we frequently think of the change in urban aged sex composition over the past 50 years as a trend from aged couples to urban widows, the trend during the same time in rural areas has been from rural widowers or bachelors to rural couples. If this trend continues, the implication is that more and more rural widows will be faced with the decision to remain on the land and try to farm it themselves, or to join the flow of rural widows to the nearby small towns.

TABLE 3.—SEX RATIO OF THE U.S. POPULATION OVER AGE 65 BY RURAL AND URBAN STATUS, 1930-70

Location of aged	Census year				
	1930	1940	1950	1960	1970
Rural nonfarm	101	100	97	80	71
Rural farm	139	134	128	104	93
Urban	86	82	80	76	67

Source: U.S. Bureau of the Census, 1930-70.

In concluding this section on the trends in rural aging, we have reason to believe that the rural aged may need more adjustment to their old age than do the elderly in general. Not only have they witnessed an aging of their social environment, they have seen a rural way of life to which they were socialized give way to an urban way of life for which they may not be prepared. As children they lived in a very young world which contained few older people—both in absolute size and in proportion. Because they were few in number and because of their rural environment, we have reason to believe that the rural aged of 1920 possessed a relatively high degree of status and respect (Cowgill and Holmes, 1972). It was this image of old age that the children who became today's rural aged envisioned for themselves. But as they grew older, they found themselves surrounded by an increasingly larger number of persons like themselves. This may function to provide them with a larger peer group with whom to interact, but it is generally dysfunctional to the extent that it lowers the status of the aged and affords them less respect than they were socialized to expect.

[1] Retained in committee files.

It has been the contention of this paper that the rural aged were the products of one culture, the participants of another. Unlike the urban aged who had only to learn to be "old," the rural aged had additionally to learn to be "urban." Of course, it is a matter of argument concerning the impact of the rural-urban differences on the individual's social environment. Here we have emphasized that difference. But it should be pointed out that as early as 1920 the spread of urban life styles and values to rural areas had already been observed and described as "rurbanization" (Galpin, 1920). Charles J. Galpin used this word to indicate the changing nature of community relations—especially as they dealt with family, friends, work, and government. He felt that easy and rapid communication between rural and urban areas was responsible for "rurbanization":

> Locality groups have tended to enlarge their boundaries . . . This trend has been fostered most of all by the development and diffusion of rapid means of travel and communication, especially the automobile and good roads.

Forty years after this initial invasion was described, Richard Dewey surveyed the work of eighteen authors of books and articles dealing with rural-urban sociology, looking for items believed "to be the basis for distinguishing ruralism from urbanism" (Dewey, 1960). Although he found five variables or concepts which had some degree of agreement, he ultimately concluded that "It may occur to one that, if this be all that there is to the rural-urban continuum, it is of minor importance for sociology." The five variables which he considered relatively unimportant were: (1) Homogeneity/heterogeneity; (2) intimate/impersonal social relations; (3) familiarity/anonymity; (4) simple/complex division of labor; and (5) "symbols of status which are independent of personal acquaintance." He continued by saying these should not be eliminated from sociology, but they should "be considered with the more important cultural facts, form and content, which are the sociologist's stock in trade."

While Dewey may be describing a very accurate account of rural-urban lack of difference in 1960, we cannot help but believe him guilty of shortsighted reductionism by the implication that rural-urban differences have always been relatively unimportant. It is likely that there will be little difference between rural aged and urban aged of tomorrow, for as the children of today they are being exposed to nearly identical cultural roles, expectations, and values. But this should in no way negate the differences to be found among the rural aged and the urban aged of today.

In conclusion, the rural aged are a product of a unique combination of social, historical, and technological events. Perhaps because of this they will be more difficult for the practitioner to deal with—being more difficult to reach both geographically and socially. Further, given the transitory nature of the rural aged character, perhaps the practitioner would be well advised to build service delivery programs designed to fulfill the needs of coming generations of aged, rather than attempting to construct specialized and temporary programs for this generation. This is not meant to suggest that we should fail to attempt to satisfy the needs of the present generation of rural aged, but neither should we conclude that delivery systems which are "successful" today will continue to be successful with future generations of elderly who will be healthier, better educated, more active, and more demanding of fair treatment.

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Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CLARK: If there had been time for everyone to speak at the hearing in Winterset, Iowa, on August 16, 1976, concerning "The Nation's Rural Elderly," I would have said:

The following replies were received:

OPAL BURGER, WINTERSET, IOWA

Our parking facilities are very inadequate here at the center.

MARJORIE DRORBAUGH, CRESTON, IOWA

The CSA needs more funding to carry out its work to help keep the rural elderly better informed of programs that will help them to live a better and more comfortable life.

