SERVICES FOR SENIOR CITIZENS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON FEDERAL, STATE, AND COMMUNITY SERVICES

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

Part 1—Washington, D.C.

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NOTE.—Four hearings on services for senior citizens were held and they are identified as follows:
Part 1—Washington, D.C., January 16, 1964.
Part 2—Boston, Mass., January 20, 1964.
Part 3—Providence, R.I., January 21, 1964.
Part 4—Saginaw, Mich., March 2, 1964.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

STATEMENTS

ADDITIONAL INFORMATION

SERVICES FOR SENIOR CITIZENS

THURSDAY, JANUARY 16, 1964

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL, STATE, AND
COMMUNITY SERVICES OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 4200, New Senate Office Building, Hon. Edward M. Kennedy (acting chairman of the subcommittee) presiding.

Present: Senators Kennedy and Yarborough.

Senator KENNEDY. The subcommittee will come to order.

Let me commence by saying that this subcommittee is going to miss the effective services of the permanent chairman of the subcommittee, Senator Engle, who has worked long in this field, who has a deep interest and an unusual understanding of the problems of the aging, and whose experience in this area has been considerable.

This subcommittee looks forward to his early return to his participation in the undertakings which we have started.

It is a pleasure to welcome you to this initial hearing of the Subcommittee on Federal, State, and Community Services. It was very kind of you—who share our concern for improving services to our senior citizens—to come here today and give us the benefit of your experienced judgment.

This is the first of a series of hearings to be conducted by this subcommittee. Next week we will go to Boston and Providence, and in the weeks ahead we hope to hold additional hearings in other areas of the country.

In these hearings we will gather information on the services now being provided for senior citizens at all levels of government and by private organizations. We will seek ways of improving these services and of stimulating new services. We will make recommendations for legislative and administrative action.

There is a need for progress on the problems of our senior citizens. Their difficulties are many. They are complex. They are serious. It is not enough to face only one of these problems, or a few of them. It is not enough to face and solve the needs of our older citizens for health care, for housing, or for other material necessities, even though those objectives have the highest priority.

A wider range of services is required if the needs of our older people are to be fairly met. This is the richest nation on earth, and I do not believe that hardship and want should be the reward which we give our senior citizens, who have served us longest.

So today the subcommittee has invited testimony from a number of witnesses who are experienced in improving services for the elderly.

We will also welcome comment on two bills, S. 1357 and S. 2000, which are relevant to our inquiry. I am confident that the information which we will compile, exchange, and evaluate in these hearings will help us to advance the quality of our lives.

So I will ask Dr. Ellen Winston if she will come to the witness table.

Dr. Winston, we welcome you here this morning. We recognize that you have an extremely lengthy and exhaustive and comprehensive statement, and with your permission, I will introduce that into the record and ask you to proceed in your own way and summarize it.

STATEMENT OF DR. ELLEN WINSTON, COMMISSIONER OF WELFARE, WELFARE ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY CHARLES LAVIN, OFFICE OF AGING, AND CHARLES HAWKINS, OFFICE OF THE COMMISSIONER

Dr. WINSTON. Thank you, Mr. Chairman.

I am Ellen Winston, the Commissioner of Welfare in the Department of Health, Education, and Welfare, and I am accompanied, this morning, by Mr. Charles Lavin, from our Office of Aging, and by Mr. Charles Hawkins, of the Commissioner's Office.

I am pleased to have the opportunity to appear before your subcommittee. The Department of Health, Education, and Welfare has varied and substantial operating programs affecting the aging, and the Secretary is Chairman of the Cabinet-level President's Council on Aging, which at the Federal level is comparable in structure to a number of State commissions on aging.

I am the Secretary's deputy for this purpose and Chairman of the Executive Committee of the Council and of its Committee on Welfare Services.

The Welfare Administration itself includes the Bureau of Family Services, which administers the old-age assistance program, covering both grants and services for older people, and the program of medical assistance for the aged, and the Office of Aging, whose sole concern is with the needs of and programs for the aging.

Prior to appointment as Commissioner of Welfare, just a year ago, I was chairman of the Governor's Committee on Aging in North Carolina, and a member of the Joint Committee on Aging of the Council of State Governments and the Federal Council on Aging.

So my interest in the field of aging goes back many years, and I was particularly pleased that a major segment of my responsibilities upon my appointment as Commissioner of Welfare related directly to the Federal responsibility for programs for older people.

Much material is available on hospital care for the aged—the major immediate issue affecting the elderly. The Department has testified on the King-Anderson bill and hearings before the House Ways and Means Committee will resume on January 20.

I know you do not expect me to add to the material which this committee itself has so ably assembled on this subject.

I shall concentrate on matters to which I have been closest, since others will speak for the States and communities during your hearings in the field.

Dr. C. A. Smith, Associate Director of the Bureau of State Services for Community Health of the Public Health Service, is here with me and will provide the information you have requested regarding the community health services program.

Persons 65 years of age and older are more likely than younger members of our society to be poor, unemployed, in ill health, living alone or institutionalized, and, of course, to suffer from a combination of these circumstances.

One-third of the elderly families, and two-thirds of unrelated elderly individuals are living on incomes which, most would agree, mean poverty, with all of its starkness and all of its associated problems.

There are, of course, a significant number in more fortunate circumstances, and our concerns encompass their total welfare just as strongly. Nevertheless, even among those whose income is adequate for most everyday needs, there are many who now lead unrewarding lives for lack of something to do, some place to go, someone to talk to, or who confront at some time in the later years special needs or situations with which they cannot cope as individuals.

There are a variety of services and facilities which only the community can provide to the elderly, just as it now provides water and highways and school systems, without regard to the economic status of individuals. We must seek to serve all elderly people, and not lend further semblance of truth to the observation that only the very poor and the very rich can obtain the services they need.

State and local governments, in recent years, have made advances in organizing to provide services to the elderly, but only about half the States have units authorized by the Governor or the legislature to stimulate and coordinate programs and functioning on an overall basis, with budget and staff. The availability of services to the elderly is spread unevenly throughout the country. More plans and programs are on paper than in practice.

The Federal Government has done and is now doing much to assist States and localities with respect to the aging. We have a strong pattern of relationships from the Office of Aging to State and local groups.

We have reached a point, however, where further significant advances require new legislation and grants-in-aid. Several bills are now before Congress which could provide the stimulus to an advance by States and localities along a broad front. Our society can well afford the funds involved.

Development of many needed services to the elderly has been long delayed, and we should now be able to move ahead, not merely toward assuring a living, but assuring a life of security, grace, and dignity in the later years.

There are now 37 States, Puerto Rico, and the Virgin Islands, which have statewide commissions or committees on aging. These vary widely in their membership and in the way in which they are able to function.

Twenty-eight have an appropriation, but the range in this appropriation is very great, from really a token contribution on the part of the State to a sufficient appropriation to have a reasonable staff.

The general functions of these commissions and committees on age are program planning and evaluation, public information, clearinghouse activities, community organization, and special projects. The responsibilities they carry follow closely upon the recommendations of the White House Conference on Aging.

The Office of Aging works closely with them and plans an annual meeting at which there is representation from all of these committees. Such a meeting is now scheduled for this spring.

In addition, 14 States now have specialists on aging in State welfare departments, which work cooperatively with the State commissions and also carry special responsibilities in this field.

More than 800 cities and counties now have planning and coordinating committees on aging. They, too, offer a variety of services, many of them meeting a special need directly; for example, promoting meals on wheels, and friendly visitors, and other types of direct service of this sort, as well as seeing that there is emphasis upon strengthened services of public and large private agencies which have some kind of helpful services to offer to the elderly.

Here, too, we have a wide range of effectiveness. And again, we offer all possible help through the Office of Aging, within its limited resources, to promote additional councils by and with the cooperation of State commissions and councils.

Generally, there are shortages throughout the country of administrative and planning personnel in this area.

We know much more about what needs to be done than we are able to do under existing conditions, than we would like to do in order to move substantially forward in the immediate future in providing the wide range of services which we know are so essential.

I shall be glad to try to answer any questions.

Senator KENNEDY. Dr. Winston, I was wondering if you could develop the position of the Department of Health, Education, and Welfare on the proposal to establish an administrator within the Department of Health, Education, and Welfare, whose prime and chief responsibility would be that of supervising the activities of the aging.

Dr. WINSTON. I would refer you, Mr. Chairman, to the testimony of the Secretary at the hearings with respect to this proposal.

It was the position of the Secretary that we had adequate administrative structure within the Department of Health, Education, and Welfare to meet our obligations and indeed to provide for expanded areas of responsibility with regard to the needs of the aging.

The Secretary, less than a year ago, established a Welfare Administration and placed within it the Office of Aging, which up to that time had been a special staff attached to his own office, so that there could be an expansion of its work, so that there could be more effort directed toward coordinating all of the many programs in various parts of the Department of Health, Education, and Welfare with respect to our elderly citizens, so that there could be greater opportunity for the Office of Aging to work closely with the Bureau of Family Services, which has greatly expanded programs for the aging as a result of the 1962 amendments to the Social Security Act.

We recognize that there have not been too many months in which to see how this new administrative structure within the Department can be fully effective, but we have many encouraging evidences of how the change the Secretary made in administration has permitted us to move forward in services to older people.

We also would recognize the fact, and again I would refer you to the testimony, that the Secretary has adequate authority to make any administrative changes within the Department which he might feel at any time would improve the overall functioning of the Department. Therefore, there is no need for any further legislation in this particular area.

Senator KENNEDY. Did you have a comment in your testimony on the administration's position in regard to S. 1357 and S. 2000?

Dr. WINSTON. I did not refer specifically in the testimony to major differences in the bills. We have summarized what we see as the needs.

We, of course, recognize the fact that there are the two major bills, but that in addition to the question on administration, which you have just raised, there is another difference, in that one bill does not contain provision for the activity centers for the aging, which we regard as so vitally important, and for the special emphasis on employment of the aging, which would be carried out through the Department of Labor.

Senator KENNEDY. Is the Department at the present time attempting to encourage the States to set up at least procedures to take advantage of this legislation, if it were passed?

Dr. WINSTON. On the pending legislation?

Senator KENNEDY. That is correct, yes.

Dr. WINSTON. I would say that at this point we are moving as far as one feels one can safely move in terms of being ready to take advantage of any new legislation in this field.

We also know that States themselves have given a great deal of attention to where their immediate needs are, so that we have no question about our ability to put into effect very promptly any additional resources that might become available.

Senator KENNEDY. Well, to be more specific, in the compilation of materials on the President's message on aging, compiled by the Special Committee on the Aging as a committee print, at page 45, there appears a table indicating the States which have established State agencies on the aging, State appropriations, and whether they have a full-time executive officer.

Now, part of the provisions of these bills would certainly require that there be a State agency to administer the funds which would be available to encourage the proposed research and training.

There are a number of States which either do not have an agency or do not have an appropriation or full-time director. And my particular question, to be more specific, was: At the present time, what, if anything, is the Department of Health, Education, and Welfare doing to encourage the States to establish these agencies, so that when the Congress does act, and if it does act favorably, this legislation can be implemented immediately, rather than waiting until that time to take what would appear to me to be the procedural step of setting up those agencies?

Dr. WINSTON. Yes. And I might say, sir, that in reference to the table, it becomes very obvious that the great need of many of these States is for money, so that they can strengthen their own coordinating central offices, so that they are prepared to move forward.

Senator KENNEDY. Well, does the legislation—you are probably more familiar with this—provide for the strengthening of State offices?

Dr. WINSTON. Yes. There is a provision for funds for State offices, very limited funds I must admit, but at least funds that would be helpful to the States in strengthening their overall administration, and we would like to enter in the record specific sections of the bills which give the detail of this, so that this will be clearly in the record.

(The sections follow:)

STATE PLANS

SEC. 1703(a). The Secretary shall approve a State plan for the purposes of this part which—

(1) establishes or designates a single State agency as the sole agency for administering or supervising the administration of the plan, which agency shall be the agency primarily responsible for coordination of State programs and activities related to the purposes of this title;"

* * * * *

(3) provides for development of programs and activities for carrying out the purposes of this title, including the furnishing of consultative, technical, or information services to public or nonprofit private agencies and organizations engaged in activities relating to the special problems or welfare of older persons, and for coordinating the activities of such agencies and organizations to the extent feasible;

COSTS OF STATE PLAN ADMINISTRATION

SEC. 1704. From a State's allotment under section 1702 for a fiscal year, not more than 10 per centum or $15,000, whichever is the larger shall be available for paying one-half (or such smaller proportion as the State may request) of the cost of the State agency (established or designated as pro-

vided in section 1703(a)(1)) in administering the State plan approved under section 103, including the costs of carrying on the functions referred to in subsection (a)(3) thereof.

Dr. WINSTON. It is not a great deal of money, but I think our experience with the White House Conference on Aging indicated the tremendously important stimulating role that even fairly modest amounts of Federal funds can have in encouraging States to move forward effectively in terms of strengthened State administration.

The estimated allotments to States under part A of S. 1357, the Senior Citizens Community Planning and Services Act of 1963, and title III of S. 2000, the Older Americans Act of 1963 (these provisions occur in both bills in identical form) are shown in the table on the following page and discussed in the prepared statement in the first three paragraphs which appear on page 18.

Estimated allotments to the States under pt. A, Senior Citizens Community Planning and Service Act of 1963, and title III of the Senior Citizens Act of 1963 [1]

State	Persons 65+, 1960		State allotments for each fiscal year—					
			1963–64		1964–65		1965–66, 1966–67, and 1967–68	
	Number	Percent distribution	Total	Maximum for administrative costs	Total	Maximum for administrative costs	Total	Maximum for administrative costs
Total, 55 "States"	16,685,622	100.000	$5,000,000.00	$857,381.75	$8,000,000.00	$968,957.28	$12,500,000.00	$1,288,133.73
Alabama	261,147	1.565	86,386.25	15,000.00	138,218.00	15,000.00	215,965.63	21,596.56
Alaska	5,386	.032	50,744.00	15,000.00	81,190.40	15,000.00	126,860.00	15,000.00
Arizona	90,225	.541	62,578.25	15,000.00	100,125.20	15,000.00	156,445.63	15,644.56
Arkansas	194,372	1.165	77,086.25	15,000.00	123,338.00	15,000.00	192,715.63	19,271.56
California	1,376,204	8.247	241,742.75	24,174.28	386,788.40	38,678.84	604,356.87	60,435.69
Colorado	158,160	.948	72,041.00	15,000.00	115,265.60	15,000.00	180,102.50	18,010.25
Connecticut	242,615	1.454	83,805.50	15,000.00	134,088.80	15,000.00	209,513.75	20,951.38
Delaware	35,745	.214	54,975.50	15,000.00	87,960.80	15,000.00	137,438.75	15,000.00
District of Columbia	69,143	.414	59,625.50	15,000.00	95,400.80	15,000.00	149,063.75	15,000.00
Florida	553,129	3.315	127,073.75	15,000.00	203,318.00	20,331.80	317,684.37	31,768.44
Georgia	290,661	1.742	90,501.50	15,000.00	144,802.40	15,000.00	226,253.75	22,625.38
Hawaii	29,162	.175	54,068.75	15,000.00	86,510.00	15,000.00	135,171.87	15,000.00
Idaho	58,258	.349	58,114.25	15,000.00	92,982.80	15,000.00	145,285.63	15,000.00
Illinois	974,923	5.843	185,849.75	18,584.98	297,359.60	29,735.96	464,624.37	46,462.44
Indiana	445,519	2.670	112,077.50	15,000.00	179,324.00	17,932.40	280,193.75	28,019.38
Iowa	327,685	1.964	95,663.00	15,000.00	153,060.80	15,306.08	239,157.50	23,915.75
Kansas	240,269	1.440	83,480.00	15,000.00	133,568.00	15,000.00	208,700.00	20,870.00
Kentucky	292,323	1.752	90,734.00	15,000.00	145,174.40	15,000.00	226,835.00	22,683.50
Louisiana	241,591	1.448	83,666.00	15,000.00	133,865.60	15,000.00	209,165.00	20,916.50
Maine	106,544	.639	64,856.75	15,000.00	103,770.80	15,000.00	162,141.87	16,214.19
Maryland	226,539	9.358	81,573.50	15,000.00	130,517.60	15,000.00	203,933.75	20,393.38
Massachusetts	571,609	3,426	129,654.50	15,000.00	207,447.20	20,744.72	324,136.25	32,413.63
Michigan	638,184	3.825	138,931.25	15,000.00	222,290.00	22,229.00	347,328.13	34,732.81
Minnesota	354,351	2.124	99,383.00	15,000.00	159,012.80	15,901.28	248,457.50	24,845.75
Mississippi	190,029	1.139	76,481.75	15,000.00	122,370.80	15,000.00	191,204.37	19,120.44
Missouri	503,411	3.017	120,145.25	15,000.00	192,232.40	19,223.24	300,363.13	30,036.31
Montana	65,420	.392	59,114.00	15,000.00	94,582.40	15,000.00	147,785.00	15,000.00
Nebraska	164,156	.984	72,878.00	15,000.00	116,604.80	15,000.00	182,195.00	18,219.50
Nevada	18,173	.109	52,534.25	15,000.00	84,054.80	15,000.00	131,335.63	15,000.00
New Hampshire	67,705	.406	59,439.50	15,000.00	95,103.20	15,000.00	148,598.75	15,000.00
New Jersey	560,414	3.359	128,096.75	15,000 00	204,954.80	20,495.48	320,241.87	32,024.19
New Mexico	51,270	.307	57,137.75	15,000.90	91,420.40	15,000.00	142,844.37	15,000.00
New York	1,687,590	10.113	285,127.25	28,512.73	456,203.60	45,620.36	712,818.13	71,281.81
North Carolina	312,167	1.871	93,500.75	15,000.00	149,601.20	15,000.00	233,751.87	23,375.19
North Dakota	58,591	.351	58,160.75	15,000 00	93,057.20	15,000.00	145,401.87	15,000.00

Ohio	897,124	5.377	175,015.25	15,000.00	280,024.40	28,002.44	437,538.13	43,753.81
Oklahoma	248,831	1.491	84,665.75	15,000.00	135,465.20	15,000.00	211,664.37	21,166.44
Oregon	183,653	1.101	75,598.25	15,000.00	120,957.20	15,000.00	188,995.63	18,899.56
Pennsylvania	1,128,525	6.763	207,239.75	20,723.98	331,583.60	33,158.36	518,099.37	51,809.94
Rhode Island	89,540	.537	62,485.25	15,000.00	99,976.40	15,000.00	156,213.13	15,621.31
South Carolina	150,599	.903	70,994.75	15,000.00	113,591.60	15,000.00	177,486.87	17,748.69
South Dakota	71,513	.429	59,974.25	15,000.00	95,958.80	15,000.00	149,935.63	15,000.00
Tennessee	308,861	1.851	93,035.75	15,000.00	148,857.20	15,000.00	232,589.37	23,258.94
Texas	745,391	4.467	153,857.75	15,385.78	246,172.40	24,617.24	384,644.37	38,464.44
Utah	59,957	.359	58,346.75	15,000.00	93,354.80	15,000.00	145,866.87	15,000.00
Vermont	43,741	.262	56,091.50	15,000.00	89,746.40	15,000.00	140,228.75	15,000.00
Virginia	288,970	1.732	90,269.00	15,000.00	144,430.40	15,000.00	225,672.50	22,567.25
Washington	279,045	1.672	88,874.00	15,000.00	142,198.40	15,000.00	222,185.00	22,218.50
West Virginia	172,516	1.034	74,040.50	15,000.00	118,464.80	15,000.00	185,101.25	18,510.13
Wisconsin	402,736	2.414	106,125.50	15,000.00	169,800.80	16,980.08	265,313.75	26,531.38
Wyoming	25,908	.155	53,603.75	15,000.00	85,766.00	15,000.00	134,009.38	15,000.00
Puerto Rico	122,207	.732	67,019.00	15,000.00	107,230.40	15,000.00	167,547.50	16,754.75
Virgin Islands	2,207	.013	25,302.25	15,000.00	40,483.60	15,000.00	63,255.63	15,000.00
Guam	1,088	.007	25,162.75	15,000.00	40,260.40	15,000.00	62,906.88	15,000.00
American Samoa	540	.003	25,069.75	15,000.00	40,111.60	15,000.00	62,674.38	15,000.00

Dr. WINSTON. Now, with respect to organizations to help the States, we have through the Office of Aging, a regional representative on aging in each of the nine regions of the Department. These regional representatives are charged with working directly with not only the State councils and commissions that exist in States, but also with State agencies, with voluntary groups, with various interested persons in the direction of encouraging the establishment of commissions or councils, or committees, or whatever they are called, in the remaining States.

One of the reasons that it has been rather slow going in terms of the States that have not moved ahead is the fact that they do not have any money which can be used to help get a central office underway in the State.

There is, of course, a great resource in each State, because they have many services for older people which are part of the legislative responsibility of the various State departments. They may have groups of organized older citizens. They may have a wide range of voluntary organizations that are particularly interested in meeting the needs of older people.

But there is tremendous need for a focus, an overall tent, as it were, for a clearinghouse, for a center out of which there can come the necessary information, where there can be a stimulus for the development of local committees on aging. It is very difficult, frankly, to set these up unless there is a State organization to promote them.

Senator KENNEDY. Dr. Winston, could you describe one of these 700 centers that have been established, for the benefit of the committee, from your own personal knowledge, and maybe something about how they would use the $10-odd million to help find employment for people who are over 60 years of age?

Dr. WINSTON. There is actually no one of these local committees or councils that is typical of the entire operation and has the whole gamut of services, and that is one of our problems.

Now, as I understand it, you are directing your attention to an activity center, rather than to a local committee or council on aging.

Senator KENNEDY. That is correct, yes.

Dr. WINSTON. The activity centers are scattered in many places across the country. Some of the very early and effective ones were developed in New York City, where they are in essence day centers. They may operate every day, which is what we recommend, or they may be in effect for several hours on several days each week.

A good activity center will provide a source for friends and companionships, where people can come in for as long a period as is comfortable and convenient for them, simply for visiting, for face-to-face associations with other people.

It provides, or should provide, a focus for recruitment and training programs for older people going into volunteer service in the community.

There are great needs for volunteers in a wide range of community activities. We would like to have a way of bringing the need for volunteer service and the older people who have skills to offer together. A good activity center would provide that kind of service.

We have, again, a demand for educational experiences and oppor-

tunities for older people, and this can cover a wide range, from older people who want literacy training, perhaps, so that they can do essential reading, through a good program of health education, consumer education, or perhaps people who are interested in getting together to study in the fields of literature or art appreciation, music, a wide range of stimulating intellectual activities.

A community center fulfilling appropriate needs would also provide for personal counseling and serve as an information and referral center.

After all, an activity center itself will not provide and should not provide many of the services that older people need, but they do need help to know where in the community they can locate these appropriate services.

I can give you more detail with regard to the individual types of programs. We even have activity centers, for example, that sponsor camping experience and various types of trips for older people.

The thing we have to recognize is that they have a wide range of interests and needs. And certainly the good activity center is going to try to provide not the whole gamut, but a substantial range of those services and needs.

And again, your activity center, to adequately meet the needs of older people, must have the essential minimum staff. There are many things that the older people can do to help run it themselves, but there needs to be a good director, with whatever supporting staff is appropriate.

Senator KENNEDY. I want to thank you.

We welcome Senator Yarborough to this subcommittee.

Do you have any questions, Senator?

Senator YARBOROUGH. Thank you, Chairman Kennedy.

It is a pleasure to be on this subcommittee my first day here. I regret that an engagement over in the Supreme Court with some constituents from my State prevented my being here at the opening of these hearings.

I regard this as a very important hearing, and it will be a great pleasure for me to serve under your chairmanship of the subcommittee.

I have no questions, Dr. Winston, but I will read the statement in full, Doctor.

Senator KENNEDY. Thank you very much, Dr. Winston.

(Dr. Winston's prepared statement follows:)

STATEMENT OF ELLEN WINSTON, PH. D., COMMISSIONER OF WELFARE, WELFARE ADMINISTRATION, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

I am pleased to have the opportunity to appear before your subcommittee. The Department of Health, Education, and Welfare has varied and substantial operating programs affecting the aging and the Secretary is Chairman of the Cabinet-level President's Council on Aging. I am his Deputy for this purpose and Chairman of the Executive Committee of the Council and its Committee on Welfare Services. The Welfare Administration itself includes the Bureau of Family Services, which administers the old-age assistance program and the program of medical assistance for the aged, and the Office of Aging, whose sole concern is with the aging. Prior to appointment as Commissioner of Welfare, I was chairman of the Governor's committee on aging in North Carolina and a member of the Joint Committee on Aging of the Council of State Governments and Federal Council on Aging. So my interest in the field of aging goes back many years and I was particularly

pleased that a major segment of my responsibilities upon my appointment as Commissioner related directly to the Federal responsibility for programs for older people.

As you know, ample material is available on hospital care for the aged—the major immediate issue affecting the elderly. The Department has testified on the King-Anderson bill and hearings before the House Ways and Means Committee will resume on January 20. You do not expect me to add to the material which this committee itself has so ably assembled on this subject.

Dr. C. A. Smith, associate director of the Bureau of State Services for Community Health of the Public Health Service is here with me and will provide the information you have requested regarding the community health services program.

PRESENT SITUATION OF OLDER PERSONS

Numbers and proportions of older persons

The elderly are a minority, but a substantial minority whose numbers and proportions have been increasing significantly. Between the turn of the century and 1960, the total population increased 2½ times, but the number 65 and over increased 5½ times to 16.6 million, or 1 in 11 of the total population. They now number 17.6 million.

Variations in circumstances

The development of programs and services must take into account the variety of circumstances in which the elderly find themselves. For the problems of aging appear in every aspect of living—income, housing, health, employment, and retirement, family relations, education, and recreation. With respect to each of these aspects elderly individuals and families are found along the whole range of adjustments from minimum to maximum.

Income

In 1962, 27 percent of families with heads age 65 and over had incomes of less than $2,000 (more than half had less than $1,500). The proportion in the income group under $2,000 was three times that of families with heads between 14 and 64 years of age. Thirty-six percent of these older families had less than $3,000 per year. About 30 percent had incomes of $5,000 and over. Among unrelated individuals 37 percent had incomes less than $1,000; 63 percent less than $1,500. The proportion of elderly in this income group was twice as high as for those under 65. On the other hand, about 12 percent of single individuals had incomes of $3,000 or over. A detailed tabulation—"Income of Older People, 1962," Supplement No. 1, "Facts on Aging," is available and I should like to submit it for the record.

Living arrangements

In 1961, almost four out of five older persons lived in their own households. Nearly half of all older people were living with their spouses in their own households, and 30 percent lived without spouse in their own households. About 17 percent were living in the households of relatives, and about 5 percent consisted almost equally of lodgers and those who were in institutions. About 7 out of 10 owned their own homes, of which about 80 percent were free of mortgages. But a great number of these homes were dilapidated.

Health

The incidence of poor health, particularly chronic illness, increases with age. The national health survey reveals that four out of five persons aged 65 and over have one or more chronic diseases. Most common are arthritis and rheumatism, cardiovascular disease, and impaired vision and hearing, but to a large extent these are not disabling to the older persons. Mental illness and malignancies afflict the aged more frequently than younger people. On the other hand, very many older persons are sufficiently healthy to work if they had the opportunity and desire.

The greater frequency and duration of illness for the average older person mean larger health costs. In 1961 the total per capita expenditure for medical care of persons 65 and over was $315—2½ times that for under-65 persons.

Employment and retirement

Although most older people have retired, 3 million in October 1963 were still working—1 out of 10 women and more than 1 out of 4 men aged 65 and over. Participation of men 65 and over in the labor force has dropped

by over one-half—from 2 out of 3 in 1900 to almost 3 out of 10 now. Of employed males 65 and over about two out of three work full time. The proportion who work in part-time or temporary employment rises with age.

From this brief overview, we can conclude that older persons are more likely than younger ones to be poor, to be in ill health, to be living alone, to be institutionalized, to be unemployed and, of course, for many, to be afflicted with a combination of these unfortunate circumstances. Nevertheless, many are relatively well off.

All should be served

It has been said that only the very poor and the very rich can get the services they need—medical care, for example. There is truth in this observation, though not the whole truth. It poses a fundamental social issue. Are the great middle classes of our country, who have worked, reared children, paid taxes, contributed to philanthropy, entitled to services when, in their old age, they need such help? We think the answer is that, in our affluent society, they do deserve such consideration from public and private agencies, with costs to be met by the individual to the extent that his resources reasonably permit. We must further recognize that if certain services do not exist in his community, the individual will be deprived regardless of his capacity to pay. Limitations of time and finances are important factors in determining emphasis in any given period, but the need for services rather than economic need should be the guideline for Federal, State, and local governments and nonprofit organizations in the development of services for older people.

We may look at older persons who need one or more of a variety of services as constituting three groups:

(*a*) Those dependent on an old-age assistance program in whole or in part who will receive such services as their States and local charitable organizations undertake to provide. These people comprised about one in every eight older persons in 1962.

(*b*) Those living in or on the edge of poverty but not receiving public assistance. From data for 1962 it may be estimated that there are at least three aged people in this category for every two recipients of old-age assistance.

This represents a very conservative view of poverty. If we set the limit at $3,000 for a family and $1,500 for an individual, half of the older persons would be considered to be living in poverty.

In 1960, for every aged couple receiving old-age assistance, there were four aged couples who were not recipients but who had an income of less than $2,000. For every old-age assistance recipient not institutionalized and not living with a spouse, there were two such individuals who were not recipients but who had incomes under $1,000 and three who had less than $1,500.

Older people of low-income move into the public assistance category for reasons which may be expected as consequences of age. A tabulation of old-age assistance experience in 31 States in July–December 1962 showed that the major reasons for opening OAA cases were loss or reduction in earnings of the recipient due to illness and layoff, medical costs, or a level of living below agency standards.

(*c*) Those whose income is above the level at which the most liberal States give public aid for basic maintenance or medical care and are able to meet usual needs. An estimated 7 out of 10 older individuals fall in this broad category. But probably only 1 or 2 out of 10 older people could, without help from some source other than current income, pay for various services which become desirable or necessary at certain stages in life.

These older people may not be aware of the availability of services they need, or may require services not offered in their communities. These services which may not be available may include income supplementation, homemaker services, skilled nursing home care, foster home care, recreational facilities, vocational retraining, preparation for retirement, placement in part-time employment, and opportunities for useful activities and social contacts.

Within this broad group, most older people cannot avail themselves of unsubsidized services to meet their frequent special needs. For example, 3 out of 4 elderly families and 9 out of 10 elderly individuals would be unable to pay $250 monthly for nursing home care. Other examples are speech retraining for aphasia, housing with special architectural features and central services, and casework services.

To be useful to an older person benefits and services must be known to him or his family and be available in his community at a price he can pay.

It is apparent that many older people cannot afford much beyond food and shelter, a radio, an occasional movie, a chair at the window or on the porch. Others may afford a modest auto, an occasional trip or stay at a resort, a new dress, some new house furnishings. Retirement, widowhood, the need for a change of living arrangements, family problems, extended illness, loneliness—these problems older persons can expect, perhaps not every month nor year, but at some time. Not everyone will experience all these crises, but some will confront several of them.

To assist and support older persons, a variety of social services and community facilities exist, but by no means everywhere. Their availability is extremely spotty. This is to be expected in a field so new and undeveloped, but the situation must change. We do not expect every man to dig his own water well. Women now bear their children in hospitals although not so long ago childbirth took place at home. In the same progressive manner, an advanced society must provide services in the community to older persons, rich or poor.

In a report on community services the Department expressed the view that:

"1. There should be accessible in the communities where they live a range of community services broad enough to enable individuals and families to cope constructively with their social, physical, emotional, and economic problems.

"2. Services should be available without regard to * * * income. The community should contribute toward the cost of such service."

STATE COMMISSIONS

The Office of Aging and its predecessors have viewed the problems of aging as a shared responsibility of the individual; his community, including voluntary organizations; and State and Federal Governments. The White House Conference on Aging Act stated "the primary responsibility for meeting the challenge and problems of aging is that of States and communities." Over the years, the Office of Aging has stimulated and encouraged every State to establish within the State Government a mechanism responsible for coordinated statewide efforts in the field of aging. It recognized this as both a traditional and effective method of assuring the development and extension, throughout the country, of programs and services benefiting the elderly.

Extension of State organization

Number: In 37 States, Puerto Rico, and the Virgin Islands, statewide commissions or committees have been established—25 by legislative action, 14 by administrative action. All but two, in Kansas and West Virginia, are permament. Mississippi has a statewide committee established by nongovernmental groups. Twelve States and the District of Columbia have no such unit.

Budgets and staff

Twenty-eight States and territories having commissions or committees have an appropriation, nine have none. Budgets range from $750 in Vermont to $190,000 in Pennsylvania. Eliminating these two extremes, the average budget is $30,000. As expected, the higher amounts are those of States with larger populations and greater resources.

Twenty-three States have a full-time executive director or executive secretary and some have additional professional staff.

Five years ago, prior to the availability of one-time grants under the White House Conference on Aging Act, about a dozen State committees had full-time executive officers and had budgets ranging between $10,000 and $100,000—most about $12,000 to $15,000.

Staffing and budgets have doubled in a period of 5 years, but this cannot be expected again without much more help than we can now provide.

Progress in State organization

The establishment, financing, and staffing of a State unit on aging is a major enabling objective. Further, it is valid evidence of the mobilization of wide and influential public support, of official recognition that problems of older persons are a legitimate and substantial special concern of State governments.

Such a growth of organization among the States was no mean achievement; it was neither quick nor easy. There were advances and retreats. The Fed-

eral Government can rightly claim some credit for its leadership. The background paper on State organization of the White House Conference on Aging points out that the national conferences called by the Federal Government were spurs to major advances in State organization. Also, the regional representatives of the Office of Aging (first appointed in preparing for the White House Conference) have unremittingly stimulated and assisted the States in this growth.

Federal legislation, including grants and other forms of support as represented in several bills now before Congress, is needed for sustained gains, even though, or I might say because, the interest of State governments and wide public support has been amply demonstrated.

Responsibilities and activities of State commissions

In general these State commissions, committees, or staff units engage in coordination, program evaluation and planning, public information, clearinghouse activities, community organization, and private projects. The scope of responsibility usually assigned to such official bodies coincides substantially with the recommendations by the White House Conference on Aging:

"(*a*) To provide a mechanism by which governmental and nongovernmental agencies can coordinate their plans, policies, and activities with regard to aging."

This is a most difficult and most important role, since services affecting older persons are provided by a number of State departments and agencies including welfare, health, vocational rehabilitation, employment service, departments of education, and in some cases recreation and housing agencies. Equally, as many kinds of programs, and many more agencies, are represented by voluntary organizations in the States.

"(*b*) To create public awareness and understanding of the needs and potentials of older persons."

Several States issue newsletters. The staff prepare statements and releases for State government officials, and speak to organizations of older persons and to voluntary organizations which have an interest in or an action program related to older persons. The Office of Aging informs States concerning basic facts on aging and new developments nationally and in the States and localities.

"(*c*) To gather and disseminate information about research and action programs, and provide a clearinghouse for current plans and ongoing activities."

Preparation of reports to the Governor and for other interested agencies and officials and responding to inquiries from individuals and organizations are other time-consuming activities. The Office of Aging digests and distributes data arising from research and factfinding efforts and informs States of changes in Federal programs.

"(*d*) To encourage State departments, universities, and other appropriate agencies to conduct needed research in the field of aging."

During the White House Conference, grants available to the States permitted them to conduct surveys. In States where there is a university or universities interested in gerontology, progress has resulted from the cooperation of such institutions and State commissions. Where there is none, some commissions have stimulated research by departments of sociology, economics, or psychology. Financing has always been a severe problem, but some funds have been available, mainly from large foundations and the Federal Government. The Office of Aging has assisted materially by providing State commissions with information regarding grants and other financial and technical assistance available, particularly from the Federal Government.

"(*e*) To stimulate training for workers engaged in services to the aging."

This area of effort has been strongly supported by the Office of Aging through the identification of the occupations which need many more trained workers and the development of curriculums and graduate training courses. A few States have been able to provide actual training or the subsidization of training by other agencies for such jobs as nurses and nurses' aid and homemakers.

"(*f*) To stimulate, guide, and provide technical assistance in the organization of local and regional councils or units on aging and in the planning and conduct of services, activities, and projects."

This has properly been the major area of activity by State commissions in their efforts to stimulate the planning and development of services for older people where they live. State staff is commonly involved in the establishment of city or county committees attached to mayors' offices or local health and welfare councils. For the most part the assistance has been in the form of stimulation and help in marshalling public support, assistance in obtaining official endorsements, and in organizing the structure and planning the work of such local councils. A few States have been able to provide grants to assist in local activities. These include Massachusetts, California, Pennsylvania, and New Jersey.

COMMUNITY COUNCILS ON AGING

More than 800 out of 3,000 cities and counties now report having a planning and coordinating committee on aging. The committees assess the needs of their older citizens, and stimulate public and voluntary agencies to provide communitywide programs of health, social services, employment, recreation, education, and housing. Among the programs that have been established in some communities—and are desirable in all—are preparation for retirement; clinics to help healthy older people maintain their health; multipurpose activity centers; teaching of arts and crafts; social, education, and recreational programs; meal centers and home-delivered meals; sales outlets for senior craftsmen; special telephone service to maintain contact with older persons living alone; friendly visitors; and older volunteer services. Not all these local councils meet regularly; few have all the programs and services described.

The contracts of the Office of Aging with communities is usually through State commissions. In those States where no State organization exists, regional representatives and other staff members have been working directly with localities.

The effectiveness of such local organizations is difficult to determine for several reasons. The local councils are fluid organizations, very few have regular staff who could be asked to provide reports, and their organization and programs do not have the uniformity that is so helpful in the collection of data nationally. In a piecemeal fashion, we do get a picture of what is going on in the localities through our regional representatives; the State commissions; visits of staff to localities to make addresses and give technical assistance; and stories and announcements sent to the publication Aging by communities that have accomplished something that merits the attention of readers.

HOW THE FEDERAL GOVERNMENT CAN HELP STATES AND LOCALITIES

I cannot attempt to cover here all that the Federal Government does in the field of aging. There are several reports and publications available on this subject including the 1962 report to the President by the Federal Council on Aging, entitled "How the Government Works for Older People." I shall concentrate mainly on what the Federal Government has done and is doing, through the Office of Aging and the Bureau of Family Services.

Office of Aging

What is it doing? The Office of Aging coordinates the work in aging of all operating units of the U.S. Department of Health, Education, and Welfare. It works with State commissions on the aging, national and local voluntary agencies, and educational institutions in order to strengthen and extend existing services, stimulate new programs, and keep the public informed of needs and programs. It is the Federal focal point and clearinghouse of information for those who work with and for the older men and women of this Nation. In addition, the staff of the Office of Aging has emphasized State and community organization, leisure-time activity, preretirement preparation, and the development of education in gerontology.

The Office of Aging carried administrative responsibility for organizing the White House Conference on Aging in 1961 and published the findings and recommendations. It plans and conducts annual conferences of executives of State committees and councils on aging to facilitate exchange of information and the sharing of experiences. In these meetings it brings together experts from every field who might contribute to the solution of problems in the States and localities. The Office of Aging provides materials and technical assistance to the States in their observance of Senior Citizens Month as designated by the President.

Since 1961, the staff of the Office have presented many papers before national and international conferences and have helped prepare the proceedings of several of these conferences. Regional representatives and staff members have assisted in and help staff approximately 175 conferences and seminars on the State and local level since 1961. To encourage the provision of professional and subprofessional training, twenty 1-day seminars were conducted at various universities in 1962 alone. Since 1961 the Office has accepted approximately 6,000 invitations from State, local, and voluntary groups to assist in developing programs in aging. Approximately 80 professional publications relating to aging have been issued by this office since 1961. This does not include the monthly publication "Aging" which has one of the widest circulations of any Government periodical. Among the series of publications which are helpful to States and localities in program planning and project development are these:

"Patterns for Progress in Aging": A series of case histories of effective community projects for older people, activity centers, employment services, nursing homes, housing developments.

"Facts on Aging": Statistical leaflets on such subjects as population trends, living arrangements, marriages, health costs, and income.

"Selected References on Aging": Brief annotated bibliographies on such topics as homemaker and volunteer services, housing for the elderly, films and film strips, and grant programs.

"Highlights of Legislation on Aging": Reports on the introduction and progress of legislation, both State and Federal, of importance to older people.

A new series on Federal programs to support projects in aging is being developed. This series was begun in response to numerous requests from States and localities for information as to sources of funds for research and demonstration projects which they are eager to undertake.

The Office of Aging is preparing a pamphlet on the legal aspects of preretirement planning and the problems faced by older people after retirement. One chapter, which we think is particularly important, gives practical suggestions as to ways in which older people can plan in advance for their care and the management of their finances in the event of illness. The pamphlet will be available to States and communities for work with and use by their older residents.

Recently the Office of Aging analyzed needs and policies in housing the elderly. It helped develop an agreement, which has been signed by the Public Housing Agency and the Welfare Administration, which will make a wide variety of services available to elderly people in public housing projects. These projects may now include central kitchens and dining rooms; increased allowance has been made for space for health and social services, and education and recreational programs. This development represents part of the response to the strong interest in housing the elderly, expressed by State and local groups in the last few years.

There has long been interest and much activity throughout the country relating to senior citizens centers. The Office of Aging, working with a subcommittee of the President's Council on Aging, has developed a definition and descriptive statement of model centers, their programs and their potentials. These materials should improve planning in what has often been a haphazard development.

What more could be done? How else can the Federal Government cooperate with States and localities? In various cities there are many ideas and much enthusiasm; there are many programs and projects, some in practice and more on paper. But the problem of sufficient funds retard State and local councils. We have seen how much in the way of studies and planning was done with $15,000 grants to each State for the White House Conference on Aging. Federal grants-in-aid to the States are sorely needed at this point to help them develop services for older people in their home communities.

Several bills introduced in this Congress provide for Federal aid and would be of enormous help to the States and to older people. Passage of such a bill would be most effective in stimulating services to the elderly. "Community services," a title common to several bills, would provide both State administrative funds and grants for community planning, services and training, with most of the authorized funds going to communities for local projects.

We have already noted that about half the States had budgets; these averaged $30,000. In most States the budgets are sufficient only for administrative purposes. The proposed grants would provide, in the first year, a maximum varying from $15,000 to $28,000 to States for administrative costs, to be matched by the State. In most cases this would mean a doubling in administrative funds for the States. This would permit substantial expansion of their ongoing programs and opportunity to extend their services.

In the second and third years the available amounts would increase under the authorization so that the most populous States like New York and California might have about $70,000 in matching funds for administrative purposes, Massachusetts about $32,000, and North Carolina about $23,000. The legislative proposals include authorization for susbtantially larger sums for project grants.

A State such as Pennsylvania would have an authorization of over $200,000 in project grants to localities, and beginning in the third year, over $500,000. Massachusetts, another large State, would have about $130,000 of grant-in-aid funds the first year, and about $325,000 in the third year. Smaller States, like Vermont and Nevada, which now have little or nothing in the way of a budget, would qualify for more than $50,000 in the first year and $130,000 in the third and following years.

Both States and communities long have stressed the need for additional Federal support. Since half of the States now do not have any funds for their own coordinating functions, or for community projects, the availability of Federal matching funds would be a considerable stimulus to the State governments and the communities to inaugurate new and strengthen existing programs. While it is true that almost all services and facilities desirable in meeting the needs of older persons may be found somewhere in the country, these are sparsely distributed, and with few exceptions communities lack most of the significant elements which make up a comprehensive program for older persons. States could make grants available not only to local governmental agencies, but also to nonprofit organizations. Federal funds could provide up to 75 percent of the cost of a project in its first year, 60 percent in the second, and 50 percent in the third.

Research, demonstration, and training projects: In addition to the need for the initiation and spread of local projects and facilities, there are areas of research, demonstration, and training, which are national in scope and implication, or would be beneficial to a number of States. For example, little has actually been done in the design and provision of housing projects for older people. There are substantial shortages of professionally and technically trained personnel, including persons broadly trained in aging, to work in State and community planning programs for the aging. Limited research has been carried out in a number of areas, for example, the consumption patterns and preferences of older people and their role as consumers in the economy; the patterns of activity and adjustment of older people of different ages and socioeconomic backgrounds, in both urban and rural areas; the nature and extent of participation in family and community life under different housing and living conditions. Several bills now pending before Congress would authorize grants and contracts with public and private nonprofit agencies, voluntary organizations and institutions for research, demonstration, and training projects which would be directly negotiated by the Department with such organizations.

Construction of multipurpose recreational activity centers: The senior activity center is essentially a community center designed especially for older people. Relatively new to the American scene, it is regarded as the most important facility in community efforts to meet the needs of older persons. There are about 700 such centers throughout the country that are open 3 or more days per week. However, only about a dozen senior activity centers have been specifically designed and built for the purpose. Many are in public housing projects, limited in size by Federal regulations. Others "make do" in large old houses, stores, and places ill suited to the requirements. They may be small and are often unsafe. Some in churches and community buildings are available only for restricted use. Equipment is limited. The establishment of activity centers for older people was urgently recommended by the White House Conference on Aging and by numerous State and local conferences.

The Smathers-Mills bill introduced in 1963 would authorize $29 million for the next 5 years to provide grants to public agencies or to voluntary organi-

zations on a 50–50 matching basis for the construction of multipurpose senior activity centers. The bill does not provide funds specifically for the staffing and operation of such centers, but some funds for these purposes could be approved by the States and used by communities from allotments available under the grants for community planning services and training. One of the bills introduced by Congressman Pepper would provide substantial sums for center operation. The Smathers-Mills bill has an important section on grants for employment projects for older persons. This would be under the jurisdiction of the Department of Labor.

Bureau of Family Services

The programs supported by the Bureau of Family Services assist needy older people to obtain various kinds of essential help they require if they are to live normal satisfying lives.

The objectives of the programs include: enough money for daily living, prompt and adequate medical care, opportunities to use individual experience and skills, opportunities to participate in family and community life, the right to manage their own affairs, and protective care when capacity for self-protection is interrupted.

The programs are administered by the States with the Federal Government participating in State expenditures for money payments to recipients, payments for medical care, the costs of social services to help individuals attain the maximum degree of personal and economic independence, and for administration.

In assisting State agencies in administering the programs, the Bureau of Family Services is responsible for providing Federal grants to States, developing guides and standards for administration based on the requirements and purposes of the Social Security Act, providing professional services for consultation, collecting national statistics, and conducting program reviews and special studies.

Old-age assistance.—Every State has an old-age assistance program that provides money payments to older recipients for maintenance. In October 1963 almost 2.2 million older persons received payments averaging $77.19 per month. This average payment varied among the States from $38.64 to $110.26 (exclusive of Guam, Puerto Rico, and the Virgin Islands). This represented a reduction in the number of aged persons served by the program over the last 2 years from 2.3 million to 2.1 million; the average money payments to cover medical costs increased. In October 1963 vendor payments for medical costs averaged $15.61 per recipient. State plans to cover some items of medical costs through the money payment vary widely. Nursing home care is the item most frequently covered in the money payment.

As the result of the passage of the 1962 amendments to the Social Security Act and to develop initiative for employment for older persons by exemption of earned income for persons 65 and over, the States in determining need for assistance are permitted to disregard the first $10 of the first $50 earned per month plus one-half of the balance below $50. Currently, 21 States have either adopted or indicated that they plan to adopt this provision.

The 1962 amendments made possible an increase of somewhat more than $4 per recipient in the average monthly payment. Between September 1962 and September 1963 the average payment per recipient, including vendor medical payments, rose by $4.12, with the average money payment per recipient going up in 46 jurisdictions.

Medical assistance for the aged.—The 1960 Social Security Amendments established a new Federal-State program of medical assistance for the aged. As of October 1963 MAA programs were in effect in 28 States and 4 other jurisdictions.

Assistance takes the form of payments to suppliers of medical goods and services under State programs; payments are for part or all of the costs. The payments are to persons 65 or older who are not receiving old-age assistance but whose incomes and resources are found by the States to be insufficient to meet the cost of necessary medical services.

States themselves decide the scope of services and determine eligibility. Under the law States must provide some institutional and some noninstitutional services. There is a wide range of services, including hospital services, physicians' services, home health care services, drugs and other medical care or remedial care that is recognized under State law.

Social services.—As the result of the Public Welfare Amendments of 1962, States were given an opportunity to provide additional social services to older persons in the public assistance programs.