VERNON R. FEE, ST. CHARLES, IOWA

I am opposed to the withholding tax proposed by IRS Commissioner Alexander. He has asked the Senate Finance Committee for authority to withhold 20 to 30 percent of all interest and dividends. The attorney for the American Bankers' Association has estimated that savings amounts alone would generate 75 million pieces of paper. Alexander claims the IRS cannot afford to compare bank reports with individual tax returns. He says the Treasury loses more than $1.5 billion in revenue each year. This is bureaucracy at its best—unable to carry out an existing law, it accuses the people of tax evasion and then asks for another law to make private business their tax collector. If the IRS plan is followed, it will really fall heavy on widows, retirees, low-income families, and those living on fixed incomes. At the end of the year, the Government would have to return all it collects from those on low incomes. The added burden of paperwork will end up costing the taxpayers money.

I am opposed to the 3-day-week congregate meal program to take effect on October 1 in St. Charles. Our group has an outstanding record and, with an expansion of the program generally, I think it unwise to cut back on the existing program.

VERNE M. HIGENS, WINTERSET, IOWA

We have been carrying hospital-health-medical insurance, also life, in case we are stricken with a long-term illness, such as cancer, stroke, diabetes, or some long illness that requires intensive care. Then we found out our little savings account had dwindled to $108 at a bank here. So I wrote to A. E. Smith, director, Madison County Department of Social Services, 110 W. Green, Winterset, Iowa 50273. A lady called yesterday and told us to drop most of our insurance. I have wanted to carry insurance to provide coverage in case of a long illness or death as we have no money, no real estate, no farm to sell or live on, no business to sell on retirement, and no big pension coming. I know I could have worked after I was 65 and that would have helped me a lot and saved the Social Security Administration a lot of money. I did have a job here in Madison County as a night

watchman for Gendler Stone Products Co. and I was getting over $300 per month. I was cut off that income right after my birthday November 29, 1968, when I became 65.

So then I finally got social security and an old-age pension—both amounted to about $160 a month, so you can see what mandatory retirement has done for me.

I would like to ask if you could get $100 more for me from social security or from something else. I was forced to retire from the post office here July 11, 1975, with only 5 years' service and only 18 hours per week, so my funds and pension fund never accumulated so we could live in retirement.

I still could be working at the post office and getting money to provide all the needs, but we are being denied all this by certain laws that have been made in Congress to deprive people like us from having money to live on. I just called the hospital here and semiprivate rooms are $59 per day and $63 for private rooms. The insurance we carry pays, $1,000 per month to persons under 65, but only $500 per month to those over 65. But we pay the same premiums that those under 65 pay, so our benefits are only one-half of those under 65. We are not able to have all the medical care we need either because of no money to pay bills or office calls.

It is too bad that people here in Madison County such as us are being denied by law the right to have medical care and money to provide it. I am asking the Committee on Aging and Congress to enact some legislation to provide money for the people and let's keep more money in the United States where it belongs and take care of us who do the voting for Members of Congress and all other elective poeple. I asked the welfare department if they would buy me two new pairs of overalls to help out and so far they have refused. And that name is A. E. Smith, director (same address as before). Why not write him a letter and ask if would do this much for me—please. Thank you. I sure hope you can do something for us right away. We need it now.

We do have a car that runs, but no money to buy gasoline nor new license for 1977.

We have borrowed $800 since May 1976 just to pay bills and live on, and now I wonder how I will repay it all. And yet I have been told by one lady in the Madison County Welfare Office back in 1972 that I could have only $117 per month while my wife was in a nursing home on medicaid. They say when I am over 65 I do not need money.

ALMA MCKINNEY, WINTERSET, IOWA

I think they should do with less help in the office. with so much visiting they can't do their work with so many around. Louise Forsyth, her daughter, Mary, her mother Neva McKebbin, her Aunt Neola, and Louise's husband too. I think the one who runs the van could pick up more at a time instead of running with one or two at time. One other thing—when the clothing room opened again, they have 2 days with volunteer helpers—one or two come one-half day. The office ladies come in, go through the clothes in boxes before we can hang them up—they want to get their pick what they can use first. I don't think that's a good rule. Two other ladies have their job—Betty Berry, Teresa Brittain. They take care of their job. I go eat meals twice a week. I think they ought to have a set price—some get by with a dime or some just sign their name and go sit down. I think this money they are getting should be spent very carefully. How lucky we are to have people do this. I enjoyed your talk, and am looking forward to hear you again.

MRS. WILBUR SAVILLE, MT. AYR, IOWA

You were asking what some of the problems confronting senior citizens are. One thing that often causes a hardship to people on social security is when people who have medicare and Blue Cross insurance go to a doctor in larger cities, they have to pay cash for the doctor's services, and then wait to collect their money from the insurance company. This can really put them in a bind until time for their next social security check or the insurance money is refunded.

Another problem is the homemakers services. More money needs to be appropriated so they can provide enough help for people unable to do all of their own work. Now these services are only provided for a few of those needing help.

Also, the congregate meals program needs enough money so they can provide meals each day instead of two or three times a week. And the same thing is true for the problem of transportation in these minibuses. More buses are needed, especially equipped so that crippled people can get into the buses easier.