Currently, 36 State departments of public welfare are taking advantage of the opportunity to provide prescribed services to aged, blind, and disabled recipients of public assistance. Thirty-six submitted plans; 32 have been approved and 4 others awaiting approval. This means that after they have identified, through social studies, older clients needing protective services, services to help them remain in their own homes, or services to help them support themselves, caseworkers will be assigned to provide social services to this group. National standards of caseload, supervision and visits enable the caseworker to have more time and more opportunity to provide services than ever before. Six States have already indicated they will provide social services to older citizens who may be potential public welfare clients. Even at this early stage, eight States will provide homemaker services, five will provide foster family care, and seven will use special voluntary services to support direct casework activity. There are 13 States in which there is a consultant on aging in the State office to give leadership in procuring services to older public welfare recipients.

Increased opportunity to use demonstration projects to test and evaluate the value of social services to older recipients of public assistance programs is also available as the result of the new amendments.

The significance of the new amendments can be judged by a report from one county welfare department (Multnomah County, Portland, Oreg.) which has indicated that homemaker services provided to older recipients in their own homes has resulted in a saving of $83,500. This amount would have been spent to house them in publicly maintained homes for the aging.

In Santa Clara County, Calif., a new project demonstrating the value of protective services to help older persons who are unable to manage their money is underway. Similar projects have been initiated in San Mateo and Marin Counties in California. A project in Forsyth County, N.C., has already demonstrated the value of teamwork in providing social services to older persons to help them find suitable living arrangements, remain in their own homes rather than be institutionalized, and live a richer, fuller life.

Standard setting for institutions.—As the result of fires in nursing homes which have cost the lives of a number of older persons, some of them recipients of public assistance, the Bureau of Family Services has been very concerned with public welfare's responsibility for older recipients housed in inadequate and dangerous living facilities. It has urged States to review their safety standards and health and humane treatment. Additional staff time will be made available to help States strengthen standards and work with standard-setting authorities by the development of additional guide material on standard setting in institutions. OAA funds pay for the care of about half of all persons in nursing homes and homes for the aged throughout the country.

Current activities.—Interpretative documents: The Bureau of Family Services has recently issued a series of guide documents on medical care and services (including drugs) in connection with the administration of the MAA program. The Bureau soon will issue interpretative documents on foster family care and protective services for older persons.

Cooperation with other groups: Through its central office and its regional representatives, the Bureau of Family services works closely with a variety of public and voluntary agencies to develop and promote programs for older people. Among these are the Family Service Association of America, American Public Welfare Association, the National Council on Aging, National Social Welfare Assembly, and the United Community Funds & Councils, Inc.

The social security program

The federally administered old-age, survivors, and disability insurance program plays a major role in achieving our national goal of eliminating dependency and want. It provides the base upon which almost every American builds his plans for family security in old age and in the event of his death or disablement.

Nearly 90 percent of the people reaching age 65 in 1963 were eligible for benefits under the program when they retired.

The social security program touches the lives of more people than any other public program. All communities have available the resources of the program, through a network of 613 district offices, 3,522 contact stations, and 45 resident

stations. People often come to the district offices not only to transact business about their social security benefits but also to talk over other problems. Staff in the local offices are responsible for knowing about other services available in their communities and providing information about these services so that individuals can get the help they need. In addition, there is active participation by the Social Security Administration in planning for development and extension of services which experience in the social security program demonstrates that people need, particularly those closely related to the individual's economic situation.

Vocational Rehabilitation Administration

Under the State-Federal vocational rehabilitation programs there has been since 1945 a steady increase in the number of older disabled individuals rehabilitated into gainful employment.

Through its research program, VRA is presenting tangible evidence on the older disabled worker's productivity. One research project designed to place handicapped workers aged 60 and over in competitive employment was so successful that 10 additional demonstration projects have been adapted from it.

Committee on Welfare Services

The Committee on Welfare Services of the President's Council on Aging, which I chair, has been examining a number of problems of older citizens with which the Federal Government and States are equally concerned. The States are responsible for the determination of need in public assistance programs. Most have related "need" to the concept of "a standard of living compatible with decency and health." The amount of monthly income set as a standard in the several States varies widely. For example, for an aged woman, alone and renting quarters, the amount of the grant in one State was $58 and in another $132. Regional variations and urban-rural differences in cost of living do not account for this wide degree of variance. We hope to develop and promulgate national guidelines to assist the States in defining levels of living in the lower income ranges and thus help them in setting their own standards.

Homemaker services bring many of the services provided through group care to the person in his own home at less expense and with greater individual freedom and personal security than is possible in institutions. Many more communities can and should provide homemaker services. To direct attention of communities to such services the committee has prepared a leaflet "Do You Have a Homemaker Service in Your Town?"

Approximately half a million older people need some help in managing their money or the affairs of daily living. This kind of help is broadly termed protective services. To emphasize the need for community help by many older citizens, a leaflet on protective services is being prepared. It is aimed mainly at civic leaders, professional social welfare personnel, and other groups.

Many older people live in rental housing that is not safe, healthful, or adequate. Yet old-age assistance payments for rent, over half a billion dollars a year, are to some degree subsidizing such inferior housing. The President has recommended that States be required to establish and enforce standards of health or safety for rental housing occupied by old-age assistance recipients. This proposal is now pending in Congress in bills introduced by Senator Smathers and Congressman Mills, H.R. 5839 and S. 1358. The Welfare Services Committee is developing suggestions on setting rental housing standards.

The Office of Education and the Welfare Administration are seeking ways to encourage State departments of education and local school boards to develop appropriate programs of education for the aging.

There is tremendous activity nationwide with respect to meeting the needs of our older citizens. Much is being done, much more must be done, including increased help to States and communities in providing the right kind of services at any particular time in the life of the individual.

SUMMARY

Persons 65 years of age and older are more likely than younger members of our society to be poor, unemployed, in ill health, living alone or institutionalized. and of course to suffer from a combination of these circumstances. There seems to be plenty of "room at the bottom" for our elderly. One-third of

elderly families and two-thirds of unrelated elderly individuals are living on incomes which, most would agree, mean poverty.

There are, of course, many in more fortunate circumstances. Nevertheless, even among those whose income is adequate for most everyday needs, there are many who lead impoverished lives for lack of something to do, someplace to go, someone to talk to, or who confront at some time in the later years, special needs or situations with which they cannot cope as individuals.

There are a variety of services and facilities which only the community can provide to the elderly, just as it now provides water and highways and school systems, without regard to the economic status of individuals. We must seek to serve all elderly people, and not lend further semblance of truth to the observation that only the very poor and the very rich can obtain the services they need.

State and local governments, in recent years, have made advances in organizing to provide services to the elderly, but only about half the States have units to stimulate and coordinate programs, with staff and staff budget. The availability of services to the elderly is spreading very irregularly throughout the country. More plans and programs are on paper than in practice.

The Federal Government has done and is now doing much to assist States and facilities with respect to the aging. We have reached a point where further significant advances require new legislation and grants-in-aid. Several bills are now before Congress which could provide the stimulus to an advance by States and localities along a broad front. Our society can well afford the funds involved.

Development of many needed services to the elderly has been long delayed. Now that we have achieved a high level of nuclear capacity and international tensions have relaxed to a degree, we should be able to move ahead toward security and dignity in the later years for all our people.

Senator KENNEDY. Our next witness will be Dr. Clarence A. Smith.

STATEMENT OF C. A. SMITH, M.D., ASSISTANT SURGEON GENERAL, ASSOCIATE CHIEF FOR COMMUNITY HEALTH, BUREAU OF STATE SERVICES, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. SMITH. Mr. Chairman and members of the committee, we also submitted a long statement, and I would like to summarize it in a very short statement at this time.

The Community Health Services and Facilities Act of 1961 was designed to stimulate the development, by States and communities, of new approaches to the delivery of out-of-hospital health care to the people who need it, especially to the chronically ill and aged.

We in the Public Health Service have been very much pleased with the strong response this legislation has received from both public and private nonprofit agencies, and still more pleased with the specific improvements in health care that have already resulted.

The formula grants to States authorized by the act have made possible the development or significant improvement of a great variety of programs which benefit the chronically ill and aged—home nursing and homemaker services, disease detection and screening, improvement of nursing homes through licensure programs and consultation, rehabilitation services, and training programs for urgently needed health personnel.

A substantial portion of these State grant funds have been passed on to local health departments and community agencies, to help them expand existing services or initiate new ones. The net result of this activity has been to make better health care more widely available to people, where and when they need it.

The complementary project grant program authorized by the Community Health Services and Facilities Act has stimulated a number of highly promising experiments and demonstrations in new or improved ways of making health services available to people.

Project grants have been awarded to universities, to a wide range of voluntary health agencies, to professional health organizations, and to many State and local health departments. The projects range from a nationwide study and evaluation of community health services to localized demonstrations within the walls of a single institution.

Some of the projects are dealing with effective coordination of services in large metropolitan areas, while others seek to demonstrate the feasibility of providing home care in rural areas where there are virtually no services available. The content of these programs bridges the entire spectrum of health needs of the chronically ill and aged.

The real impact of the Community Health Services and Facilities Act will not be apparent for some time. The act is designed to combat extremely complex problems—shortages of manpower, trained in the skills required by modern medicine, shortage and maldistribution of facilities in changing communities, overlaps and gaps in existing community services. None of these can be solved overnight.

Nevertheless, progress under the act has already exceeded our highest hopes. Most of the activities and projects generated by the act are only a year or two old. But already they are producing two kinds of benefits.

For the citizens of the communities in which activities are underway, a greater variety of improved health services is now more readily available. Many of them, for the first time, can now get the kind of care they need. For those people not yet reached directly by the act, the demonstration activities now underway offer the hope that their communities may profit from the experience of others by adapting successful new methods to their own needs.

Thus far we feel that the Community Health Services and Facilities Act program has made an impressive and promising start. We look forward to the increasing fulfillment of this promise, as the results of these early projects are disseminated and adopted by more communities across the country.

I would be glad to try to answer any questions you might have, Mr. Chairman.

Senator KENNEDY. Doctor, do you think that the legislation proposed will facilitate your present efforts, the undertakings which you have mentioned here this morning?

Dr. SMITH. Yes, sir; I think it would.

Senator KENNEDY. And are there any specific areas of the legislation which from your own experience you think are particularly well adapted to the types of undertakings which you are interested in?

Dr. SMITH. I think one of the real needs in meeting the health needs of the aged is the organization of community facilities, some of which are at present available and are not used to top capacity, some of which could be used by the agencies in a coordinated manner.

One of the things that was particularly impressive to us was a project done in one of the large metropolitan areas, where health

services were building up around a categorical approach to the blind, and the blind were withdrawing from existing community services and were not utilizing the general services of that community.

This might be perfectly all right in a large metropolitan area, but it is entirely unworkable in a smaller area. Consequently, by coordinating the services, ongoing activities necessary to the health needs of the blind can be utilized.

Senator KENNEDY. The counsel has two questions, here, Doctor, if you would be kind enough to respond to them.

Dr. SMITH. Yes, sir.

Senator KENNEDY. Dr. Smith, in your prepared statement you indicate that fees are charged in some of these programs, where the recipients are able to pay. Would you say these fees defray a substantial percentage of the cost of the program, a negligible percentage, or some percentage in between?

Dr. SMITH. This varies from community to community very much. I think, on the average, since these are demonstration programs, the applicant shows that the community will support this demonstration program after a period of 3 years. Consequently, through either payment directly by the patients served or by welfare or other Government organizations, the projection builds up over a period of only minor support the first year to moderate support the second, and to total support after the third year.

Senator KENNEDY. You mean self-sufficient in the sense that the patient pays the cost? Or self-sufficient in the sense that the State and locality pays it rather than the Federal Government?

Dr. SMITH. I was talking about the State or metropolitan areas.

Senator KENNEDY. I see.

Dr. SMITH. The Federal funds will be withdrawn in most of these projects after a 3-year period.

Senator KENNEDY. All right, sir. Now one more question: What, if any, amendments to the Community Health Services and Facilities Act of 1961 has the Public Health Service recommended?

Dr. SMITH. At this time, sir, we are not recommending any change in this act.

Senator KENNEDY. Thank you, Dr. Smith.

Any questions, Senator Yarborough?

Senator YARBOROUGH. No questions, Mr. Chairman.

Senator KENNEDY. Thank you very much, Dr. Smith.

(Dr. Smith's prepared statement follows:)

STATEMENT BY C. A. SMITH, M.D., ASSISTANT SURGEON GENERAL, ASSOCIATE CHIEF FOR COMMUNITY HEALTH, BUREAU OF STATE SERVICES, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the committee, I am very pleased to be with you today, to discuss with this committee the advances in delivery of health care, especially to the chronically ill and aged, that have resulted thus far from the Community Health Services and Facilities Act of 1961. We in the Public Health Service have been deeply gratified by the response of our colleagues in States and local communities across the Nation to this new opportunity for improving health services, and even more by the specific gains which have been achieved in bringing better care to people who need it.

It is self-evident that the health care of individuals and families depends ultimately on local action, community by community. There has been wide-

spread concern about the growing gap in American life between our level of scientific knowledge in health and our ability to deliver the fruits of that knowledge to the people whose lives could be prolonged and whose strength could be restored through its effective application. There is a continuing need to develop new kinds of service, new patterns of care, which can make the best in modern medicine widely and conveniently available.

The Community Health Services and Facilities Act of 1961 was an instrument designed to stimulate States and communities to try out promising new approaches in the field of out-of-hospital services. Special, but not exclusive, emphasis was given to the needs of the chronically ill and aged. It was designed to encourage such programs as organized community home-care services, to bring to the chronically ill patient in his own home the various kinds of care his condition might require—home nursing care, physical and occupational therapy, nutrition services, and the like. Other projects envisioned included the establishment of health service information and referral centers, to assure that existing community programs were being effectively used; training programs for the health personnel needed to conduct out-of-hospital services; programs to upgrade the quality of care in nursing homes; and many others.

Specifically, the act as passed in 1961 (1) provides formula grants to States to assist them and their local communities in increasing the availability and improving the quality of out-of-hospital services for the chronically ill and aged, and (2) authorizes the Public Health Service to make projects grants to State and local health departments and other public or nonprofit private agencies for studies, experiments, and demonstrations looking toward the development of new and improved methods of delivery of health care. Legislative authorization for these grant programs extends for a 5-year period ending June 30, 1966.

FORMULA GRANT PROGRAM

The availability of chronic illness and aging formula grant funds to States, a significant portion of which in turn has been passed on to local health departments and nonprofit community organizations and agencies, has materially helped in the development and improvement of the scope, quality, and availability of out-of-hospital health services for chronically ill and aged persons. Funded programs in virtually all States have included a wide range of out-of-hospital health services—home nursing and homemaker services, disease detection and screening, improvement of nursing homes through improved licensure programs and consultation services, rehabilitation services, and training programs for medical services, nursing, and ancillary personnel (see exhibit 1).

Impressive as the overall figures may be with respect to the number of States having initiated or extended their consultation services to nursing homes, the chronic illness screening programs assisted by grant funds, the number of communities with information and referral services started since fiscal 1962, the best way to gain an appreciation of the impact of this formula grant program in its first several years is to present some specific undertakings in a few States and communities illustrative of the ways in which grant assistance has been used to develop and improve the scope, quality, and availability of out-of-hospital services for the chronically ill and aged.

Particularly heartening has been the use made of chronic illness and aged grant funds by a large number of States to assist local communities—at the grassroots where most services to people are delivered—in establishing or expanding their own chronic illness programs.

In California, for example, Federal funds have been subgranted to 40 local health departments for 62 local projects. Helped by such subgrants, Los Angeles County was able to establish a program for improving the quality of care in nursing and convalescent homes in the county. In addition, a system of following patients discharged from several county general hospitals to nursing homes has been initiated to insure continuity of care. In Kern County, such funds have been used in extending home nursing services to eligible welfare recipients; and initiation of a program of professional education in rehabilitation for the local medical profession. Contra Costa County has been able to set up a friendly visitor services program. About 50 volunteers have been recruited and trained to date. They regularly visit elderly persons with health and health-related problems—the ill, homebound, shutin, and isolated. About one-third of the patients visited are in convalescent and chronic disease hospitals, one-third are in the county hospitals and boarding homes, and the remaining one-third are in their own homes.

One small but nonetheless important thing that has been done in a number of States (e.g., Florida, Illinois, Michigan) with the assistance of formula grant funds has been the setting up of so-called loan closets. These loan closets are a source of specialized equipment such as hospital-type beds, wheelchairs, etc., commonly needed if a chronically ill person is to be properly cared for in his or her own home. In many communities, especially smaller areas, there is an inadequate supply of this kind of equipment; in such cases patients otherwise might not be discharged from a hospital and cared for in their home except for the availability of suitable equipment through such loan closets.

In Iowa, coordinated home care programs have been developed in Des Moines, Sioux City, Davenport, and Earlham. These home care programs are now being expanded to provide homemaker and personal care services to ill and handicapped individuals in their own homes and to provide continuity of care to the convalescent and chronically ill on release from hospitals. For these services, individuals are charged fees according to ability to pay. It is expected that as the benefits of the program are demonstrated, increasing local support will be obtained until the budget deficit of the program will be provided completely from local sources at the end of 5 years.

In Delaware, formula grant funds support a nursing home improvement program aimed at the improvement of nursing care, records, nutrition, sanitation, and safety for those of the aging population confined to nursing homes. This statewide program has been extremely successful and has demonstrated the possibility of achieving large results with a relatively small investment.

As a direct result of a demonstration in one county, the Arkansas State Health Department is using its formula grant funds for an expanded program of nursing service in the home in 19 counties, with 6 additional county medical societies now requesting similar service. In the 19 counties, a total of 5,599 nursing visits were made between January 1 and June 30, 1963.

Almost 90 percent of the CI funds available to South Carolina were utilized in providing nursing and dietary consultants, physical therapy, and medical social services to bolster a determined drive to upgrade nursing home care in the 60 licensed homes in that State. In addition, a glaucoma survey of nursing home patients was conducted in cooperation with the Medical College of South Carolina, following a successful dental survey the previous year.

PROJECT GRANTS

As of January 1, 1964, 407 applications had been submitted for consideration under the Community Health Services project grant program. Applicants have included universities, a wide range of voluntary and professional organizations as well as many State and local health departments.

Of the 371 proposals reviewed to date, 136 or approximately one-third have been approved and are now operating as on-going community projects. The types of activities being supported range from a nationwide evaluation and study of community health services to a demonstration of the practical use of flame retardant linens in a small midwestern home for the aged. Other projects involve the development of coordinated home care and referral programs; the provision of homemaker and home nursing services to the chronically ill and aged; screening techniques suitable for mass case finding; the most effective methods of meeting the dental and vision needs of the homebound; and a variety of rehabilitation projects. Many of the projects being supported will develop entirely new community programs; others by coordinating existing services, will assist local health departments, hospitals, voluntary organizations and other groups to meet the health needs of the community by obtaining maximum utilization of on-going programs and existing facilities.

Perhaps the best way to review the accomplishments of this grant program to date would be to consider a small but representative selection of the 136 projects thus far approved.

Two-year grant to Pinellas County Health Department (St. Petersburg)

As 1 of 4 persons in this community is over 65 years old, Pinellas County faces a tremendous task in its efforts to provide out-of-hospital nursing care. The first step in developing the necessary nursing services is to specifically identify the scope of the problem and the most effective means of over-

coming it. This field study will pinpoint needs and serve as a basis upon which to develop an expanded home nursing program. The data elicited will also provide guidelines for other communities facing similar problems.

Three-year grant to the Massachusetts Association for the Blind (Boston)

Handicapped persons including the deaf, the aged, the epileptic, the blind and others are ordinarily thought of as requiring specialized services solely because of the nature of their handicap rather than the nature of their needs. As a result, these handicapped are seldom served by generalized health and welfare community agencies. This project will demonstrate a method of assessment by professional specialists and referral of patients in the above-mentioned categories in an effort to adapt existing generalized services to meet the specialized needs of the handicapped.

Three-year grant to the Nevada Tuberculosis and Health Association (Reno)

The purpose of this project is to establish a homemaker service for the chronically ill and aged in a sparsely populated rural area having limited medical and social services. A supervisor and six full-time homemakers are now providing care to the homebound in a multicounty portion of eastern Nevada. This program has been very successful and is resulting in a considerable savings in costs of care, prevention of institutionalization and earlier release of patients. As modest fees are being charged and in view of the excellent community cooperation, there is every indication that this service will continue upon termination of Federal assistance.

Three-year grant to Mount Sinai Hospital (Cleveland)

Both public and private housing programs for elderly people are developing in the United States at an increasing rate since the first public housing project for older persons was built by the Cleveland Metropolitan Housing Authority in 1937. Experience indicates the need for some type of organized medical care programs within these developments. This program will establish and evaluate a medical care program in such a housing project and will obtain information which will serve as the basis for the establishment of other medical care programs which will fully meet the needs of elderly residents. This program involves the opening and staffing of a clinic which will provide admission physical examination, periodic reexaminations, and maintenance services including medical social services, dietary counseling, and occupational and physical therapy.

Three-year grant to the Seattle Artificial Kidney Center, Swedish Hospital

This project will enlarge the current 3-bed center to a 10-bed facility to reduce and study the costs of the treatment by periodic hemodialysis of patients with chronic uremia. It will demonstrate that this form of treatment is worthy of community support, and will work out with appropriate agencies in the area a pattern of long-term community support including a method of determining each patient's own contribution. The facility will also be used for demonstration and training purposes for groups from other communities who plan similar facilities.

Three-year grant to the School of Home Economics, Louisiana State University

This project is aimed at (1) demonstrating methods of training homemakers using home economics teachers and (2) developing curriculums for training homemakers in different kinds of communities. As a result of this project an estimated 125 home economics teachers will be trained for leadership responsibilities in community training programs for homemakers. Such trained homemakers, in turn, will help alleviate the personnel shortage in nursing homes and hospitals by making it possible to care for more chronically ill and aged people in their own homes.

Three-year grant to Massachusetts Health Research Institute (Boston)

This grant proposes to determine the roles of a geriatric hopsital in the development of appropriate out-of-hospital services for the chronically ill and aged in its service area. This project also establishes a closely integrated evaluation unit to study the mechanism by which chronically ill persons can

be kept in their own environment or hospitalized for restoration and returned to their own communities as soon as possible. The basic objective is the definition of better methods of evaluation, referral, and continuity of care applicable to the growing geriatric problem.

EFFECTIVENESS OF ASSISTANCE, PROBLEMS, AND DIFFICULTIES

The real impact of the Community Health Services and Facilities Act will not be apparent for some time. A new program cannot be launched or an existing one expanded without much time-consuming work. Moreover, the kinds of problems for which this act is designed are highly complex, involving manpower which cannot be trained overnight, facilities that cannot be built in a day, modes of cooperation among agencies and groups that have worked apart for years.

Nevertheless, tangible results are appearing at an increasing rate and the movement toward a wider range of out-of-hospital services is picking up great momentum.

In the manpower field virtually all the health professions and ancillary disciplines are in short supply. The pool from which personnel is drawn for community services must be increased. Across the board, there is need for upgrading of quality of service, updating outmoded concepts and practices. Moreover, we are barely beginning in the health professions to make optimum use of ancillary services—such as those of the chairside assistant in dentistry, the laboratory technologist, the public health advisers and field workers.

Above and beyond the need for facilities and manpower is the need for improved ways of delivering the entire gamut of health services, from the instillation of healthful life patterns, through case finding and diagnosis to therapy, restoration, and care. The area of methodology is in many ways the most difficult of all. The problem is essentially organizational and the solutions must satisfy the needs and enhance the services of private practioners of medicine as well as the national and local, public, and voluntary health agencies.

The problems encountered in developing assistance under the Community Health Services and Facilities Act are inherent in the situations the act is designed to remedy. They are related to the explosive growth of population and the no less explosive growth of medical knowledge—factors which have combined to yield serious shortages of health manpower trained to deliver up-to-date services. They are related also to the changing face of the community itself, with its attendant problems of organization and uneven distribution of facilities and services. None of these is amenable to quick and easy solution.

Nevertheless, progress under the act has already exceeded our optimistic estimates. Although most of the activities stimulated by the act are only a year or two old, they are already producing two kinds of benefits—direct benefits to the citizens of communities in which the projects are underway, in terms of better health care more easily available where and when it is needed; and indirect benefits to the citizens of other communities which can adopt and adapt effective new methods developed through the act to the solution of their own problems.

As more and more of the experimental and demonstration programs prove their effectiveness, and as these success stories are disseminated, the beneficial results of the Community Health Services and Facilities Act should multiply manyfold. Thus far we feel that the program has made an impressive and promising start. We look forward confidently to the increasing fulfillment of this promise.

EXHIBIT 1

Summary of use of chronic illness and aging funds (fiscal 1963)

Activity:	*Number of States*
Nursing home care:	
Consultation services	37
Training activities for operators and personnel	19
Educational programs and development of training materials	15
Licensing, inspection, and improvement of standards	21
Rehabilitation and therapy services	25
Nutrition services	14
General expansion	5
Home care services:	
Nursing services	19
Expansion or establishment of program	8
Coordinated home care	6
Training of personnel	10
Consultation services	4
Homemaker services	10
Education and training	21
Assistance to local units:	
Consultation	11
Financial	9
Staff	4
Equipment	4
Support of demonstration and other special local projects	16
Information and referral services	17
Detection and screening	25

NOTE.—Grant funds were used for initiation, extension, improvement, or support of these broad categories of chronic illness activities in the number of States indicated based upon their State plans.

Senator YARBOROUGH (presiding). The next witness is Mrs. Margaret C. Schweinhaut, chairman of the Maryland State Commission on Aging.

Good morning, Mrs. Schweinhaut. We welcome you to the committee. You may proceed in your own way.

STATEMENT OF MRS. MARGARET C. SCHWEINHAUT, CHAIRMAN, MARYLAND STATE COMMISSION ON AGING

Mrs. SCHWEINHAUT. Thank you very much, Senator.

I think the last time I had the pleasure of speaking with you, you were kind enough to come to our Governor's conference on aging at Maryland University. You gave us a very inspiring keynote address.

Senator YARBOROUGH. You were kind enough to extend the invitation. I enjoyed the visit to the university very much.

Mrs. SCHWEINHAUT. Senator, I should like to pick up one point that was made by Commissioner Winston with respect to the administrative aspects of this whole matter of problems of aging.

I call to your attention the fact that since 1961, when we had the White House Conference on Aging, we have been talking, studying, gathering statistics, testifying, identifying problem areas, and so on, and those of us who are in the field and working directly within the communities have now long since identified the problem areas, and we are very impatient indeed for action.

I would like to call to your attention, Senator, that we do have in many States channels for quick action in the form of the State commissions on aging, many of which were organized in anticipation of the White House Conference on Aging. Unfortunately, about half of them have now fallen by the wayside because of lack of action and support.

They could be brought back to life, I think, if there was another injection of hormones in the form of some small financial aid from the Federal Government. It is a necessary requisite toward reestablishing these commissions.

In Maryland, we are legislatively established and were in operation in advance of the White House Conference on Aging. But the $15,000 which the Congress gave us to prepare for the White House Conference made it possible for us to do a great deal in the way of alerting our communities as to what it was all about, and thereby creating great interest within the communities in the problems.

Unfortunately, again, we do not have and have not had enough money to maximize these efforts, that since the White House Conference, therefore, we have had a sad loss of impetus. I believe that this must be rectified quickly or we are going to have to start all over again, and lose forever the wonderful forward motion that had been created as a result of the White House Conference on Aging.

It would be my hope that the Congress, through this bill, would grant to the State commissions on aging, at least those which are legislatively established, enough money to quickly bring the benefits of this bill to the people we are talking about.

It is very distressing, when working in the communities, to realize that a magnificent body of information is being gathered all the time, but it is so fragmented. It is possible to take advantage of this Federal program if it is strictly medical, but nothing else. It is possible to take care of this one if it is strictly employment and nothing else. And so on down the line.

And so you fragment the individual. We need desperately, I think, in all of the States, to have one group which looks at the older person as a whole person, with several of these problems, and to extend overall help, not fragmented help.

Through the grant provisions of this bill, we could begin such an approach.

Coming now to the proper administrative setup.

If we believe our own medical experts who are predicting a life extending to 100 or 125 years within the foreseeable future then those of us working in this field must plan in terms of that enormous life expansion.

If this is true, then the 18 million oldsters today will rapidly increase, and we are going to have, if we do not plan carefully today, a very chaotic and critical situation, and one very expensive to meet.

And so, when we talk about the administrative setup that we need, I hope the Congress will think in terms of a situation susceptible of growth as the problem itself grows, and not merely in terms of what is the expedient, easy way to do it today.

It is my hope, and my own thought—and I dislike disagreeing with Commissioner Winston, because I admire her very deeply, and I think that she is a marvelous woman doing a wonderful job—but I think that the time has come—indeed, I think it is past—when there must be, within the structure of the Federal Government, an easily and quickly identifiable administration handling problems which affect older people, and that this administrative arrangement in turn moves quickly into the States and from the State level into the communities where the older people we are talking about live.

Any other approach is merely attempting to alleviate today's problems. It is not the statesmanlike approach of building a foundation upon which a good structure may be built in anticipation of what we are told will be a tremendous expansion of our elderly population.

That is the principal point I wanted to make. I would further say, Senator, while many of the people speaking before you may not emphasize the need for money—I for one say quite frankly that we need money in the States. We need it for purposes of good and quick coordination of all the programs. We need it in order to continue to identify in the State what the job is, and how we can best do it.

One further point, Senator: To most people born before the year 1900, the word "welfare" is a very sad word indeed. And while I understand, appreciate, and even agree with Commissioner Winston's large, broad view of welfare, I disagree thoroughly that this matter of the care of our aging people in all of its aspects should be under any department that carries the word "welfare."

It is a very unfortunate development and contrary to other approaches of the Congress and of the Senate, particularly with respect to our older people.

When we talk about medicare, we say we must preserve the right of the older person to his dignity. The President said yesterday: "We must not trade the dignity and self-respect of an older person for welfare, for charity."

I hope that this same thing will continue to permeate the attitude of the Congress as they consider these problems. It is deeply important and deeply American that we continue to insist that our older people keep their dignity all of their lives, and that through legislative acts or administrative acts we do not even to the smallest extent deprive them of that very precious possession.

That is my statement, Senator.

Senator YARBOROUGH. Thank you. That is a very fine statement.

I recall when the enabling legislation was being passed to authorize the calling of the White House Conference on the Aging in 1961. That proposal was being considered by the Labor and Public Welfare Committee before this committee was created. And there was discussion, there, about the amount of money that would be required.

Are you suggesting that there be another White House Conference on Aging? Do you think that is necessary? Or do you think the

machinery exists for stimulating these existing or quiescent State agencies, if they are doing nothing, the State commissions, into activity?

Mrs. SCHWEINHAUT. Yes; I am suggesting what we already have, we stimulate.

In quite a few States you have State legislatively established commissions, as we do in Maryland, but in quite a few States, these commissions or committees went out of existence about a year after the White House Conference.

So I would think that another grant to allow these local commissions or State commissions to do the job that the White House Conference helped to identify needed doing. I think that is what is most needed.

Senator YARBOROUGH. I would like to ask the staff, in connection with the testimony of Dr. Smith and the earlier testimony, to place in the record the amount of money that has so far been advanced under the Community Health Services and Facilities Act of 1961.

Dr. Smith gives specific instances of how these funds were used. I would like to know what the extent of the appropriation has been, how it has been distributed, whether part of it is unused, and what is available. I do not believe the paper states the amount.

I think we should show the use of that money in the record, whether more efficient uses are indicated, or whether more money is needed, or in the fiscal sense what is needed in that regard, under that 1961 act.

(Information referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE, BUREAU OF STATE SERVICES,
Washington, D.C., March 30, 1964.

Mr. J. W. NORMAN,
Senate Special Committee on Aging,
New Senate Office Building, Washington, D.C.

DEAR MR. NORMAN: This is in response to your request for certain information to be placed in the record in connection with the testimony before your committee on January 16, 1964, of Dr. Clarence A. Smith of this Bureau. Attached are two copies of the information.

Sincerely yours,

PAUL Q. PETERSON, M.D.,
Assistant Surgeon General, Associate Chief for Operations, Bureau of State Services (CH).

COMMUNITY HEALTH SERVICES AND FACILITIES ACT OF 1961

The major new and revised authorizations provided by the Community Health Services and Facilities Act of 1961 were—

1. An increase in the limitation for grants to States for community health services under section 314(c) of the Public Health Service Act from a maximum level of $30 to $50 million.

2. An authorization for a new program of up to $10 million annually for a period of 5 years to provide for special project grants to public and nonprofit organizations for studies, experiments, and demonstrations of new or improved methods for providing health services outside of hospitals primarily for chronically ill or aged persons.

3. An increase in the annual appropriation ceiling from $10 to $20 million for a period of 3 years for grants-in-aid to States for the construction of public and nonprofit nursing homes under the Hill-Burton program.

The funds appropriated and obligated as a result of these authorizations are as follows:

	1962	1963	1964
1. Grants for community health services:			
Authorization [1]	$20,000,000	$20,000,000	$20,000,000
Appropriations (chronic diseases and health of the aged)	6,000,000	13,000,000	13,000,000
Obligations	4,859,000	11,383,000	[2] 13,000,000
2. Special project grants:			
Authorization	10,000,000	10,000,000	10,000,000
Appropriations	3,000,000	6,000,000	7,000,000
Obligations	2,294,000	5,598,000	[2] 7,000,000
3. Grants for construction of public and nonprofit nursing homes:			
Authorization	10,000,000	10,000,000	10,000,000
Appropriations	8,500,000	10,000,000	10,000,000
Obligations	8,500,000	10,000,000	[2] 10,000,000

[1] Authorization available for programs other than chronic diseases and health of the aged.
[2] Estimate.

1. Following are the allocations to States of grant-in-aid funds for the chronically ill and aged:

	1962 allocations	1963 allocations	1964 allocations
Alabama	$138,800	$304,200	$302,400
Alaska	40,000	60,000	60,000
Arizona	40,000	83,300	85,900
Arkansas	104,400	222,000	217,500
California	356,300	829,800	838,400
Colorado	52,200	114,800	114,600
Connecticut	56,900	130,000	131,400
Delaware	40,000	60,000	60,000
District of Columbia	40,000	60,000	60,000
Florida	168,900	416,900	425,600
Georgia	143,600	321,200	321,500
Hawaii	40,000	60,000	60,000
Idaho	40,000	60,000	60,000
Illinois	253,500	571,900	571,000
Indiana	143,600	320,400	320,300
Iowa	111,500	237,100	231,300
Kansas	80,500	175,800	173,200
Kentucky	133,100	294,500	292,200
Louisiana	111,700	255,600	255,800
Maine	40,300	85,600	86,200
Maryland	72,700	167,500	165,600
Massachusetts	150,300	338,000	334,100
Michigan	197,600	449,800	459,100
Minnesota	121,200	265,200	260,200
Mississippi	121,600	271,400	267,400
Missouri	152,900	338,200	333,800
Montana	40,000	60,000	60,000
Nebraska	54,100	117,900	115,300
Nevada	40,000	60,000	60,000
New Hampshire	40,000	60,000	60,000
New Jersey	143,900	332,600	332,700
New Mexico	40,000	60,000	60,000
New York	417,900	941,200	939,200
North Carolina	168,100	370,400	368,500
North Dakota	40,000	60,000	60,000
Ohio	262,000	600,800	611,600
Oklahoma	92,700	205,200	206,200
Oregon	58,300	126,400	127,600
Pennsylvania	339,900	759,900	762,100
Rhode Island	40,000	61,600	61,800
South Carolina	96,700	209,200	207,500
South Dakota	40,000	64,100	62,400
Tennessee	145,000	328,400	325,600
Texas	284,500	653,300	657,900
Utah	40,000	60,000	60,000
Vermont	40,000	60,000	60,000
Virginia	119,800	277,900	279,000
Washington	83,600	188,200	189,300
West Virginia	74,800	159,300	157,100
Wisconsin	131,000	286,800	287,600
Wyoming	40,000	60,000	60,000
Guam	40,000	60,000	60,000
Puerto Rico	96,100	223,600	221,100
Virgin Islands	40,000	60,000	60,000
Total	6,000,000	13,000,000	13,000,000

2. The 135 special project grants approved through December 31, 1963, covered the following areas of activity.

Area of activity:	*Number of grants*
Administration of community public health programs	1
Studies of people's attitudes toward health programs	1
Training and utilization of personnel	12
Studies of costs and methods of financing health services	0
Home care, homemaker services and nursing care	37
Extension and improvement of facilities and services for chronically ill and aged, including nursing homes	7
Central referral and information services	19
Public education and communication	3
Organization to provide health services	27
Surveys of health needs, facilities, or problems	6
Evaluation of specific treatment practices or techniques	13
Screening	4
Other	5
Total	135

Of these, 129 were made to States and 6 to national agencies as follows:

Alabama	2	New Hampshire	1
Arkansas	1	New Jersey	3
California	8	New York	17
Colorado	4	North Carolina	4
Connecticut	4	North Dakota	1
District of Columbia	4	Ohio	8
Florida	3	Oklahoma	3
Georgia	2	Oregon	3
Hawaii	2	Pennsylvania	13
Kansas	2	Rhode Island	2
Kentucky	3	Texas	2
Louisiana	1	Virginia	3
Maryland	3	Washington	5
Massachusetts	6	West Virginia	4
Michigan	3	Wisconsin	1
Minnesota	2	Puerto Rico	2
Missouri	6	National agencies	6
Nevada	1		

3. Following are the allocations to States of grant funds for construction of nursing homes:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE, DIVISION OF HOSPITAL AND MEDICAL FACILITIES

Hospital construction activities—Nursing homes

States	Allocation for fiscal years		
	1962	1963	1964
Total	$18,500,000	$20,000,000	$20,000,000
Alabama	558,957	603,311	591,594
Alaska	100,000	100,000	100,000
Arizona	145,587	164,391	165,133
Arkansas	335,976	361,254	341,558
California	917,772	1,015,798	967,572
Colorado	173,482	188,039	163,945
Connecticut	107,672	118,165	135,307
Delaware	100,000	100,000	100,000
District of Columbia	100,000	100,000	100,000
Florida	552,700	617,571	644,957
Georgia	616,664	666,114	645,327
Hawaii	100,000	100,000	100,000
Idaho	100,000	100,000	100,000
Illinois	579,358	628,733	678,521
Indiana	454,763	490,075	489,091
Iowa	305,536	329,015	322,595
Kansas	236,354	254,719	249,607
Kentucky	481,421	519,957	515,374
Louisiana	483,840	525,723	534,843
Maine	127,195	138,599	135,580
Maryland	245,874	269,134	266,506
Massachusetts	367,599	398,383	390,171
Michigan	648,413	703,087	746,544
Minnesota	375,094	406,467	393,150
Mississippi	451,178	490,445	474,022
Missouri	428,571	463,485	440,205
Montana	100,000	100,000	100,000
Nebraska	151,396	163,923	157,910
Nevada	100,000	100,000	100,000
New Hampshire	100,000	100,000	100,000
New Jersey	351,196	384,650	398,932
New Mexico	121,583	133,476	136,826
New York	877,901	950,735	936,831
North Carolina	752,087	813,635	768,057
North Dakota	100,000	101,081	102,133
Ohio	752,500	816,402	895,499
Oklahoma	304,155	329,171	322,518
Oregon	173,680	188,546	176,172
Pennsylvania	978,671	1,058,595	1,118,006
Rhode Island	100,000	100,000	100,000
South Carolina	436,010	469,407	454,846
South Dakota	100,070	108,328	100,809
Tennessee	568,351	615,213	609,057
Texas	1,115,259	1,214,395	1,227,634
Utah	110,306	120,639	116,812
Vermont	100,000	100,000	100,000
Virginia	501,571	547,540	547,925
Washington	241,356	262,004	263,586
West Virginia	261,990	279,244	287,260
Wisconsin	393,630	427,291	421,165
Wyoming	100,000	100,000	100,000
Guam	14,073	15,058	15,030
Puerto Rico	493,468	540,644	539,359
Virgin Islands	6,741	7,558	7,534
American Samoa			4,497

Senator KENNEDY (presiding). Thank you very much, Mrs. Schweinhaut.

Mrs. SCHWEINHAUT. Senator Kennedy, I should like to reiterate a point I was attempting to make with Senator Yarborough.

With the deepest admiration for Dr. Winston, I do not agree that we have a proper administrative setup with respect to our older citizens today. I say this because I believe that the Senate of the United States needs to look at this problem in light of the promised great expansion of life expectancy. When this time comes, we will need an enormous increase in the various programs for older people. We must have them.

Today we need to lay the groundwork upon which we can build a structure administratively which will be susceptible of expansion when this tremendous life expansion occurs.

This is, I believe, the statesmanlike approach. The situation we have today, while it may serve as an expedient, is only that, and is not a basis upon which we can build for the future. It unfortunately involves the inclusion of the "welfare" concept with respect to our older people and this is repugnant to the wishes of those to be served by our programs. It is contrary to the wishes of today's elderly and will not meet the needs as we see them for the future.

Senator KENNEDY. Have you found that there has been any lack of administrative facility, as far as your relationship with HEW is concerned?

Mrs. SCHWEINHAUT. No; it has been excellent. From our own area representative in Charlottesville, Mr. Burton Aycock, Dr. Kent, Commissioner Winston, all of the staff have been extremely cooperative in every way. We have had everything from them except money, and that I understand they cannot give to us.

There is no question of lack of helpful cooperation at all. I simply think that it is time we begin to lay the groundwork to build upon for the future. Experience tells us there is no other sensible way to do it.

Senator KENNEDY. Thank you very much. I am going to ask Dr. Frank Furstenberg if he will come to the witness stand.

STATEMENT OF DR. FRANK FURSTENBERG, DIRECTOR, AGING CENTER, SINAI HOSPITAL, BALTIMORE, MD.

Dr. FURSTENBERG. Senator, thank you for taking me out of turn. I do have to return to my practice in Baltimore, and I appreciate the consideration.

Senator KENNEDY. Do you have a copy of your statement, Doctor?

Dr. FURSTENBERG. No; I do not. I am going to tell you something about our aging center in Baltimore, and I'm afraid it will sound a little bit as though I were in collusion with Mrs. Schweinhaut, because I am going to emphasize money, also.

But 4 years ago, our hospital, Sinai Hospital, moved to northwest Baltimore from the central city and there we have a modern new facility serving northwest Baltimore, an urban-suburban community.

Here we serve a cross section of the community and not just a basically depressed area as is so often the case in the central city. In the new location, we are the community hospital. Four years ago, we proposed to the Public Health Service that we establish coordinated

services for the aging in the outpatient department, to include more than medical care. We wished to explore the use of the present facilities for the community, and to develop new facilities when necessary for comprehensive and coordinated services for the aging, using the hospital as a center for these services.

We proposed an information and counseling service. We also proposed to give total medical care for a selected group of aged persons and we planned to develop an organized home care program. We also hoped to develop other services which the aging person needs in order to remain stabilized in the community, rather than allow that person to gravitate to dependency, a nursing home or a chronic disease facility.

Indeed, we hoped to find out what it took to keep people functioning in the community, rather than to wait for catastrophic illness to occur and then watch the patient gravitate into chronic dependency. We have been fortunate to be able to carry out some of our proposals and have had some results. Indeed, we have been able to do more than we anticipated.

We have been trying to find out what a voluntary hospital, working with solo practitioners, can do. We have tried to develop group practice concepts for the physicians and team work in the care of the aged, using the resources of a modern hospital, with all its special services, in the interests of this group.

Thus, we have established an information and counseling service for the entire community given without a means test. Anyone can call our service at the hospital to inquire about problems of aging relatives or friends.

Some of the inquiries concern simple things: "How do I get a physician to come to my home?" "What do I do to place a relative in a nursing home?" "What nursing homes are there and can I afford them?" "How does one obtain hospital equipment for use in the home?" "Where are there recreational facilities for my mother?" and many similar requests. The community often looks to us now for information for the aging problems in the Metropolitan Baltimore area.

Senator KENNEDY. How was this coordinated with the State facilities, if any?

Dr. FURSTENBERG. The State facilities?

Senator KENNEDY. Or State organization.

Dr. FURSTENBERG. We have the hearty approval and support of the Baltimore City Health Department, State health department, and the State and city commissions on aging. Indeed, Mrs. Schweinhaut was present and spoke at the official opening of our center 3 years ago.

When we established our information center for aging, there was no other formal information center in the city of Baltimore. Since that time, Baltimore has a general information center for all social and health problems operating under the auspices of the Baltimore Health and Welfare Council.

We still have the only specialized information and counseling service for the aged and, in this sense, we do not supersede any other group. While every social agency receives inquiries on aging, we have become specialists in this service, and often are called upon to give information to other social agencies.

May I just mention a case which typifies what happens. A representative from the St. Vincent de Paul Society called us just recently, requesting help from our aging center information service. They were interested in a couple, age 70 and 76, who lived in northeast Baltimore. Our center is in northwest Baltimore. This couple has a retarded son, 50 years of age. The sole means of support of this couple was social security and a pension, but they were $22 over the means test standard in Maryland for medical assistance for the aged; that is, the family's income is $157 a month. You are not eligible for medical assistance for the aged if the income for a couple is over $135 a month and $95 a month if you are a single individual. Thus, this couple could not be classified as medically indigent and eligible for medical assistance for the aged. This family has a family physician, whom they've had for years, and with whom there is a good patient-doctor relationship. They really didn't want to use a clinic, but they needed help. One of the two patients is a diabetic and the bills for the drugs were $10 a week alone. What they asked, then, was for us to assume the drug bill, but this we could not do. In addition, we could not accept these patients for comprehensive medical care in our clinic, that we operate for the aged, because these patients live out of our district. Our services in this clinic, which include making necessary home calls, do not extend to the entire city.

In our aging center, we now have 6 Sinai staff physicians working part time who give comprehensive care to 225 individuals. These patients are seen in our outpatient department for their office visits and necessary home calls are made when indicated. The patients receive needed ancillary services and care is directed to keeping these patients functioning in their home environment.

All these patients are medically indigent. They have had to pass a means test to be eligible for care. We are not treating private aged patients.

This is a brief description of our program in the comprehensive care clinic. In this we are bringing the concepts of group medical practice to the aging and blanketing them with total medical care. They receive the needed extra services such as nursing care in the home, occupational therapy, recreational therapy, when it is indicated. We have developed group counseling for some of these individuals. We bring selected depressed persons to the hospital and offer them group therapy. We have also used volunteers as friendly visitors who go out to withdrawn persons and give them occupational and recreational therapy to the home.

Of course, Sinai is a hospital and not a relief agency. We are trying to utilize the facilities that are available in the community and, again, I say, are not superseding other operating programs.

We have also developed an organized home care program which I will not elaborate upon more than to say that this is an extension of hospital services into the home. When a patient no longer requires the complex services of hospital care but still requires a galaxy of services, doctor's care, laboratory services, nursing services, and social services, we bring these services out to the home. This allows us to make more sensitive use of the hospital beds for the sicker patients and move patients into the home who no longer need to stay in the hospital bed but will profit by convalescent care in the home. Home care is also given to

patients with chronic illness and not limited only to those who are aged.

Senator, this is the program that we have developed in the 3 years and it seems to have had a considerable impact on our hospital, the community and on our city, as well. This is a demonstration program that we feel has proven itself.

We were fortunate. We would not have been able to initiate these services without a Public Health Service grant from the Division of Chronic Illness. But we would not have been able to develop the program if we had not found other moneys. We were fortunate, also, in receiving a grant from the Maryland State Health Department. They have given us support to enlarge our services for chronic illness. These moneys come to the State from the Federal Government. Finally, we would not have been able to develop some of the special services in this program unless we had support from private sources.

And this is the point that I wish to make at this time: that many of us in medicine know pretty well what the components are for a program for the aging. We know what should be done, but we will not be able to develop these services until we have the moneys for personal health services.

Personal health services are costly. We are trying to learn what these realistic costs are and we need money for a continued program to determine this.

While we have been fortunate at Sinai Hospital to find funds in Baltimore, most communities, I do not believe, would be this fortunate. What is necessary is a considerable expenditure of funds for such demonstration programs in many areas. While our demonstration in northwest Baltimore has some significance for the rest of Baltimore, money for demonstration programs will be necessary in Baltimore and certainly in other areas in Maryland.

I would like to urge that the committee consider financing long-term demonstration programs for personal health services of this type.

I could go on, Senator, but I would be glad to answer any questions.