YVETTE WILSON, WINTERSET, IOWA

I have a job that didn't exist 2 years ago because of title III transportation, an act to help older Americans. I am a part-time van driver and the transportation secretary at the multipurpose center in Winterset. I also serve in other capacities there to directly serve and help the senior citizens, a most rewarding occupation. However, I have some misgivings about the Older Americans Act and all the other legislation which makes free services available to an ever-growing segment of our population. Because of increased advances in medical technology, Americans are living longer and, because of the declining birth rate, older people are becoming a larger percentage of the population. It is true that 40 percent of rural older folks live below the national poverty level, but this is just a statistic.

Except for increased need for medical care and its proportionately higher cost for older people, most older persons can live more easily under the poverty level than can young or middle-aged Americans who are raising and educating children, acquiring possessions needed to run a home, who require more calories from food (therefore needing more food) and need more clothing to meet the work-a-day world. Most senior citizens these days, especially in rural areas, don't require a lot of clothes because they aren't real active and don't wear out or soil the things they have. They have already had a lifetime to acquire all the material things they truly need, and many own homes bought and paid for years ago. There are exceptions in many cases. I know. I really believe though that a great many of these poverty level people don't even want the services available to them. Take the new transportation system for example: In this county of over 11,000, about 2,631 are eligible to ride the van. However, in 1976 only 212 different individuals in the county have used it once or more. Two good friends, both over 60, say they won't because, although they feel it is a good thing for some few, it doesn't justify the money spent and therefore, indirectly, the increase in taxes they and younger people of America have to pay. Even though I benefit personally from this particular program, I agree with them.

Why should we have medicare, transportation, congregate meals, reduced college tuition, reduced admittance prices to many activities, low-income housing, home health care, etc., for 60-plus people and not for the general population? It is clearly discriminatory. I know it is true that more special funds are becoming available for other age groups; for example, money for summer recreation for low-income children 8–13 (we have a program out of this center) and man-power, which helps finance jobs and education for poor young adults, but here again, all the "programs" I know about all deal with the poor, the cost of which middle income persons are carrying. I work because with four school-age kids we can't get along on his income alone, yet he makes too much to make our boys eligible for reduced price school lunches or summer recreation or winterization of our home, or reduced costs of child care for our youngest while I work. Something's wrong somewhere. Sure, these programs produce jobs for folks my age (I'm one), but I just get paid the minimum wage, as does the outreach worker here who is buying a house and raising three teenage boys on her bimonthly take-home of $175. In her case, she could make more on unemployment or welfare. I sure don't have the answers, but I do have a lot of questions. I know mandatory retirement at age 65 is for the benefit of young and middle-aged families, but a great source of human potential is literally discarded. I don't know one of the senior citizens I am acquainted with that I don't think is worthy of government help, and I'm happy for those who have benefited by it, but the contradictory attitudes I've just described still keep running through my mind and I feel we are slowly becoming a total social society, and I'm against that.

OPAL WOODS, TRURO, IOWA

We, the undersigned, would like to have the congregate meals program continue the 5 days per week. Although some of us can't attend every day nor can we meet our 25-per-day quota, we hope this service will not be discontinued as we feel there is a real need for it in our community: Mr. and Mrs. J. L. Morse, Effie B. Spencer, Veda Johnson, Frank Weitt, Enid Dudney, Margaret Winter, Daisy Barnes, Lula Smith, Alta Rhynd, Peggy Looper, Leea Snyder, Phyllis Lorenzen, Jessie Hiatt, Mildred Hazen, Gletha Lytton, Grace Perry, Mary Fenimore, Bernice Brant, Wylma Roby, Georgia Jones, Ralph Jones, Evelyn Kephart, Alvin Kephart, C. R. Woods, Opal Woods, Edith Youmans, Ruby Camp, Cleo Creger, Mabel S. Torbet, Helen Durbin, Ethel Seamans.

MARION W. YOUNG, DES MOINES, IOWA

After working in the social service field for the past 2 years as an information and referral specialist, I feel that the elderly's two biggest unmet needs are housing and handyman-chore service. Much was said at this hearing about housing, but I was surprised that handyman-chore was not mentioned (unless it was mentioned by the last panelist—I had to leave before he spoke).

Surely, people need their grass cut, weeds pulled, and certain minor repairs, such as putting in light switches and replacing washers in leaky faucets. What elderly person can pay the prevailing wages for these services?

Also, I would like to see some type of coordination between the funding agencies that allocate funds to titles III and VII of the Older Americans Act and title XX of the Social Security Act. Title XX can do anything that titles III and VII can do, except there is a means test for title XX.

My real concern is this: Most of the agencies that channel funds down to the service providers are interested in only allocating funds and the programs they fund. Personally, I think the commission on aging and the area agencies should assume the role as advocate for the elderly and, through a cooperative effort with other community resources, see that all services are delivered.

I am 61 years old!

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