Senator KENNEDY. I think that has given us really an insight into the hospital itself and the problems of the aging that it addresses itself to, and I feel that this will be extremely helpful to the members of the committee in their understanding of the greater needs of this bill as they apply to your own particular situation.

And I want to thank you very much, Doctor, for coming down and being with us today and telling us the story of the Sinai Hospital in Baltimore.

Mr. William C. Fitch.

We want to welcome you to this hearing.

STATEMENT OF WILLIAM C. FITCH, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION

Mr. FITCH. Thank you.

Senator KENNEDY. I see your statement here, Mr. Fitch. If you want to proceed in your own manner, we will put the statement in its entirety into the record, and if you want to summarize it in your own words, you are welcome to do that.

Mr. FITCH. Thank you. I will keep it brief, and I have other things that could be introduced in the record.

(Mr. Fitch's prepared statement follows:)

PREPARED STATEMENT OF WILLIAM C. FITCH

Mr. Chairman, my name is William C. Fitch. I am the executive director of the National Retired Teachers Association and the American Association of Retired Persons. These are two nonprofit, nonpartisan organizations of 700,000 older persons determined to help themselves and each other.

On behalf of our associations, I would like to commend the committee for scheduling this series of hearings and to express my appreciation for the opportunity to testify.

My presentation will be divided into three parts:

1. District of Columbia Council on Aging.
2. Pending legislation.
3. Role of voluntary organizations of mature adults.

DISTRICT OF COLUMBIA COUNCIL ON AGING

It is difficult to understand why action has been so long delayed in the Nation's Capitol, where of all places, a positive, practical example could and should be set for the States and progressive communities.

My firsthand knowledge and experience with the District of Columbia program began almost immediately upon assuming my present position in October of 1959. Because of my activities as director of the Special Staff on Aging in the Department of Health, Education, and Welfare and my responsibilities for staffing and planning for the White House Conference on Aging, I was asked to serve as the chairman of the Conference Committee for the District of Columbia pre-White House Conference on Aging.

A 43-page report of recommendations from the District of Columbia Conference compiled in September 1960 included a strong proposal for "an enlarged and strengthened Council on Aging."

A petition was also sent from the Conference to the Board of Commissioners of the District "to take whatever steps are necessary to establish a permanent Commission or Council on Aging on a firm legal basis with adequate financial support."

Our association sent a telegram to the Commissioners on October 4, 1960, in support of a permanent Council as did other interested organizations.

The telegram was acknowledged by the President of the Board of Commissioners who added, "The Commissioners are very sympathetic to this need and you may be certain it will be given careful consideration."

This "careful consideration" resulted in a denial of $16,000 requested to provide for staff for a Council and a statement that there were no "tangible results" from the advisory group.

Accepting this challenge, a list of 22 activities of the Council was prepared to document the accomplishments of the group, but funds were not forthcoming.

A flurry of interest has been shown from time to time, but not until Commissioner Duncan asked a small informal advisory group to prepare a background paper for action, did any real interest develop.

I served as the chairman of a group of six persons to appraise the situation objectively and to recommend a program of action.

On February 12, 1963, a report was submitted to Commissioner Duncan. The report was prepared in four sections:

1. General Background on Aging in the District.
2. Resources and Needs for the District.
3. Recommendation for a Council on Aging.
4. Action Program for the Council.

A copy of the report is attached to this statement.

A formal presentation of the report was made to the Commissioners who "agreed to take the matter under advisement."

I was then asked to repeat the presentation to the Citizen's Advisory Committee. At this meeting the members responded favorably and a committee was appointed to study the matter further.

It is interesting to note this statement in the special message of President Kennedy on the "Needs of Older People."

"Finally, the District of Columbia should make every effort to take full advantage of Federal legislation aiding senior citizens. There is no reason why the District of Columbia should not be a leader and a model in its community senior citizen program." The Special Staff on Aging in HEW offered to assist in the formation of a council. Dr. Kent, the director, pointed out that 45 other States and 839 cities had similar organizations.

Congressman Fogarty, chairman of the House Appropriations Subcommittee was critical in commenting on the cooperation of the Commissioners saying "the District was lagging on care for the aging."

More recently there have been encouraging indications that the Citizens Advisory Committee favored the Council on Aging as originally presented to the Commissioners. Ways are being considered to implement the report.

I am encouraged, but also deeply aware of 4 wasted years that might well have witnessed the solution of many of the problems confronting the older citizens of the District—which indirectly affect us all.

PENDING LEGISLATION ON AGING

The Older Americans Act introduced jointly by Senator McNamara, and Congressman Fogarty offers great promise of assistance in the development of new or improved programs to help older persons through grants for community planning and services for training, through research or training project grants.

The bill would also establish within HEW an operating agency to be designated as the "Administration for Aging." This agency would separate the programs on aging out of the welfare setting in which they are presently considered.

It is urgent that, as we are asked to "pursue poverty wherever it exists," we must distinguish between the elderly who are independent and self-sufficient and those who are in need of public welfare.

The Older Americans Act makes possible a balanced program in aging to enable our older people to secure equal opportunity, to the full and free enjoyment of income, health, housing, employment, and the pursuit of meaningful activity.

Grants would be authorized for projects for community planning and coordination of programs, demonstrations of programs, training personnel, and the establishment of new or expansion of existing programs.

The hearings on this bill completed last year indicated almost unanimous support by all except those with vested interests in the administration of aging under a welfare concept. There is widespread hope that positive action on the bill can take place in the early days of the 1964 session of Congress.

It would be helpful if the District could be in a position to take advantage of the grant programs and allocation of funds possible under the provisions of this legislation.

ROLE OF A NATIONAL VOLUNTARY ORGANIZATION OF MATURE ADULTS

It is not possible or would it be desirable to separate the responsibility of the Federal, State, and community services from the role of older persons themselves. Each has a vital part to play and the need for a coordinated approach is the challenge to every force working in the best interest of older persons.

We have taken our responsibility as the representative of our 700,000 members very seriously. At the national level we have established programs to assist in stretching fixed retirement income. Ours was the first organization to make health insurance available after 65, we have filled over 1 million prescriptions for our members as part of our nonprofit drug service and have been a major factor in reducing drug prices for many other older persons at the community level. Our members can get quality brand hearing aids at a considerable savings and even foreign travel at rates that make exciting new horizons possible.

We have hospitality centers in St. Petersburg, Fla., Long Beach, Calif., and here in Washington, D.C. These serve the needs of our members and other older persons in search of friendly associations, advice in living arrangemnts, health facilities, recreational outlets and employment opportunities.

Another community service that has had its beginning in Washington, D.C., is our "Institute of Lifetime Learning" and the "Every Wednesday Morning Lecture" series. These are entertaining, educational, and inspirational programs designed to keep the older person informed and stimulated and to give a new

dimension to adult education that more nearly meets the needs of the mature adults who have a continuing interest in the world around them and who want to be able to accept their rightful places as responsible, informed citizens.

Our associations have been attempting to replace the outdated image of old age as a period of rejection and waiting, with a more accurate representation we call dynamic maturity.

To the extent that we can help to project this new image as widely as possible, we have our own pavilion under construction for the New York World's Fair in 1964–65 which we have named dynamic maturity. It is a tribute to the achievements of age and the prospect of making the later years a period of creative maturity with faith in the future, confidence in self, concern for others, and participation in service.

Perhaps the most positive note as we plan for 1964, is the delayed recognition of the full potential of the aging, and the extent to which they can be recruited in the service of their communities and the Nation.

On behalf of our associations, I pledge to your committee the support of our members in implementing the findings of your committee and in the creation of programs that will place the needs of older Americans in proper perspective to make the later years truly a period of reward and achievement.

Mr. FITCH. I was asked, before coming here, to give background on the District of Columbia activities for the Commission and Council on Aging, and so I would like to comment on that first, and then, very briefly, comment on the legislation and the role of our own association.

I am well aware of the time and the number to follow me, so I will try to keep within the time limit.

My name is William C. Fitch, I am the executive director of the National Retired Teachers Association and the American Association of Retired Persons. These are two nonprofit, nonpartisan organizations of 700,000 older persons determined to help themselves and each other.

On behalf of our associations, I would like to commend the committee for scheduling this series of hearings, and to express my appreciation for the opportunity to testify.

As I said, I will present my testimony in three parts, one on the District of Columbia Council on Aging, the pending legislation, and the role of a voluntary organization of mature adults.

On the District of Columbia Council on Aging, it is difficult to understand why action has been so long delayed in the Nation's Capital, where of all places the positive, practical example could and should have been set for the States and progressive communities.

My firsthand knowledge and experience with the District of Columbia program began almost immediately upon assuming my present position, in October of 1959. Because of my activities as Director of the Special Staff on Aging in the Department of Health, Education, and Welfare, and my responsibilities for staffing and planning for the White House Conference on Aging, I was asked to serve as the chairman of a conference committee for the District of Columbia pre-White House Conference on Aging.

A 43-page report of recommendations from the District of Columbia Conference compiled in September of 1960 included a strong proposal for an enlarged and strengthened Council on Aging. A petition was sent from the Conference to the Board of Commissioners of the District to take whatever steps are necessary to establish a permanent Commission or Council on Aging on a firm, legal basis, with adequate financial support.

Our association sent a telegram to the Commissioners on October 4, 1960, in support of a permanent Council, as did other interested organizations.

The telegram was acknowledged by the president of the Board of Commissioners, who said:

The Commissioners are very sympathetic to this need, and you may be certain it will be given careful consideration.

This careful consideration resulted in a denial of $16,000 requested to provide the staff for the Council, and the statement that there were no tangible results from the advisory group.

Accepting that challenge, a list of 22 activities of the Council was prepared to document the accomplishments of the group, but funds were not forthcoming.

A flurry of interest has been shown from time to time, but not until Commissioner Duncan asked a small, informal advisory group to prepare a background paper for action did any real interest develop.

I served as the chairman of a group of six persons to appraise the situation objectively and to recommend a program of action.

On February 12, 1963, a report was submitted to the Commissioner, and the report was prepared in four sections: The general background of aging in the District, the resources and needs of the District, recommendations for a Council on Aging, and an action program for the Council.

I think a copy of the report is either attached to the original, Mr. Chairman, or is on its way.

A formal presentation of the report was made to the Commissioners, who agreed to take the matter under advisement. I was then asked to repeat the presentation to the Citizens Advisory Committee. At this meeting the members responded favorably, and a commitee was appointed to study the matter further.

It is interesting to note this statement in the special message of President Kennedy on the "Needs of Older People."

Finally, the District of Columbia should make every effort to take full advantage of Federal legislation aiding senior citizens. There is no reason why the District of Columbia should not be a leader and a model in its community senior citizen program.

The Special Staff on Aging in HEW offered to assist in the formation of a council. Dr. Kent, the Director, pointed out that 45 other States and 839 cities had similar organizations.

I am disturbed as I think you will be that the figures 1 year later, as Dr. Winston has given them, show that many of these have passed out. Only 34 States now have them in about 700 communities.

Congressman Fogarty, chairman of the House Appropriations Subcommittee, was critical in commenting on the cooperation of the Commissioners, saying:

The District was lagging on care for the aging.

More recently there have been encouraging indications that the Citizens Advisory Committee favored the Council on Aging as originally presented to the Commissioners. Ways are being considered to implement the report.

I am encouraged, but also deeply aware of 4 wasted years that might well have witnessed the solution of many of the problems confronting the older citizens of the District—which indirectly affect us all.

PENDING LEGISLATION ON AGING

The Older Americans Act introduced jointly by Senator McNamara and Congressman Fogarty offers great promise of assistances in the development of new or improved programs to help older persons through grants for community planning and services for training, through research or training project grants.

The bill would also establish within HEW an operating agency to be designated as the "Administration for Aging." This agency would separate the programs on aging out of the welfare setting in which they are presently considered.

It is urgent that, as we are asked to "pursue poverty wherever it exists," we must distinguish between the elderly who are independent and self-sufficient and those who are in need of public welfare.

The Older Americans Act makes possible a balanced program in aging to enable our older people to secure equal opportunity, to the full and free enjoyment of income, health, housing, employment, and the pursuit of meaningful activity.

Grants would be authorized for projects for community planning and coordination of programs, demonstrations of programs, training personnel, and the establishment of new or expansion of existing programs.

The hearings on this bill completed last year indicated almost unanimous support by all except those with vested interests in the administration of aging under a welfare concept. There is widespread hope that positive action on the bill can take place in the early days of the 1964 session of Congress.

I think it would be helpful if the District could be in a position to take advantage of the grant programs and allocation of funds possible under the provisions of this legislation.

ROLE OF A NATIONAL VOLUNTARY ORGANIZATION OF MATURE ADULTS

It is not possible or would it be desirable to separate the responsibility of the Federal, State, and community services from the role of older persons themselves. Each has a vital part to play, and the need for a coordinated approach is the challenge to every force working in the best interest of older persons themselves.

We have taken our responsibility as the representative of our 700,000 members very seriously. At the national level we have established programs to assist in stretching fixed retirement income.

Ours was the first organization to make health insurance available after 65. We have filled over 1 million prescriptions for our members as part of our nonprofit drug service, and have been a major factor in reducing drug prices for many other older persons at the community level. Our members can get quality-brand hearings aids at a considerable savings, and even foreign travel at rates that make exciting new horizons possible.

We have hospitality centers in St. Petersburg, Fla., Long Beach, Calif., and here in Washington, D.C. These serve the needs of our members and other older persons in search of friendly associations, advice in living arrangements, health facilities, recreational outlets, and employment opportunities.

Another community service that has had its beginning in Washington, D.C., is our Institute of Lifetime Learning, and the Every Wednesday Morning Lecture series. These are entertaining, educational, and inspirational programs designed to keep the older person informed and stimulated, and to give a new dimension to adult education that more nearly meets the needs of the mature adults who have a continuing interest in the world around them and who want to be able to accept their rightful places as responsible, informed citizens.

Our associations have been attempting to replace the outdated image of old age as a period of rejection and waiting, with a more accurate representation we call dynamic maturity.

To the extent that we can help to project this new image as widely as possible, we have our own pavilion under construction for the New York World's Fair in 1964–65, which we have named "Dynamic Maturity." It is a tribute to the achievements of age and the prospect of making the later years a period of creative maturity with "faith in the future, confidence in self, concern for others, and participation in service."

Perhaps the most positive note as we plan for 1964 is the delayed recognition of the full potential of the aging, and the extent to which they can be recruited in the service of their communities and the Nation.

On behalf of our associations, I pledge to your committee the support of our members in implementing the findings of your committee and in the creation of programs that will place the needs of older Americans in proper perspective to make the later years truly a period of reward and achievement.

Thank you.

Senator KENNEDY. Mr. Fitch, I want to thank you for your comments on the Council on the Aging, and this pending legislation, as well as the voluntary organizations which play such an important role.

Mr. Fitch, if you would, very briefly, will you address yourself to the question about setting up an Administrator within the HEW, and about your own experience with the needs of senior citzens in this field, why you feel that there should be such an Administrator, if there should be?

Mr. FITCH. I feel very strong, personally, because I spent 3 or 4 years in the Department as the Director of the Special Staff on Aging, and was quite disappointed, frankly, when the Department was reorganized, and placed the Staff on Aging under the Welfare Commissioner. The staff was really at the point of being recognized as an important part of the Secretary's Office. The problems of aging were beginning to get recognition across the board.

As Mrs. Schweinhaut has said, all of us respect Dr. Winston for the fine job she has done, but the people that we serve, and others in this age category, resent having their interests and problems considered as part of a welfare setting.

In spite of the fact that there is the possibility of a broader definition of welfare, to most people welfare means public assistance. In order to have the programs of aging put in proper perspective, we felt that the Older Americans Act did this by establishing a commission for aging in which the broad range of problems that we now recognize, and which were identified through the White House Conference on Aging, could be given more consideration at the positive level than it would be within the framework of a welfare program.

Senator KENNEDY. Very good.

Thank you very much.

Senator KENNEDY. Mrs. Gladys Kraft.

We are delighted to have you with us this morning.

STATEMENT OF MRS. GLADYS KRAFT, GOLDEN AGE WORKER, THE JEWISH COMMUNITY CENTER, WASHINGTON, D.C.

Mrs. KRAFT. Mr. Chairman, I want to thank you on behalf of the members of the center and myself for your invitation to me to appear in this hearing.

Senator KENNEDY. Mrs. Kraft, we will print your prepared statement in the record completely. I was wondering if you would like to proceed in your own way, and possibly summarize this, to the benefit of the committee. We will introduce your testimony in its entirety.

Mrs. KRAFT. Thank you, Senator.

What I would like to do, then, is just excerpt parts of the statement, which I think will summarize it.

Senator KENNEDY. Fine.

Mrs. KRAFT. The golden age program, which is sponsored jointly by the Jewish Community Center of Greater Washington and the District of Columbia section of the National Council of Jewish Women, is held at the center's building on 16th and Q Streets, Northwest, and is now in its 13th year.

The objectives of the golden age program, which were outlined by the sponsoring organizations, essentially are to provide a program for older men and women that will help them to live happily, converting their abundant leisure time into constructive and satisfying activities. So we set up a program based on the interests and needs of older people, which aims to combat loneliness—and I will not go through all of these things, but I think that it is essential simply to highlight—helping people to do things for themselves, helping them to make maximum use of their capacities, giving them opportunities for creative expression, opportunities to participate both in the life of the Jewish community and in the overall community, and to find ways in which they may be of service, as well as simply having them receive service.

The people that we serve are from under 60 to over 90 years of age. During the past year we had approximately 400 different people coming and about 200 who attend regularly each week.

We serve both Jewish and non-Jewish members of the community, and the people who come to the program come from all over the Greater Washington area, many traveling for a good hour to an hour and a half, taking two and three buses, in order to be at the program.

Most of the people live alone. They live on limited retirement incomes.

I think it is obvious, though, that if they can get to the program, they are fairly active and able, and not ready to be consigned to the rocking chair.

The program is open 2 days a week, Tuesdays and Thursdays, regularly scheduled from 10:30 a.m. until about 3:30 p.m., but we have people who arrive as early as 9 in the morning and stay throughout the entire day, visiting in the lounge.

We are open 52 weeks a year, though during the summer months we do have more modified activities, essentially because our building is not air conditioned, and we do not have proper outdoor facilities.

Our weekly schedule essentially provides for a program of small group activities, and on Tuesdays it focuses on small group activities, which we have found to be the most appealing and the most meaningful.

We also on Thursdays have a large meeting and lunch on both of these days, so that it is a full day of activity for the people who come.

The programs also include special holiday events, birthday celebrations, outings, and that sort of thing.

We have a golden age board elected by the members, which, under the guidance of our worker, helps to plan the programs, to hear the comments and suggestions of the members, and see if they can put them to work, and it also administers a cheer fund which is made up of special contributions from the members, so that people, when they get sick and are in the hospital, will know that someone is going to remember them and write to them and perhaps send them some flowers.

Through the board, we have many committees, where members take responsibility for a great deal of the work of the club—almost as many committees, I think, as the Senate.

The members of the committees, of the various committees, know that their jobs are important, and they take them very seriously. And I would just like to give you one little illustration, here, of a gentleman who helps come set the tables.

He is on a serving committee, and he arrived last Tuesday morning at 10 o'clock. He is usually there at 9. And you will recall the snowstorm last Tuesday. He came in, trudging through the snow, and I looked at him and wondered what he was doing there, because we really expected very few people. But he came and said that he knew there were going to be some people there, and if they were there, tables needed to be set, and luncheon needed to be prepared. And he was right. We did have about 15 people who came in, in spite of the very bad weather.

In the program we have put special emphasis on our small interest group. Each member can know that he belongs, and his help is needed, and he has a say in planning the program, and that he will be missed if he does not come.

The number of members in these small groups ranges from about 10 to 25, depending upon the activity. They are under the guidance of staff specialists who are skilled not only in the activity but in working with older people in adapting the program to the individual needs of each person, helping each person to find a place.

The relationship of the member to this group leader often assumes great importance, because the leader is frequently the only sensitive

and understanding ear available to the member. At present, we have seven special interest groups that meet each week. Members may participate in as many as their interests and energies may permit.

Most choose one or two of these groups, but there are a core of members who are in as many as time permits them to be in. And we also have many, or at least a few, who like mainly to be spectators.

I will not go into, but I think you might find interesting, the material on what each of the groups does. But I would like to just list the groups.

We have an arts group, a dramatics group, a keep-trim club, which is a relatively new activity among senior citizens, where we have 15 minutes of calisthenics, which start out first seated in the chair, and then standing behind the chair and holding on to it, followed by shuffleboard, modified bowling, games of toss ball, and so forth.

I would like to tell you just one little incident about our discussion group. We have among our members many who came to the United States many years ago to escape tyrannical governments and persecution, and then devoted their productive years to earning a living and raising a family. They reached their later years with little understanding of how a citizen can influence his government in a democracy.

Therefore, when the discussion group was organized, it provided members with a forum for sharing their daily concerns and frustrations. As months passed, however, more and more time was devoted to the problems of how on a retirement income do we pay for food, drugs, and medical care as prices were rising.

The suggestion was made that they forward their thoughts to the then Senate Committee on Aging, but they felt this was not a very important idea, and they were rather indifferent to it. Why would Congress want to hear from them?

After a few weeks of discussion, however, a letter finally was forwarded to the McNamara committee. In response to that letter, two members of the group were invited to testify at the hearings before the committee.

Though as I say here, it was a turning point in the life of the group, I cannot begin to tell you the great meaning that this had for this particular group of people, that a U.S. Senator would be interested in hearing what they had to say. It really was a turning point, and was a wonderful experience for the group to know that somebody was interested, really interested, in what they had to say, and they now knew, as a group, that they could play a vital role in helping to shape legislation that would affect their daily lives.

Also as part of the program, our members have been able to participate in other activities in the community as these have been available, and they have taken a very active role in the whole question of working toward health care legislation.

We have also attended, 30 members have attended, a broader senior citizens conference in Atlantic City, which was a very exciting experience for the group, and a very meaningful one.

Since members feel very comfortable and at home at the center, they come to us with many problems that cannot be handled within the scope of our program and staff skills. The Jewish Social Service Agency, which offers special casework services for older adults, has

been most helpful in working with some of these referrals, as well as in directing to the center those whom they feel could benefit from the group program.

But there has been throughout the community, beyond this, a very limited amount of service available to our older adults for many of their very pressing needs.

We feel that in conducting the type of program that we have, which has been of such great benefit to each person who comes, one of the key items is the question of staff.

The staff at this program consists of a golden age worker, part time, and the specialists who serve as group leaders.

Much time at this point is spent in training staff right on the job, because there are very few people who are really qualified to do the job.

In addition, we have volunteers who help out from the Council of Jewish Women, but here we have a problem that volunteers, the work volunteers do, is work really that the golden agers themselves can do, and so we are now running an employment service for our volunteers to see if we can find other activities for them.

The program as it is set up now, by both sponsoring organizations, is financed by some money from members, and some from the Council of Jewish Women, and from the community center.

I have been asked to comment on the assistance that we may have had from the Federal and District Governments.

Essentially, the help that we have asked for has been in the form of speakers and material, and where we have asked for this we have been most cordially helped and given assistance, and we are grateful for it, but needless to say, there is very little that we can turn to within the District government.

We have had some experience in the past year and a half in setting up or in working with a program in Montgomery County. And in this new program, we have come up against a stone wall in relation to many problems—inadequate transportation, inadequate facilities, very little staff, and these are things that really, if programs are to be expanded and developed in new areas—these are problems that must be met with immediately.

We have also received requests from various synagogues for help in training their staff and in giving them program ideas and so forth, and we have been unable to be of any assistance, there, because of lack of staff time and funds.

The center's current program, we feel, has demonstrated the need for and the validity of this type of service. However, we are constantly reminded by the participants in the program and by others who simply do not have the means to get to us that the program must be expanded, and ways must be found to make it possible for them to come.

In order to serve older people more fully, older people who, by the way, have little time to wait, we at the center feel that we have got to expand our present program to 5 days a week. We have to provide special training for our staff to work with older adults. We have to improve and enlarge facilities, so that they are better suited to meet the needs of the older adults.

We must arrange for less expensive and more adequate transportation. We need to develop new kinds of facilities away from the

heat of the city. And we also need to study and develop programs for the coming generation of older adults, who have been born, educated in this country, and for whom our present programs may not be suitable.

In the light of these immediate needs, and with the knowledge that the local voluntary dollar will continue to be highly inadequate, agencies such as the center must look to the Government sources for assistance.

We therefore would like to lend our full support to the provisions in the proposed legislation whereby the Federal Government would provide funds to local communities and to nonprofit private agencies to support further development of these urgently needed programs.

Senator KENNEDY. Mrs. Kraft, just one question. You said you have about 400 taking part in the program, 200 regularly. How many could you take? What is the capacity?

Mrs. KRAFT. With our 2-day-a-week program, I do not know how many additional we could take. A lot would depend upon the actual facilities and staff.

We have a very large building at the center, which is used essentially by golden agers during the day. And to that degree, we certainly, if we now operate 2 days a week, could operate 5 days a week by multiplying that by what—adding 3 extra days on, using exactly the same facilities, but with more staff.

In addition to that, however, if we could convert some of our facilities to the use of the members—and by this I mean that all of our rooms are multipurpose rooms, so to speak, and if we are able to set up the kinds of facilities where we have decent storage space that people can get to, where they do not have to wait for someone to bring things, because they are up on the fourth floor and have to be brought down for the handicraft group and so forth—so this would make a big difference in our actual capacity for serving people.

I do not know how many more we could serve at the center, but we surely could serve a great many more.

The other problem is that even if we had these facilities, there are many people who could not afford to come even twice a week.

We had one woman who said she would love to come to the dramatics group, but it is more important for her to come to the choral and discussion groups, and since she cannot afford the $1.25 it costs her round trip to take the two buses, she just has to make a choice.

These are the kinds of things that are very disturbing, when you realize that you have something to offer, and that people really do want it, and not only want it but need it.

We have one other instance of a woman who came in with a prescription that she had one day. She said she spent $20 every week on this particular prescription. She could barely afford it. And she decided that it was more important for her to spend the carfare to come down to the program. She said this was better medicine than anything else.

Well, maybe the prescription really was not needed, then. But when you find people making these kinds of choices, it becomes a rather distressing problem.

So that we feel we have the knowledge, we have the ability to deal with this problem, but we do need the extra help.

Senator KENNEDY. Thank you very much.

(Mrs. Kraft's prepared statement follows:)

PREPARED STATEMENT OF MRS. GLADYS KRAFT, GOLDEN AGE WORKER, JEWISH COMMUNITY CENTER OF GREATER WASHINGTON

Mr. Chairman, my name is Mrs. Gladys Kraft; I am the golden age worker on the staff of the Jewish Community Center of Greater Washington. I want to thank you on behalf of the center, the members, and myself for your invitation to appear at this hearing. I am pleased to be able to report to you on the golden age program, a senior activity center program here in the District of Columbia, and to indicate some ways in which the Federal and District governments might be helpful in carrying out the work of this center.

The golden age program, which is sponsored jointly by the Jewish Community Center of Greater Washington and the District of Columbia section of the National Council of Jewish Women, is held at the center's building on 16th and Q Streets NW., and is now in its 13th year.

The objectives of the golden age program, which were outlined by the sponsoring organizations, essentially are to provide a program for older men and women that will help them to live happily, converting their abundant leisure time into constructive and satisfying activities. So we set up a program based on the interests and needs of older people which aims—

(1) To combat the loneliness of older people by providing increased opportunities to meet new friends and enjoy each other's company—opportunities for fun and relaxation;

(2) To help members to do things for themselves and for others, thereby reinforcing their feelings of self-respect and usefulness;

(3) To help members to make maximum use of their capacities, while accepting the limits set by their age;

(4) To stimulate members to renew old skills and hobbies and to learn new ones, gaining the satisfaction that comes from creative activity;

(5) To provide opportunities to appreciate and participate in Jewish cultural life;

(6) To encourage appreciation of the American heritage and to have opportunities for experience in democratic living; and

(7) To provide opportunities for members to use their skills and energies in volunteer service in the community.

The above are the objectives outlined by the sponsoring organizations.

WHOM DO WE SERVE?

During the past year, approximately 400 different people have taken part in this semiweekly program, with close to 200 attending regularly. These members range in age from under 60 to over 90 years, with the bulk of the membership between the ages of 65 and 75. Most of the members are Jewish, and we have been pleased to find that non-Jewish older adults feel comfortable and participate actively in the program. About 20 percent of the members are men. Although there are some married couples, most of the members are widows or widowers and have lost other lifelong friends in recent years. Members live in many sections of the Greater Washington area. While many have spent all of their adult lives in this city, there are a large number who have left their home communities and moved to Washington to be near their children. There is a wide range of vocational and educational experience among the members. The greatest number have been either housewives, shopkeepers, or salesmen, with their education having stopped at the elementary or high school level. While more than half of the members live alone, some are in the homes of their children as part of a three-generation household. Although none is completely free of physical ills, they may be described generally as active and able.

Most are living on limited retirement moneys consisting of minimum social security benefits, in some cases supplemented by savings and/or pensions.

THE PROGRAM

The golden age program is open 2 days a week—Tuesdays and Thursdays—with regularly scheduled activities from 10:30 a.m. to 3:30 p.m. The program includes an informal lounge, a large assembly meeting, and small group activities. The lounge is open from 9 a.m., and some members come early and spend the entire day. In addition, there are various special events such as holiday celebrations, special outings and trips, and occasional meetings with other senior groups.

The program is open 52 weeks a year, with a somewhat modified program during the summer months since our facilities are not air conditioned.

THE WEEKLY SCHEDULE

On Tuesdays, the handcrafts group meets in the morning, while a few members help to prepare the light lunch which is served at 12:30. Due to the fact that they live and usually eat alone, often inadequately, eating together is an extremely important part of the program. In the afternoon, members renew long-forgotten skills or develop new ones by singing with the choral group and then joining the discussion group or spending the entire afternoon in the art class. New friends are made by visiting and relaxing in the lounge. About 60 people come each week to participate in some part of the Tuesday program.

On Thursday mornings, the dance group meets. A trained instructor modifies the dances to the abilities of the members. This is the time, too, for occasional committee and board meetings. At lunchtime, there is a large meeting of the Golden Age Club with an average attendance of 160. Programs for these meetings include committee reports, birthday celebrations, holiday programs, entertainment by members, and an occasional guest performer or speaker. These meetings are kept to 1 hour in length, including lunch, so that there is time for members to take part in whatever activity interests them for the afternoon—the Keep Trim Club, dramatics group, card games, or bingo.

THE GOLDEN AGE BOARD

The golden age board of 14 members is elected by the club membership to serve on a rotating basis. The board meets monthly, under the guidance of the golden age worker, to plan the club meetings and special events and to hear the comments, complaints, and suggestions of the members. It also administers the cheer fund, which is made up of special contributions from the members and is used to bring cheer to those who are ill.

COMMITTEES

Through board committees, the members take responsibility for much of the work of the club. The hostess committee welcomes new members; the serving committee sets the tables and helps to serve lunch; the cheer committee keeps in touch with members who are ill, sending a gift to those who are hospitalized, and visiting those who are confined to home; a community service committee handles requests for special clerical jobs for community agencies that can be done at the center; a newsletter committee puts out an occasional newsletter; the bulletin board chairman helps to keep items of interest posted; and the membership committee helps to register members and also writes to each member during his birthday month. These work committees usually have just a few members, and appointment to them is often a highly coveted assignment. The members know that these jobs are important and that others are depending on them, and they are able to carry out their responsibilities accordingly. (One illustration of this: on the serving committee is a gentleman who is a former restaurateur. He usually arrives early and has all of the tables set before the rest of the committee arrives. All of you remember last Tuesday's snowstorm; he arrived an hour later than usual because of bad traveling conditions. He said that he had come because he was sure others would come out, too, in spite of the bad weather, and he would be needed to help with the lunch. He was right.)

SPECIAL INTEREST GROUPS

In developing the program, we have placed emphasis on the small, special interest groups where each member knows that he belongs, that his help is needed, that he has a say in planning and carrying out the program of the group, and that he will be missed if he doesn't come. The number of members in these groups ranges from 10 to about 25, depending on the activity. They are under the guidance of staff specialists who are skilled not only in the activity but in working with older people, in adapting the program to the individual needs of older people, and in helping each person to find a place in the group. The relationship of the member to the group leader often assumes special importance, because the group leader often offers the only sensitive, understanding ear available to the members.

At present, there are seven special interest groups meeting each week. Members may participate in as many of these as their interests and energies will permit. Most members choose one or two of these groups, but there is a core of members who are in as many groups as the schedule allows. There are also a few members whose participation is limited to "spectating"; for some this represents meaningful activity.

In the crafts group, members work on a variety of projects—sewing, weaving, jewelry making, to name a few. One of the men, a former house painter, was not interested in any of this, but he was challenged by the complex work involved in designing and making a mosaic tile plaque. Last month, two of these handsome plaques were mounted in the lobby of the community center at a special ceremony attended by all of the members. These represented the work of two members over a period of several months. Our member now has a new skill which he is sharing with others, and a great sense of achievement.

The choral group had a rather heated discusion at one meeting, because one member felt that the group was working too hard and that the leader was expecting too much of them. The other members said that it was because of this hard work that the group could sing so well and was invited to sing for other groups in the community. It was agreed, however, that some portion of each meeting be set aside for "singing for fun," making it possible to maintain the high standards and still finding time for the group to relax together.

In the dance group, the music is slowed down a bit, and the folk dances are modified to the abilities of the members. The program alternates a waltz or fox trot with a folk dance, and the members enter into each with energy and enthusiasm. In addition to the number of skilled dancers, our leader was equally surprised to discover that there were two members present who had never danced before.

In the art class, we have found that beginners and experienced artists can work side by side, each with opportunities to discover new forms of creative expression with paint and canvas. The members are so pleased with their work that a public showing is being planned for the spring.

The dramatics group has prepared skits for the entertainment of the entire membership. Working along with the leader, the group has had to develop new material, particularly in pantomime, to conform with the limitations imposed by weak voices and to provide parts, even for the bit players. Performances by the members are satisfying not only to the performers, but are eagerly anticipated by the audience.

The Keep Trim Club, just 1 year ago, was greeted with skepticism, but now has many active members. The session starts with 15 minutes of calisthenics—with members seated in a chair or holding on to it—followed by shuffleboard, modified bowling, and games of toss ball.

A discusion group has had a most interesting time during the past few years. Many of the members of our group came to the United States to escape tyrannical governments and persecution and then devoted their productive years to earning a living and raising a family. They reached their later years with little understanding of how the citizen can influence his government in a democracy. Therefore, when the discussion group was organized, it provided members with a forum for sharing their daily concerns and frustrations. As months passed, more and more time was devoted to the problems of paying for food, drugs, and medical care. The suggestion that they forward their thoughts to the then Senate Subcommittee on Aging met with indifference. Why would Congress want to hear from them?

After a few more weeks of discussion, a letter was forwarded to the McNamara committee. In response to that letter, two members of the group were invited to testify at hearings before the committee. It was the turning point in the life of the group. The members now understood that as a group they could play a vital role in shaping legislation that affects their daily lives.

PARTICIPATION IN THE COMMUNITY

As an outgrowth of these activities, members have had additional opportunity to take part in some citywide programs such as the annual spring festival at the Guy Mason Center and the citywide hobby show conducted by the District of Columbia Recreation Department. The interest of the members in the health care legislation led to meetings with other senior groups in the city, to exchange ideas and to plan and carry out some specific action programs.

Last spring, 30 members attended a 3-day Senior Citizens Conference in Atlantic City, under the leadership of the National Jewish Welfare Board. The great interest and enthusiasm that developed from these contacts with older adults from other communities pointed up the possibilities and the need for much more of this kind of program.

OTHER COMMUNITY SERVICES

Since members feel very comfortable and at home at the center, they come to us with many problems that cannot be handled within the scope of our program and staff skills. The Jewish Social Service Agency, which offers special casework services for older adults, has been most helpful in working with some of these referrals as well as in directing to the center those whom they feel could benefit from the group program.

STAFF

The staff for the golden age program consists of the golden age worker (on a part-time basis) and specialists who serve as group leaders under the supervision of the golden age worker.

Our experience has shown that skilled staff is crucial to the achievement of the objectives indicated above. Much time is now spent in training staff on the job. Thus we are simultaneously developing our staff and the program.

VOLUNTEERS

Volunteers from the Council of Jewish Women assist with refreshments, help to plan menus and to prepare and serve the lunches. One volunteer assists in the handcrafts group, and another serves as a resource for special guest performers. Many of the volunteers have been coming regularly each week, since the beginning of the program 13 years ago. As the program develops and the members take on additional responsibility for some of these services, we need to look for new ways to use our volunteers.

ADMINISTRATION AND FINANCING

The program is administered by a joint committee of the sponsoring organizations. It is financed with money from three sources:

(1) The members pay an annual membership fee of $3 to the Jewish Community Center. In addition, each member contributes up to 25 cents when the box is passed around at lunch time and purchases tickets for special outings.

(2) The District of Columbia section, National Council of Jewish Women makes an annual contribution to the program.

(3) The Jewish Community Center, which receives its funds from membership dues and the United Givers Fund, appropriates funds for the program.

ASSISTANCE FROM THE FEDERAL AND DISTRICT GOVERNMENTS

The agencies that we have approached for assistance in our program have been most helpful in providing speakers and material for our use. These have been the local Social Security Office, the Housing and Home Finance Agency, and the Special Staff on Aging in the Department of Health, Education, and Welfare. We were particularly pleased that the Special Staff on Aging was able to provide one of its staff to serve as a consultant for our group in a workshop

at the Atlantic City conference. We also had the benefit of a visit and consultation with another member of their staff.

The willingness of these agencies to give staff time to our program has had a twofold benefit—first, they have been able to provide expert information and guidance; and second, their participation in program indicates to the members the human concern and interest of our Government.

MONTGOMERY COUNTY GOLDEN AGE LOUNGE

I believe it would be of interest to this committee to know that, in addition to the golden age program in downtown Washington, we have also been working during the past 18 months to develop a golden age lounge program in Montgomery County. After working on its own for 4 years, the Montgomery County section, National Council of Jewish Women asked the center for professional help with this program. Both organizations now cosponsor the weekly program, and a member of the JCC staff is in charge. In this program, the problems of inadequate financing, facilities, staff and transportation are highlighted.

In developing new programs in the suburbs, assistance in each of these areas is needed.

We have also received several requests from synagogues who have turned to the Jewish Community Center for help in developing programs for their senior members, providing a clearinghouse of program ideas and in training staff. We have not had the staff, time, or funds to meet these requests.

CURRENT PROGRAM NEEDS

The center's current program has demonstrated the need for and validity of this type of service. However, we are constantly reminded by the participants in the program and by others whom we are unable to serve that the program must be expanded. In order to serve fully the older people who have little time to wait, we at the center must—

(1) Expand the present program to 5 days a week.

(2) Provide special training for staff who are to work with older adults.

(3) Improve and enlarge the facilities so that they are better suited to the special needs of an older adult program.

(4) Arrange for less expensive and more adequate transportation to the program.

(5) Develop a new summer program with appropriate facilities away from the heat of the downtown area—in a day camp or overnight camp.

(6) Study and develop programs for the coming generation of older adults, born and educated in this country, for whom our present programs may not be suitable.

In the light of these immediate needs and with the knowledge that the local voluntary dollar will continue to be inadequate, agencies such as the center must look to Government sources for assistance.

We, therefore, lend our full support to the provisions in the proposed legislation whereby the Federal Government would provide grants to the local communities and nonprofit private agencies to support the further development of these urgently needed programs.

Senator KENNEDY. The next witness is Mrs. Virginia Maxwell, president of the Friendly Visiting Volunteer Council of Maryland.

Mrs. Maxwell, we will put your whole statement into the record, and if you would like to summarize it, we would appreciate that, because of the time factor.

Thank you very much.

STATEMENT OF MRS. VIRGINIA B. MAXWELL, PRESIDENT, FRIENDLY VISITING VOLUNTEER COUNCIL OF MARYLAND

Mrs. MAXWELL. Thank you, Senator.

It is indeed a pleasure to have an opportunity to express to this subcommittee a very important service, though rather limited service, in our State.

About 7 years ago, a letter came to my attention, in my official capacity, from an elderly 80-year-old very alert patient in a nursing home. This letter was quite impressive in expressing a need. She indicated that she was no longer part of the community, and felt at a loss, and felt this was handicapping her in living out a contented life.

As a result of this letter, I contacted the Voluntary Health Agency, as well as the Nursing Home Association in our State, to determine what we could do about this problem, and we came up with the conclusion that utilizing friendly visiting and volunteers was the answer.

Through much effort, we did this.

The volunteers themselves felt very good about such activities, and wanted to continue and to give service. However, they felt the need for some coordination of their services, because many omissions were occurring, as well as duplication of services.

The only financial support that we have had to date has come from staff time of both the voluntary and official agencies.

We also felt that one solution to our problem was to organize some kind of coordination council. We turned to our Commission on Aging for some sponsorship. This has in effect brought about some remedy to our problem.

We realize this is not a perfect setup. However, it has met most of the recognized need.

One of the problems of an organization of this type is the lack of coordination, as you well can see. Another reason that adequate coordination is essential is the number of services now currently available to the elderly, of which they cannot avail themselves, since existence of some services is even unknown, and in other cases lack of finances in transportation prevents utilization.

In order to alleviate this problem, provisions must be made for States and local agencies to assume responsibility for coordinating voluntary services and providing consultation to individuals, agencies, and nursing homes.

For this purpose, I would recommend that Federal support be given to States for reestablishing and continuing State commissions on aging. It seems that providing funds for these commissions prior to the White House Conference on Aging without providing for implementation of the recommendations of the Conference is not realistic.

In Montgomery County, we have received Federal grants for training of occupational therapy assistants, which has done a great deal to increase the utilization of voluntary visitors in appropriate roles.

There are needs for grants for other subprofessional groups, such as nursing aids, homemakers, dietary workers, and so forth, who are necessary to local aging programs that need to be met.

I feel Federal aid to the adult education of these groups is essential if these needs of aging are met.

Much emphasis and Federal support has been given to professional educational programs, but this very important group has been overlooked.

Interestingly enough, you will find that many of the services extended to the elderly are actually given by relatively untrained individuals. I do not mean to minimize the need for assistance in the professional educational program, but to bring to your attention the need for training of subprofessional groups to serve in the United States.

As we have found in our experience with the friendly visiting volunteers, orientation to nursing homes of a list of "do's" and "don'ts" was inadequate. Training programs had to be developed to be implemented.

I do not feel that any other groups working in this important area can do so proficiently without some type of training program.

In summary, I would recommend Federal financial aid to States to support an agency whose sole responsibility will be to coordinate available services to the elderly. This should be accomplished through financial support, consultation services through local official agencies, and Federal funds to provide State official and local official agencies funds to provide the necessary training of subprofessional workers.

Mr. Ellis Duke, president of the Maryland Nursing Home Association, is in the room today, who was very active in the beginning of organizing this friendly visiting service. He will be glad to answer questions, as well as myself, Senator.

Thank you.

Senator KENNEDY. Thank you, Mrs. Maxwell.

There is one line that you did have on page 3 of your statement, where you said Federal aid to adult education of these groups is essential if the needs of the aging are to be met.

Did you envision any extension of the recommendations that are before the committees as expressed in this S. 2000 and S. 1357?

Mrs. MAXWELL. I apologize. I do not know these bills well enough to speak.

However, what I am essentially recommending is that we are faced today with a number of workers working with the elderly who have not been prepared in any field.

I feel that we ought to look at this realistically, that economically, professional services across the board, given directly to the individual, become very expensive, that we need to realistically look to preparing subprofessional groups to work under supervision of professional groups.

I referred to my own profession, that of nursing. I feel we need to expand nursing aid training programs to provide these to citizens; nursing care in the home, nursing homes, and in hospitals.

Thank you.

Senator KENNEDY. That is very fine. But those areas are described in the bill, and I think are the areas where there has been the greatest need demonstrated, and I think that your reassurance from your own personal experience in nursing in these other areas is something which is important for this subcommittee. So I appreciate your comments on that question.

Thank you very much.

(Mrs. Maxwell's prepared statement follows:)

PREPARED STATEMENT BY VIRGINIA B. MAXWELL, INSTITUTIONAL PROGRAM COORDINATOR, MONTGOMERY COUNTY HEALTH DEPARTMENT, ROCKVILLE, MD., CHAIRMAN OF FRIENDLY VISITORS COUNCIL OF MARYLAND

The need for volunteer services was brought to my attention in my official capacity in Montgomery County's Health Department when I received a letter from an 80-year-old former nursing home patient. Here are some excerpts from the letter:

"We talk much today about inalienable rights. I think the old, the dependent, the lonely, those so easily forgotten, have an inalienable right to those

things that make the difference between a contented and peaceful waiting and hopeless resignation.

"Foremost among my sharpest impressions as a patient in a nursing home was the unnecessary unhappiness caused by unrelieved idleness—and the consequent depression and discouragement of the long, empty days. As I saw this condition, I became convinced that it was not only the cause of unnecessary suffering, but was a deterrent of physical improvement * * *."

"And so I am hoping to hear more of what I am told is a practice in some of the care homes, of providing something for their patients to do. For those, however old and ailing, there are easy and simple occupations which result in happy and new relationships and often general improvement."

As a result of this letter I contacted the Montgomery County Tuberculosis & Heart Association and District No. 2 of the Maryland Nursing Home Association to determine what could be done to meet this need. One of the outcomes of these meetings was the idea of utilizing volunteer visitors in nursing homes to carry out such activities as reading to patients, writing letters for them, playing games with them, taking them for walks and rides, etc.

The executive director of the Montgomery County Tuberculosis & Heart Association and I contacted numerous local service, civic, and church groups. These groups were most receptive to the idea of visiting patients in nursing homes, and immediately went to work.

However, very soon after the voluntary services were implemented, the volunteers became aware of a need for coordination of their services. They found several groups were visiting the same nursing homes, and others were not being serviced.

As a result of their concern, conferences were scheduled with the Maryland State Commission on the Aging to determine how this new service could be utilized more efficiently. Following these conferences, the Friendly Visiting Volunteer Council of Maryland was established under the sponsorship of the State commission on the aging.

The only financial support that has been received thus far has been through voluntary and/or official agencies who supply a staff member for each of the counties. This support is essential to provide the necessary training for the volunteer visitors prior to their utilization in nursing homes.

On the local level in Montgomery County the program has been coordinated by several different voluntary groups, such as the United Women's Religious Organization, Federation of Women's Clubs, Salvation Army, and the Montgomery County Chapter of the American Red Cross. Since many of the elderly, who need this service, are not in nursing homes but are in their own homes, it was decided to extend these services to them.

The coordinating groups receive referrals from individuals, or nursing homes, requesting friendly visiting service. The service is promoted through referrals by the public health nurses and social workers, and routine newspaper and radio announcements.

Additional voluntary groups are identified and contacted through a list published by the Montgomery County Health & Welfare Council.

This is certainly not a perfect setup; however, it has served to meet much of the recognized need. One of the problems in the organization is that of lack of adequate coordination. Certainly four groups working fairly independently cannot completely meet the needs of the elderly without duplication, or omission, of service. This is true throughout the State.

Another reason that adequate coordination is essential is the number of services currently available to the elderly, of which they cannot avail themselves since the existence of some services is unknown, and, in other cases, lack of finances and transportation prevent utilization. In order to alleviate this problem, provisions must be made for State and local agencies to assume the responsibility for coordinating voluntary services and providing consultation to individuals, agencies, and nursing homes. For this purpose, I would recommend that Federal support be given to the States for reestablishing and continuing State commissions on the aging. It seems that providing funds for these commissions prior to the White House Conference on the Aging, without providing for implementation of the recommendations of the Conference, is not realistic.

In Montgomery County we have received some Federal grants for training, such as the occupational therapy assistants program, which has done a great deal to increase the utilization of the volunteer visitors in appropriate roles. There are needs for training grants for other subprofessional groups such as

nursing aids, homemakers, dietary workers, etc., who are necessary in the local aging programs which remain to be met. I believe Federal aid to adult education of these groups is essential if the needs of the aging are to be met. Much emphasis and Federal support has been given to professional education programs, but this very important group has been overlooked. Interestingly enough, you will find that many of the services extended to the elderly are actually given by relatively untrained individuals. I do not mean to minimize the need for assistance in professional education programs, but to bring to your attention the need for training of the subprofessionals that serve the elderly in the United States. As we found in our experiment with the Friendly Visiting Volunteers, orientation to the nursing homes with a list of "do's and don't's" was inadequate, and training programs had to be developed and implemented. I do not feel that any of the other groups working in this important area can do so proficiently without some training program.

In summary, I would recommend: (1) Federal financial aid to States to support an agency whose sole responsibility will be to coordinate services available to the elderly; this should be accomplished through financial support and consultation services to local official agencies; and (2) Federal funds be available to State official agencies, and/or local official agencies, to provide the necessary training programs for subprofessional workers.

Senator KENNEDY. Patricia Gilroy is our next witness.

STATEMENT OF MISS PATRICIA A. GILROY, EXECUTIVE DIRECTOR, HOMEMAKER SERVICE OF THE NATIONAL CAPITAL AREA, INC.

Miss GILROY. Thank you, Mr. Kennedy.

I would like to introduce Mrs. C. Worth Sprunt, a member of our board, and also chairman of a subcommittee of our board that reviewed our services to the aging and some of the needs and problems that we felt needed looking at in order that our program might better serve these people.

I do hope that time will permit Mrs. Sprunt to join in the informal discussion following my testimony, because I think she brings to us a refreshing board member's viewpoint.

Senator KENNEDY. Maybe if you could summarize or capsulize them, we would be able to save more time. We have until 12:15, and we have five additional witnesses, so we are really pressed for time on this, and we have two who are from out of town, so we want to try and at least hear everyone, if we can.

Miss GILROY. Fine.

Senator KENNEDY. If you could maybe just hit the highlights of this, we will print your complete statement in the record.

Miss GILROY. I would be very happy to do that.

Homemaker service is a very old-fashioned idea, which has been adapted to present-day needs and problems. It is fairly new, however, in the field of health and welfare. This is a surprising thing, I think, in view of the fact that it is an outgrowth of the family idea and the conviction that it is almost always better for families and individuals to remain in their own homes and neighborhoods where they are comfortable and where they know people and people know them than it is to be placed in institutions for the aging.

I will omit reference in my discussion at this moment to other aspects of the Homemaker Service except that which relates directly to services to the aging.

There are many different kinds of agencies throughout the country which function under different auspices, and their programs vary according to the particular limitations or programs of the specific agencies.

In the District of Columbia, in the National Capital area, we have a voluntary independent agency, whose only function is to provide homemaker service.

Our service, as well as other voluntary agencies, are supported by a combination of fees from clients, purchase of service contracts, United Givers Fund, or its local equivalent, contributions and benefits, and so forth, carried on by the board of directors.

Our agency program is a small program. We are a young agency, just having reached our fifth year.

During this past year——

Senator KENNEDY. Miss Gilroy, could I just ask a question? Maybe it is answered in your testimony.

Are Homemaker Services rendered by voluntary organizations? Do they receive some kind of compensation for the services they provide?

Miss GILROY. Homemaker services in the District? In the National Capital area?

Agencies vary. Some agencies are under departments of public welfare or public health, and are operated totally with tax moneys, often with matching moneys.

In the voluntary agencies, they may be operated solely from voluntary funds, or with some arrangements for purchase of service contracts from public agencies.

Things are a bit more unique in the District of Columbia, however.

Senator KENNEDY. But there is no national policy with regard to homemakers, that runs consistently throughout the States and the District, is there?

Miss GILROY. No, sir; there is not.

Our experience here reflects the national picture, which has been reviewed before.

Our older persons are sick more often than our younger ones. The older population increases more rapidly than the younger ones, and aged citizens have far less incomes than younger ones.

Although many others have incomes from social security or other retirement programs, it is rarely enough for them to take on the burden of additional medical and health needs, and more rarely is it sufficient to pay even token costs for ancillary services, such as homemaker service.

In a study of our cases over a 28-month period, which Mrs. Sprunt may perhaps mention further to you, at least 50 percent of our people were able to pay nothing, and the average payment of the other 50 percent was less than 25 cents an hour.

This brings us, then, to one of the major problems in providing homemaker services to the aging in the District of Columbia.

With the exception of old-age assistance and aid to totally disabled persons programs, Federal moneys cannot be used to purchase homemaker services from a voluntary agency, even though family incomes are sufficiently low to necessitate Federal subsidies for housing, medical care, and hospital care.

And yet the vast majority of the people who need the service are not eligible for these public assistance programs. The requests for service which we, as a voluntary agency, receive, from public health agencies and hospitals and from public housing in the District of Columbia, far outstrip the services we are able to provide through our voluntary sources.

Federal funds for research and demonstration grants are most valuable and should be continued, but these do not provide the essential ongoing services to these people.

If we are to help those who urgently need our services and the growing numbers who will need them in years to come, much more service will be necessary, and more adequate financing to provide service for the many who require it over a long period of time, and for the majority whose fixed incomes necessitate supplementary assistance from public and voluntary agencies.

I have excerpted my statement almost out of recognizable form.

Senator KENNEDY. I think this has given us some idea about the role of the homemaker.

Mrs. SPRUNT. Have you any questions you would like to ask me?

Senator KENNEDY. I previously asked a question with regard to the kind of national policy or national standards which have been adopted, or whether there was such a policy, but I think that part has been pretty well answered.

I might just possibly develop that to some extent, not limited to the financial aspect.

Does the homemaker organization really depend upon local sorts of standards and local rules and local administration?

Mrs. SPRUNT. Well, there are national standards that we follow, but it is administered in Washington entirely locally.

Senator KENNEDY. I see.

Mrs. SPRUNT. And the money is raised locally for us

And the thing that strikes me, as a layman, as I work with this, is the great economy of this thing, because some of these older people, with only 4 hours of service a week from the homemaker, can remain in their own homes, and remain independent and keep out of these crowded, expensive, burdensome institutions, where they are divorced from the community.

So that it is a great saving of dollars and cents, quite apart from the human needs involved.

Senator KENNEDY. I did not have an opportunity to read this testimony before, but I will certainly look forward to reading this, and then, as these hearings continue, and we have some questions, we will direct these to you.

Thank you very much for coming.

(Miss Gilroy's prepared statement follows:)

PREPARED STATEMENT OF MISS PATRICIA A. GILROY, ACSW, EXECUTIVE DIRECTOR, HOMEMAKER SERVICE OF THE NATIONAL CAPITAL AREA, INC.

Mr. Chairman and members of the committee, I am Patricia A. Gilroy, executive director of the Homemaker Service of the National Capital Area, Inc. I am very pleased to have this opportunity to talk with you today about homemaker service and especially about the program for the aged in the Washington area. I am accompanied by Mrs. C. Worth Sprunt, a board member of our agency and the chairman of a special study committee on the needs of the aging and our services to them. In the discussion which follows

this formal testimony, her observations as a volunteer will provide us with a different and fresh approach.

At the outset, I would like to tell you about homemaker service in general. The primary function of homemaker service is to maintain and strengthen family life by providing this service to families with children, the aged, ill and disabled. Homemakers are mature, responsible women who are carefully selected, trained, and placed in homes where there is a social or health problem which requires outside help if the person or family is to stay at home. Through provision of these services, children can remain in their own homes during the illness or absence of their mother, elderly persons can continue in their own familiar surroundings longer than might otherwise be possible, ill and disabled persons can be discharged from hospital as soon as they are ready and be assisted to maximal independent functioning, and many families can be helped to improve their standards and skills in child care and home management. All homemakers are supervised by appropriate health or welfare personnel in order to make certain that the changing needs of the family are being met and that the homemaker herself receives the help she needs to perform her tasks competently. Depending upon the needs of the individual or the family, homemaker service may include care and supervision of children, marketing, planning, and preparation of meals, and special diets, light cleaning, care of clothing, planning expenditures, rearranging work areas, performing those personal care services exclusive of nursing service, which are necessary for chronically ill and disabled people. Although homemaker service is a fairly recent development in the health and welfare field, it is an old-fashioned service, which has been adapted to present-day needs and problems. It operates on the conviction that it is almost always better for families to stay together in the home and neighborhood they know and with the people who know them than it is to be uprooted and placed in foster homes or institutions for dependent children or in institutions for the aged.

There are 300 agencies which provide homemaker service in almost every State, including the District of Columbia and Puerto Rico. Their programs vary in auspices and may be administered by public health or welfare departments, voluntary family and children's agencies, voluntary health agencies or, as in the Washington area, may be administered by an independent voluntary agency whose only function is to provide homemaker service. Programs and eligibility for service may also vary from agency to agency depending upon the limitations and function of the particular agency. In our agency and within our resources, service is provided to all of the groups previously mentioned. Sources of support also vary and may include programs which are totally supported by Federal moneys or by a combination of fees from clients, purchase of service contracts, United Givers Fund or its local equivalent, contributions, benefits, and so forth.

For the purposes of this hearing, I will confine my remarks from this point on to our program for aging in the National Capital area.

The agency was established 5 years ago by the intensive efforts of many citizens following a communitywide study of the need for homemaker service. It consists of a board of directors of 35 men and women, a director, 2 full-time and 2 part-time professionally qualified social workers, and 27 homemakers. With a total income of $120,060 in 1963, we were able to provide service to 465 families which included 41 ill and disabled persons under 65, 107 aged people living alone, 34 aged couples and 283 families with 1,198 minor children.

To us these are impressive figures but equally impressive and of urgent concern are these: While we provided service to 141 aged individuals and couples, we had to refuse service to 270 either because we had no homemaker available or because long-term care was needed. Both of these reasons are immediately and directly related to limited financial resources. From the outset we have been able to give only temporary emergency help and have not been able to accept cases which required long-term service. Our experience in these 5 years, however, demonstrates rather pointedly that a little help and support can often enable elderly persons to remain independent; that help must be given on a steady, long-term basis to be of real and lasting value; and that remaining in their own homes is often the most desirable course for individuals, families, and the community—especially in view of the overcrowded, often inadequate, and expensive institutions that are the alternative.

Homemaker service for the aging may involve full-time service during early convalescence or in the final stages of a terminal illness or as little as a few hours a week for a more active person. The duties of the homemaker may include tidying up the apartment or home, shopping and preparing enough food to last until her next visit, picking up drugs, doing light laundry, taking the person out for a walk, helping with a bath and a myriad of little things but most importantly to care and to be interested in the welfare of the person. For the most part, we have found that part-time service available more frequently works out better than a full day less frequently. Elderly people look forward to the days the homemaker will be coming and all too often she is the only one who does come for weeks or months on end. Until recently, we had one homemaker assigned to a public housing unit who looked after 10 to 12 elderly people ranging in age from 70 to 100. More of this is needed and should be given. I might add parenthetically that we also employ several elderly women as homemakers. For the most part, they are widowed or retired from full-time employment and want to serve others while supplementing their incomes with part-time employment. These women do an exceptionally fine job with the aged and chronically ill.

Although our experience is limited it does reflect the national picture. Aged persons are sick more often and for longer periods than are younger people, the older population increases more rapidly than the younger, and the aged citizens have far less income than younger ones—50 percent of the 18 million people over 65 have total incomes less than $1,000 a year. Although many others have some income from social security or other retirement programs, it is rarely sufficient to take care of their major medical and health needs and even more rarely sufficient to pay even token costs for necessary ancillary services, such as homemaker service.

In a study of our aged cases over an 18-month period we found that 50 percent of the aging people we served were able to pay nothing while the remaining ones or their families were able to pay an average of 25 cents an hour.

This brings us then to one of the major problems in providing homemaker service to the aging in the District of Columbia and in the metropolitan area. With the exception of old-age assistance and aid to disabled persons programs, most Federal moneys cannot be used to purchase homemaker service from a voluntary agency even though family incomes are sufficiently low to necessitate Federal subsidies for hospital and medical care and public housing. And yet the vast majority of the people who need the service are not eligible for OAA and live on fixed incomes too moderate or too meager to carry the financial burden alone. The requests for service from public health agencies and hospitals and from public housing in the District far outstrip the service we are able to provide through voluntary sources. The Federal funds for research and demonstration grants are most valuable and should be continued but these do not provide the essential on-going services.

The economy and value of homemaker service has been amply demonstrated here and throughout the country. If we are to help those who urgently need homemaker service now and the growing numbers who will need it in years to come, much more service will be necessary. More adequate financing will be needed for the many who require it over a long-term period and for the majority whose fixed incomes necessitate supplementary assistance from public and voluntary services.

Thank you again for inviting us here. We hope you have found this brief sketch of homemaker service helpful and will be glad to answer any questions you might have.

Senator KENNEDY. Mr. Pikser.

STATEMENT OF GEORGE M. PIKSER, EXECUTIVE DIRECTOR, JEWISH SOCIAL SERVICE AGENCY, WASHINGTON, D.C.

Mr. PIKSER. Senator Kennedy and members of the committee, I hope you were not trying to decipher that rough draft I mailed in, because I thought you wanted a copy before the meeting.

Senator KENNEDY. Mr. Pikser is the executive director of the Jewish Social Service Agency in Washington, D.C.

We welcome you.

(Mr. Pikser's prepared statement follows:)

PREPARED STATEMENT OF GEORGE M. PIKSER, EXECUTIVE DIRECTOR, JEWISH SOCIAL SERVICE AGENCY, WASHINGTON, D.C.

Mr. Chairman, members of the committee, I have been asked here today to testify particularly on two aspects of services for the aging with which I understand you are concerned, information and referral service, and a program of counseling to the aging. So that you may be able to evaluate my testimony, let me tell you a little something about the agency of which I have been executive director for 15 years. The Jewish Social Service Agency of Greater Washington has been in existence for 75 years, and is comprised of five different departments. The family services department is essentially counseling to persons in marital, social, or psychological distress, and includes service to all members of a family unit. It also provides financial assistance to many Jewish families. The Child Welfare Service focuses on families and children in which there is a need for the child to be separated from his family, or in which such a separation has recently occurred (specifically the program provides foster care for children, the purchase of residential treatment service for very severely emotionally disturbed children, service to unmarried mothers, adoption placements and other related activities). We have a refugee and resettlement program in which we find homes and jobs for newcomers to this country; we have a child-guidance clinic which provides treatment to emotionally disturbed children who are living at home, along with treatment for their families, and we have a program of services for the aging which is 5 years of age. Most of the agency programs are financed by the United Givers' Fund, and by voluntary contributions. Our refugee resettlement program is financed in its entirety by the United Jewish Appeal and our services to the aging is financed partly with UGF funds and partly with a 2-year grant from the Agnes and Eugene Meyer Foundation.

I will devote myself only to the program of services to the aging. We had always served the aging population in our family services program, but it had long been recognized that this service was inadequate, that services to the aging required a different pace of work, a different group of facilities and resources, and a more aggressive attitude. In our family counseling program we schedule appointments a week apart, most generally, and we leave it to the client to seek out the agency and cooperate actively in using the help we provide. We quickly found that the aging were hesitant about using our services, could not be counted upon to seek out the agency program, and could not be counted upon to follow through regularly without more encouragement than we could give. Despair, hopelessness, and pessimism characterized their approach to us. Further, when they came to us, the counseling very often needed supplementary resources which were not developed within the agency at that time.

Consequently 5 years ago we designated one of our caseworkers as a specialist in a program of services for the aging. Her main focus at that time was to develop foster homes for the agency, homes for aged persons who could not continue to live at home alone, but who did not need institutional facilities. We pay $150 a month to these foster homes, which are always individual families, who take in one or at most two elderly people for us, and who cooperate closely with the agency in the kind of treatment, the environmental and social milieu they provide, etc. We recoup whatever we can from the aging person, if he has income such as social security or public assistance, or if his family can assist. If necessary we absorb as much of a loss in this program as is called for, and from time to time we have had persons in foster homes for whom we received no reimbursement. The program has worked well, and at the present time we have about 10 people in such foster homes.

We have found foster homes a very useful device in helping people remain out in the community, rather than being relegated to an institution, if they have sufficient personal strength for this. For the most part the arrangements have been very happy, and the person living in the foster home has felt wanted and in many cases even loved.

A year and a half ago, with the assistance of a grant from the Meyer Foundation, we employed an additional caseworker and launched a program of friendly visiting to shut-ins. The caseworker supervises 22 volunteers, all of whom have taken a special orientation program given by the agency. All of the 22 except 1 are women, some of moderate private means, some quite well-to-do. They have all undertaken on a once-a-week basis to visit some elderly person who is confined to his home or to an institution because of his age or his ill health, some-

times physical, sometimes emotional. The activity they undertake during their visits varies with the visitor and with the person being visited. In some cases they play cards, in others they just engage in conversation, in other situations you have what could be called an occupational therapy program, and very frequently the volunteers use their visits to take the shut-ins for a ride, out shopping, or just out into the fresh air if the weather is suitable.

We have found the record of service remarkable. The volunteers have left only because of reasons such as moving from the city, etc. They have been unfailing in keeping their appointments or in making excuses in plenty of time when they cannot keep their appointments. They work under close supervision of the social worker, and direct their activity along whatever treatment plan is in effect. The most spectacular success in this program has been in our use of friendly visiting volunteers to patients at St. Elizabeth's Hospital. He have succeeded in obtaining the release of three women who had been in the hospital for more than 15 years, and who would have apparently been there indefinitely. The presence of a friendly person who is interested in their welfare led to such a marked improvement, that the hospital staff was delighted, and the three are now in the community. One of the three removed from the hospital to one of the Agency's foster homes, which she has now left after 2 years of residence there and is independent in the community. A second who was in the hospital for 15 years has been restored to civil service status and is back on her Government job. I cannot tell you very much about the third at this moment. All three continue to have contact with their "friends" as they call them.

The reason I give you all this detail is germane to my subjects. When we first started our program we considered counseling as a specific part of the program, perhaps as the main part, and we found that even when our aggressive approach to the aging, such as having our caseworker present at meetings of the Golden Age Club, making home visits frequently, waiving fees in our aging service, resulted in the establishment of a relationship (which was not often), the relationship quickly broke down because the aging needed, in addition to counseling, some very real help about specific and tangible problems which beset old people, financial, problems of housing, of companionship, of loneliness, of health, and we had no resources. Now that we have a program of resources, such as the friendly visiting program, the foster home program, financial assistance, and because we have developed a good deal of knowledge about the availability of nursing and convalescent homes, recreational facilities, job opportunities, etc., the aging approach us primarily for help in these areas. Contact around these problems indicates that there is also a pressing need for counseling and guidance around social and psychological problems of aging, and that much good can be done with such counseling provided it is accompanied by and part of a program of simple, tangible, and easily understandable services. Counseling as an entity in itself, I am afraid, will not become a useful service. Most often the aging do not feel that they are in a "problem group," and in need of counseling, until a specific problem becomes manifest. Then they want help, but focused first on their specific problem. From this can stem a relationship which can grow into many areas, including psychological and social problems. Counseling is a necessary accompaniment and a concomitant of specific and real environmental services, and becomes immensely valuable, and has led in many cases to a new outlook, to rapprochement between parents and estranged children, etc. Similar thoughts come to my mind when you talk of an information and referral service; at a meeting I attended recently I was informed that one of the District of Columbia departments was planning to set up an Information and Referral Service for the Aging, and I am afraid I was rather impatient in my continuing questioning, "information and referral to what?" It turned out in this case that this was an information and referral service concerning clinical hospital services available, how they can be used, etc., and this does seem to meet a real need. However an information and referral service is a meaningless service unless there are resources to which a person can be referred. The Health and Welfare Council of the National Capitol Area, for instance, has an information and referral service for all social and economic needs, but their frustration, often expressed, is that even when the client is articulate and clear-minded about what he needs and presents his request in a very forceful and understandable manner, they are frustrated because there is often no place to which they can refer the person. Again an information and referral service is a vital necessity and a means of bringing order into chaos, providing there are the resources to which an aging person can be referred. Convalescent facilities are not suf-

ficiently developed, temporary nursing homes for people of very modest means are not available in this community, the recreational facilities are beginning to develop, but are still very poor. Our foster home program and friendly visiting program are very small, and do not serve the whole community. There is a foster home program operated out of St. Elizabeths Hospital. But it is obvious that if we have 10 foster homes, the community needs hundreds; if we have 22 friendly visitors, there should be for the rest of Washington 222. I am familiar for instance with the Golden Age Club of the Jewish Community Center of Washington, which meets once a week. The entire building of the Community Center resounds with noise and excitement on Thursdays when the Golden Age Club meets, and there are hundreds of people of all races and religions there, and there could very well be a Golden Age Club activity there every day of the week were it not for the fact that the Jewish Community Center does not have sufficient funds to run the program more than once a week. I imagine the same is true of the Golden Age Club of the District of Columbia Recreation Department.

We, in our aging program have begun to experiment with group therapy to people who are living in private nursing and convalescent homes. Even these people of means, who have the resources with which to pay a sometimes high rate, find that the physical care is not enough and they eagerly await the visit of our caseworker who comes there once a week to lead group discussions on various subjects such as relationships with children, philosophy toward growing old, how to enjoy the declining years, etc. We leave it to the old folks to have the topics they want to discuss, and to pace the meeting. We presently have two such groups encompassing, combined, about 20 people. From what the 2 people doing this tell me, we could very well use 15 people as a beginning, running 15 groups weekly, and still not fulfill the need in this community of which we know, and I am sure we do not know, even half of the need, to give aging persons an opportunity to express themselves, to ventilate their grievances and to seek a better adjustment toward life and their social problems in their declining years.

In summary I repeat, counseling yes, is a necessity, but it must accompany other and tangible services. Information and referral yes, if there is something to which to refer.

Mr. Senator and members of the committee, thank you very much for the opportunity you have given me, if there is anything I can answer more specifically, I would be pleased if you would let me know now, or perhaps later.

Mr. PIKSER. I will only summarize and will deal only with part of the statement.

I was asked to come here to speak specifically about information and referral service and about counseling service.

We have in our agency now for 5 years a special program of services for the aging, which includes among other things a friendly visiting service which is very active and very successful, in which we use only volunteers supervised by one social worker, volunteers from all walks of life, different kinds of education, different economic backgrounds, different interests.

They have all worked remarkably well, once we have selected the proper volunteers, and we have found that the supervision we have given them has been adequate for the purpose to which we use them.

I make the statement, because I think it pertains to some testimony heard earlier.

We also have a program of foster home care for aging people, people who cannot live alone any longer, but who do not need institutional care. We place these people with private families whom we have selected, and we supervise the place, and the old folks go on living as members of the family, perhaps as absent grandparents. And this, too, has been quite successful.

We do not have identified in our agency program an information service, and we have deliberately refused to identify a program as such, even though we do provide that service to the community.

My testimony may be misinterpreted, I am afraid, as being opposed to the establishment of information and referral services and counseling services. This is far from the truth.

What concerns me is that it is much easier and much less expensive to establish an information and referral service and a counseling service, which is after all the form of a service, than it is to establish the service itself.

We have in Washington, for example, in the Health and Welfare Council an information and referral service, but the people there ask: "Information about what? Referral to where?"

It is one thing to have a structure. It is more important, I think, to have the substance which the structure refers people to. We need in Washington a multitude of services for the aging which do not exist.

Our agency serves 25 shut-ins in homes and hospitals with our friendly visiting service. We ourselves could easily serve 50, if we had more social workers or friendly visitors.

On an assumption, if we could use 50, the city of Washington could use 500.

There is no agency with funds prepared to provide the service. We have 10 foster homes. There is a small foster home program operating out of St. Elizabeths Hospital. I know of no other in Washington.

If our small agencies serving only a segment of the population, and a relatively advantaged section of the Washington population, needs 10 foster homes, then the community again needs 500 or Lord knows how many.

And these services are not available. I think that we need an information and referral service when we have the facilities to which we refer people.

The same holds true for counseling. When we first began our program 5 years ago, and we were one of 40 agencies selected by the Family Service Association to experiment in the field of services of the aging, our focus was counseling, purely counseling. And the old folks could not be less interested, because the ones who came to us had specific problems. They needed a place to live. They needed a good, inexpensive clinic. They needed companionship. They needed money.

When we expanded our aging program and began to provide the other services, we found then a rich need for counseling. Someone would come to us about getting a companion or a friendly visitor. And once the contact was established there through the use of counseling skills around a problem he recognized, then we could go further with him on his initiative into areas which needed exploration and the exploration of which benefited him.

But when we had counseling alone, without the substance of the tangible environmental things that the old folks need so generously, our counseling service was not successful.

Senator KENNEDY. One of the comments you made was about placing people, senior citizens, in other people's homes, and having them live as absentee grandparents.

Did you say in old people's homes?

Mr. PIKSER. No.

Senator KENNEDY. I thought you said that you placed senior citizens in other people's homes.

Mr. PIKSER. That is right. We pay for it. Our rate is $150 a month, which is about the most economical form of care that you can find in the community.

We had one old man, for instance, who is blind and had been blind for many years, and had applied to the Hebrew Home for the Aged, and could not be taken in, because they had no room. So they referred him to us for foster home placement, and we placed him out in the country with a Seventh-Day Adventist family. This was a grandmother and her daughter and her daughter's children. There was no man in the house. I do not know whether they were divorced or widowed or what-have-you. But there were three generations of women and no man in the house.

We placed him there, and the grandchildren took to him immediately. They would lead him to the bathroom and lead him around the house, and he would tell them stories. And when the Hebrew Home for the Aged had a vacancy, he refused to go.

These are people who needed the money. They were not poverty stricken, but $150 a month is useful. They had the room, and he is a fine companion. And we have 10 such situations.

Now, as I say, we are a small agency. We have one foster home where the foster mother—you will forgive me—is in her seventies. We have living with her one woman who had been in St. Elizabeths Hospital for 20 years, until we assigned a friendly visitor to her, who took her out, upon recommendation of the hospital staff, of course, who visited with her in the hospital, and then took her and shopped for her, and took her down to shop for herself. And now this woman is out of the hospital with her rights restored and living with her foster mother.

Another one is also living there. This one came directly, referred by her son. She was a woman past 65 who had been a concert violinist in her day, and was living happily with her son and daughter-in-law, and small children, and had been for many years. But all of a sudden she became senile. And she was more often a problem than the two little children.

Most of the time she was in command of her faculties, and the arrangement in this foster home was just suitable, so we placed her, also. We have these two women, living with their 70-year-old foster mother, who is, as a mother should be, older than they, somewhat.

Senator KENNEDY. That is very interesting.

I want to thank you very much, Mr. Pikser. I appreciate your coming down here and testifying.

I would like for Mr. Edelman, and Mr. Fitzpatrick and Mr. Roney to come up here, if they will, to submit their statements for the record.

(Prepared statements of Messrs. Edelman, Fitzpatrick, and Roney follow:)

STATEMENT OF JOHN W. EDELMAN, ACTING PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman and members of the Subcommittee on Federal, State, and Community Services for the Elderly, I am John W. Edelman, acting president of the National Council of Senior Citizens and the Greater Washington Area Council of Senior Citizens.

The national council is an education and action organization composed of well over 1,700 member organizations. The program and legislative goals of the national council, which are the basis of my testimony here today, have been debated and voted on by both forward action of our national convention and, on certain issues, by referendum to all our senior groups.

The national council was formed as a result of meetings of senior citizens at the 1961 White House Conference on Aging, when it was decided that independent senior citizen groups should have some national organization through which they could have a national voice to help implement the Conference findings on aging and on other needs and concerns of older people.

The national council feels very strongly that the services of the Federal Government for the senior citizen are, at the present time, poorly organized; although some of the programs in special areas such as housing are functioning quite well, though limited in scope. The national council favors a U.S. Commission on Aging or an Administration on Aging separate from the Welfare Administration. Senior citizens do not feel that they should be categorized as being welfare cases. We have the strongest convictions on this point. We emphasize that in our view it has been a fundamental error to place the operation of programs for the aging under the direction of an office whose primary responsibility is dealing with welfare problems. But even more important, the national council feels that at the present time the concerns of aging are at too low a level and need the added stature and position which they now lack. The Office of Aging has failed to accomplish this, especially since it is subsumed under the Welfare Administration. We urge that Congress place by law the concerns of age either in the hands of a Commissioner, of an Administration on Aging, or in a special U.S. Commission on Aging. We urge that the programs of such a unit be strengthened along the lines of the Fogarty-McNamara bill which provides also for grants to the States and funds for demonstration and training projects.

We feel that the present programs are geared primarily to the professionals and that a more balanced program would include considerably more aids to senior citizens to encourage them to help themselves, plus aids to professional agencies to aid senior citizens. We feel that with the help of information and timely advice, more older people will be able to remain independent. We would suggest that the publications of the Children's Bureau of the Department of Agriculture be taken as examples of how materials can be prepared for both the professionals and the great lay public, which would do much toward enabling individuals and groups to help themselves.

We urge the continuation and expansion of housing for senior citizens both in quantity and variety. More money should be allocated for loans and we urge that the HHFA undertake a variety of selected experimental projects in low-cost senior citizen housing, experimenting with such things as prefabrication in housing, mobile homes, and rent subsidy in a determined and broad-scale effort to bring rentals down below the $60-a-month level.

We urge that the Department of Labor develop guides to help senior citizens and local employment services do for senior citizens what the State employment and local services have done for youth employment through such organizations as YES (Youth Employment Service). We feel very strongly that each State should have a State commission on aging and each local community its committee on aging with representation from bona fide senior citizen organizations at both levels. We feel that representation of senior citizen groups will help prevent these groups from taking a highly paternalistic view and orient these bodies so that they always give primary consideration to aiding older people to help themselves. However we realize that State commissions desperately need the assistance that will be given them through the Fogarty-McNamara bill; and therefore urge its adoption so that these State bodies may be able to really tackle the enormous job that needs to be done in this field everywhere in the United States.

We hope that the States and local communities will proceed then to develop many types of leisure-time programs including senior citizen centers in every community. Unfortunately, we find that city recreation departments have too often restricted freedom of speech among the older people in discussing issues and problems of aging. We urge that any actions of the Congress should stipulate that freedom of speech should be allowed in senior citizen centers and senior citizen leisure-time programs. The vast majority of senior citizens are not in their second childhood, nor should they be relegated to kindergardens, where they receive directions on everything they do or say. Equally, we hope that these centers will not be eldergardens, but places where senior citizens can learn, can participate actively in community affairs and can be free in developing their

leisure-time activities. These centers should be sources for community improvement as well as recreation and education for the retired.

We urge the development of home health services in every area of the country as an absolute necessity for good health for older people. However, we realize that without the financial support given by hospital care through social security, the development of this service in many areas is impossible.

We urge that the State departments of public welfare and the state legislatures improve the levels of benefits under their old-age assistance programs. In too many areas, including much of the South, old-age assistance payments simply provide the means for living at a level only slightly above starvation. This need not be. We cite Alabama as an example of what a Southern State can do to improve old-age assistance benefits and urge that others do as well during the coming months.

We advocate and insist that local communities seriously explore reduced bus fares for senior citizens during nonrush hours, such as has been done in Detroit and Los Angeles. Today transportation costs, and we mean public transportation, have risen to the point where many older people are forced to lead restricted lives and deny themselves many opportunities for fruitful contacts and community service.

We urge that community agencies, hospitals and volunteer service bureaus seek to recruit numbers of selected and carefully screened senior citizens as volunteers. We are urging our membership to extend themselves to volunteer for all such essential projects and activities. Encouragement should be given at all levels to senior volunteers and we ask that the Federal, State, and local governments work out practical methods of recognizing older people who are doing much to strengthen America. We urge that local welfare departments in particular assist old-age assistance recipients to work in a voluntary capacity in a community so that these people can give to the country as well as receive. This may require local welfare departments to provide extra expense money for old-age assistance volunteers, but the things that these people could do would either mean savings or an actual contribution to community betterment.

We urge that State insurance commissions be more alert in the matter of insurance frauds and ask that they set up regulations to require insurance policies be written as simply as possible and in large type so the policies can be read by the tired eyes of many of our citizens.

We ask that the Food and Drug Administration continue its campaign to protect older people from frauds and health quackery.

We do urge that the National Health Institute and the Public Health Service do more to educate senior citizens and the general public on how to cope with disability and geriatric health problems.

We strongly recommend that the Federal Government set an example by providing more preretirement preparation for civil service employees than is now available. The programs which have been developed in a number of agencies for a limited number of employees, especially those employed by Health, Education, and Welfare, Agriculture and Defense, are most encouraging. We hope that the State and local governments will also act promptly to develop preretirement preparation programs.

Of course the national council feels that there is a need for hospital insurance through social security, and we are submitting comprehensive testimony on this to the House Ways and Means Committee. Without this program substantial progress cannot be made on the economic problems of older people. We do urge that Congress increase the level of social security payments in line with the cost of living.

We support President Johnson's appeal for extension of the food-stamp plan. It is a bitter pill for older people who are living at the starvation level to continue to hear about food surpluses. This program has been in the pilot stage too long. It should be pushed nationwide.

Finally, we would urge that your committee recommend that Congress take some action to give the programs on aging in the Federal Government the additional funds that are needed and also place this program where the concerns of the President will be reflected.

The late President Kennedy had deep concerns for older people as reflected by his early sponsorship of the King-Anderson bill and a bill to provide an administration on aging. Indeed, without his efforts while a Senator, it is doubtful this very committee would be in existence. Yet, throughout his short but dramatic terms as President, we feel the bureaucracy which was placed between

the special office on aging and the President prevented this program from reflecting his views. We hope President Johnson will not be hampered in this manner and that age will come to mean more than welfare and poverty.

TESTIMONY OF CHARLES E. ODELL, DIRECTOR, OLDER AND RETIRED WORKERS DEPARTMENT, UAW, AFL–CIO, DETROIT, MICH.

(Submitted by John Fitzpatrick, executive director of the Metropolitan Detroit Council of Senior Citizens)

Mr. Chairman and members of the committee, I am grateful for this opportunity to present my views on the question of structure in Government in the interests of older people. It is particularly important at this time because of the emphasis given by President Johnson and his administration in recent days to the so-called war on poverty. While it is undoubtedly true that about one-half of the older people in this country have individual incomes that are below subsistence levels, I for one believe that it is a great and serious mistake to deduce from this that the solutions to their problems will be found through public welfare programs. This, in my judgment, is the unfortunate direction in which the Department of Health, Education, and Welfare has been moving in the past several years, and the trend in this direction may well be accelerated by the "war on poverty."

At the time that Congress passed the Social Security Act during the administration of Franklin D. Roosevelt and ever since until very recent times, the concept of social insurance was presented as the fundamental bulwark against loss of income and loss of status in the retirement years of life. Old-age assistance, administered through welfare departments with restrictive means test, residency, filial responsibility, and lien provisions, was presented as a necessary but declining phase of the old-age security problem. For 7 years now, many of us, including in my judgment a majority in both Houses of Congress have been fighting to preserve and extend the social insurance principle, and indeed to preserve and extend the social security system itself by adding a modest hospital insurance benefit as a matter of right to the old-age social insurance system. We have seen, beyond any question, that providing such benefits as an extension of the public welfare system through the old-age assistance program or even through the more liberal provisions of the Kerr-Mills program, is not a workable alternative to the social insurance approach.

I, therefore, find it increasingly difficult to understand how the administration and the leadership in HEW can seriously prepare to project all of its concern for coordination, leadership, and direction of services to older people under the aegis of the so-called Welfare Administration in HEW. As an umbrella for dealing with poverty and with the so-called indigent aged, the Welfare Administration is an appropriate administrative machinery, but let us not make the mistake of forcing all older people over into the status of indigency before they can qualify for services from Federal and State agencies. Now my friends in HEW who defend this administrative monstrosity will tell you that I am exaggerating the case, that they have not abandoned social insurance as the principle bulwark to provide income and health security in retirement; that welfare as defined in the Constitution is a broad umbrella which should not and need not be restricted to the concepts of indigency and the means test. My response to all this is that the distinctions which exist in the public's mind between public welfare and social insurance are distinctions drawn over the years by those who are running the Department of HEW. If there is a stigma attached to public welfare, they helped to create it and perpetuate it by decrying the means test and the indignities to which public welfare clients are subjected and by promoting the concept of income and health security as a matter of right under the time-tested social security system. I happen to agree with them that this was the proper thing to do. I happen also to agree that it is time to eliminate some of the demeaning and obnoxious indignities that now surround the determination of eligibility for old-age assistance and medical aid under the State public welfare programs. But I resent the notion that the older people of this country shall be used as the sacrificial lambs in the belated efforts now being made to build a more positive image for public welfare.

The facts are that all older people are not indigent; nor do they wish to be considered indigents even though they may be teetering on the edges of poverty; and they wish to maintain their independence and dignity even though they may be denying themselves access to some benefits which they can get only at the price of undergoing investigation of their income, assets, and potentials for filial support. I would like to cite several practical examples of this which have come recently to my attention. The first occurred over a year ago when we surveyed a sample of our retired membership in Wayne County to determine their interest in selling their homes and moving into more modern, high-rise rental housing. Seventy percent of the respondents said, in effect, "we prefer to stay where we are and we don't want anyone prying into our income, assets, and financial situation. We will leave our homes for the last time either in an ambulance or a box." A second example is the one that developed last fall in Michigan when Governor George Romney proposed a homestead tax deferment plan for senior citizens as a part of his so-called tax reform program. The Governor was shocked and dismayed to find the overwhelming numbers of older people regardless of party affiliation or political beliefs who reacted violently against this proposal. Why? Because to qualify for tax deferment, the older person would have to apply through the welfare department and undergo an investigation of income and assets. Further, it was proposed to place a lien of 5 percent interest against the estate for all taxes deferred. The older people of Michigan will long remember this ill-conceived attempt to "pauperize" them in exchange for a legerdemain of tax foregiveness at the expense of their estates and their heirs.

There are, of course, many good and badly needed features to the Smathers-Mills bill, and it would be unfortunate if there seemed to be any fundamental difference of opinion among those who oppose its organizational features over other aspects of the bill. I certainly support the sections dealing with grants to States for planning and to communities and nonprofit groups for demonstration programs. The need for research and for incentives to encourage universities to establish professional training programs for work with older people is certainly great. There is also need to provide incentives to professional personnel working in disciplines and programs that could be of value to older people, to pursue both in-service and out-of-service professional training for work with older people.

As the director of a program which sponsors and promotes the development of multiservice centers for older people, I have mixed feelings about this section of the Smathers-Mills bill. While it is true that too many senior center programs are poorly housed in unsafe, poorly equipped quarters, thereby indicating the need for new construction in this field, there is a more serious problem in providing adequate, professionally trained leadership for such programs. Since funds at the local level are severely limited for the developmental of center programs, I would hate to see all or most of the limited funds available spent for new construction or alteration of buildings and little or none spent to provide the kind of professional leadership required to put life and heart into the building once it is constructed. Perhaps the answer to this problem is to broaden the section on centers to include some provision for grants to provide staff in new buildings at least on a short-term basis.

Returning to the question of organization structure, I would like to present briefly several other basic arguments in favor of the concept of an Administration for Aging within HEW rather than an Office of Aging within a welfare administration.

1. Many aspects of aging, including most of the programs of HEW are not provided under the direct or even the indirect leadership of public welfare in the States. There are only a little over 2 million of the 18 million older people in America who are on old age assistance. Only about 150,000 are served in any given month by Kerr-Mills. The trend has been to try to reduce the numbers of aged on public welfare. Let us not undo all these efforts by administrative action which plays directly into the hands of those who would like to destroy the social security system and have us return to home relief and the county poor-farm as the principle bulwark against the insecurity of old age.

2. Grants to States, communities, and nonprofit groups under the proposed bill cannot and should not be administered primarily or exclusively through the Welfare Administration and/or State departments of public welfare. It would be confusing, if not catastrophic, to have demonstration, research, and training projects in the fields of education, health, recreation, employment, rehabilitation, and so forth, being submitted, reviewed, and channeled primarily through the

State department of public welfare and/or the Welfare Administration. Other departments of State and local government as well as private nonprofit agencies in these fields would resent, if not ignore, grant programs channeled in this manner.

3. Many of the voluntary agencies with National, State, and local program for older people would find it difficult if not downright repugnant to their memberships as well as their older clientele to become identified for purposes of planning, coordination, and leadership with a National and State program in aging which derived its authority and support primarily from the field of public welfare.

Finally let me say in all sincerity that I think the Welfare Administration now has more than enough to do as one of the pivotal agencies within the Federal Government in President Johnson's declaration of war on poverty. Let the Welfare Administrator and her counterparts in State government dig into this problem in depth, and let the problems of older people be met primarily by an Administrator for Aging, who sees it as his or her primary responsibility to keep as many older people as possible off the public welfare rolls, by providing them through social insurance and a broad spectrum of community services with the means to avoid indigency.

This is surely a decent and honorable approach to the problem and one which most Americans who want action for older people will understand and accept. The late, great President John F. Kennedy said in his speech to the National Council of Senior Citizens in June of 1963:

"If the King-Anderson bill is passed, it will have been carried on the backs of older people." Let us now make every effort to pass the Fogarty-McNamara bill which contains most of the good features of the Smathers-Mills bill and which provides for an Administration for Aging. In so doing we will be repaying a small part of our debt as a nation to the older people of a country on whose backs much or most of our achievement as a nation in the past 65 years has been carried.

Thank you Mr. Chairman for this opportunity to present my views.

STATEMENT BY JAY L. RONEY, DIRECTOR, PUBLIC WELFARE PROJECT ON AGING, AMERICAN PUBLIC WELFARE ASSOCIATION, CHICAGO, ILL.

Mr. Chairman and members of the committee, we are glad to have an opportunity to come before your committee to discuss with you the services in the field of aging which are now being rendered by various levels of public welfare, and particularly to tell you, from our observations, what is going on among the State and local departments of public welfare as they deal with meeting the needs of older people.

AMERICAN PUBLIC WELFARE ASSOCIATION

The American Public Welfare Association, under the leadership of Miss Loula F. Dunn, executive director, is the national voluntary organization of local, State, and Federal public welfare departments and of public welfare officials and workers at all levels of government. Its present membership consists of approximately 1,650 agencies representing public welfare at both the State and local levels as well as a number of agencies in the voluntary welfare field and approximately 6,400 individual members.

These public welfare departments provide financial assistance, medical care and preventive, protective, and rehabilitative services not only for the aged but also for the blind, disabled, dependent children, and other needy persons. This is accomplished through more than 3,000 county welfare offices throughout the Nation.

PUBLIC WELFARE PROJECT ON AGING

The public welfare project on aging, established in 1959 through a 4-year grant made possible by the Ford Foundation, has directed its efforts to help State and local public welfare agencies establish and operate or expand and improve programs designed to meet the social, economic, and health needs of the aging. The project has worked closely with Federal and voluntary organizations in various areas relating to the welfare of older persons. These include casework services, State planning, community planning, protective services, and

group work. In addition to participating in regional conferences annually, we have had constant communication with State and local public welfare departments and have offered consultation toward the improvement of a variety of services for the older persons.

This project, which is drawing to a close next month, has directed its efforts through providing institutes, seminars, and workshops regarding social services, program planning and administrative patterns in relation to older persons. It has involved more than 300 persons representing various levels of public welfare staffs from 47 States and 1 territory as it determined current operations, progress, problems, and next directions. More than 50,000 publications resulting from these sessions have been distributed to all State welfare departments and other agency members. To provide further information as to the subject areas covered and the thinking of the participants, we have brought, for your review, our publications list and several selected publications relating to the aging. The most important document is our policy statement, approved by the association's board of directors, "Aging—Public Welfare's Role," excerpts of which we respectfully submit for inclusion in the record as part of our statement. We also have an on-going national committee on aging which directs its efforts to consideration of current activities, needs, and problems as they relate to public welfare.

Our observations, reaffirmed by reports submitted by representatives from public welfare departments, have indicated a strengthening of services to the aging across the Nation. These constructive developments have been the result of a number of factors: the White House Conference on Aging, the Senate Committee on Aging's incisive studies, the Welfare Administration's Office of Aging, and the voluntary groups, particularly the National Council on the Aging and the Family Service Association of America, as well as our own project efforts. The 1962 Public Welfare Amendments and the legislative developments in housing, health, etc., have made a marked contribution.

On Monday and Tuesday of this week, we held a session in which public welfare personnel from more than 30 States representing different levels of operation met with us to evaluate progress, problems, and next steps with respect to improvement of services to older persons over the past 4 years. It was the consensus of this group that the institutes and seminars held under our sponsorship have definitely resulted in the strengthening of local and State services to the aged since implementation of ideas has occurred as a result of a deeper understanding of the needs of aging and the services they require. The widespread dissemination of publications has given inspiration and pointed up directions for improvement of programs. These have also served as training materials. The inclusion of sessions on aging at the association's six annual regional conferences and biennial conferences have helped provide additional knowledge to stimulate concern regarding the older person and the variety of methods which can be employed to serve him better.

As we have reviewed the field of aging from our vantage point, it would appear that the following constitute problem areas for State and local public welfare departments as they work in the field of aging:

1. Income maintenance

Although there has been improvement, in the cash benefits and in reduction of the age of beneficiaries in OASDI, and in maintenance payments in old-age assistance, there still continues to be a vast majority of our citizens whose incomes are still inadequate to provide the bare necessities of life. To a great extent, the amount of grants provided by States for OAA recipients is low; in others, there exist "maximum ceilings," thus creating an inadequate level of assistance to meet the specific needs of an aged person which would help him maintain dignity and self-respect. (There are many States which still do not revise benefits in accordance with the increased cost of living.) The extent of public welfare responsibility for income maintenance will be influenced by the extent of other governmental programs and the adequacy of benefits to meet a reasonable standard of living.

2. Financing health services

Although considerable progress over the past 4 years has been in the field of medical care for the aged with the increase in Federal matching funds for OAA, the expansion of nursing home care, and the implementation of the Kerr-Mills law passed by Congress in 1960, considerable stress is still placed on the need for a comprehensive health insurance program for the aged. Although the Federal

Government, State and local welfare departments have moved into the improvement of nursing home care programs, there is continued need for marked attention in this area.

3. Housing

Because many aged persons are receiving limited or inadequate OAA grants, many older persons continue to live in unsuitable and unsafe quarters. The various governmental programs which have moved into alleviation of this problem have, to date, not yet been able to affect many recipients of old-age assistance. Efforts are now being directed to a wide array of housing alternatives as they relate to improvement of current dwellings, public housing, etc. Wherever possible, efforts should continue to be made to maintain for the older people their independent arrangements as long as possible.

4. Adequate social services, including meaningful activities

Directors of State and local public welfare departments recognize that the scope of provision of essential social services is dependent on the professional competency of social workers and the availability of community resources. Although there has been improvement on a spotty basis, the extent of services offered the aging continues to be limited because of the high number of untrained staff and high caseloads assigned to them.

(*a*) *Casework and counseling services.*—Particularly essential is the need for casework and counseling services, not only on a preventive basis, but also to provide encouragement and reassurance to persons coping with current medical, social, and economic problems.

(*b*) *Congregate and domiciliary care.*—In relation to congregate and domiciliary care, although there has been improvement in the adequacy of numbers and in standards, there is still need for incorporating many of the rehabilitative features. Of particular meaningfulness to the aged is the need for careful, diagnostic studies of persons being released from the mental hospitals to the community. Many of these persons are now being placed in congregate facilities.

(*c*) *Provision of homemaker services and friendly visitors.*—There has been a gradual increase in the number of local communities that have established programs of homemaker services and friendly visitors to the aging served by public welfare. However, further expansion is indicated. If efforts are made to maintain individuals within their own homes, these two services are of marked value.

(*d*) *Recreation and meaningful activities.*—There has been an improvement in the expansion of recreational activity centers throughout the Nation. With the exception of some urban communities, this is still spotty and many centers have a limited program. There appears to be continued need for day-care centers, multiservice centers, and sheltered workshops.

(*e*) *Protective services.*—As the 1962 Public Welfare Amendments are being implemented, considerable attention is being paid to the need to develop protective services for those older persons who can no longer handle their affairs independently. Implementation in the provision of protective services has been gradual. We look forward to an increased development of these services, but recognize the problems involved since their solution requires an interdisciplinary approach by the medical, social, and legal fields.

5. Funds for training

Few services can be strengthened for the aging unless caseloads are reduced and staffs are trained. There has been progress in stressing the need for training but, in the majority of States, caseloads remain high and existing staffs are unable to cope with the number of assigned cases unless additional staff is provided. There is marked need for continued in-service training directed toward a broad understanding of the emotional, social, and health needs of the aging, together with an awareness of resources and methods of motivating individuals to make use of existing opportunities within their capacities.

There is a critical need for the provision of Federal training grants since skilled personnel is essential to carry out the rehabilitative programs already authorized.

6. Trained community leaders

Although many States have established commissions and councils and many local communities have established committees on aging, there is still a marked need to train for leadership in the field of community organization, which will involve the entire citizenry. In the absence of an organized welfare council, the

local public welfare director has responsibility for assuming a leadership role to help his community focus attention on the needs of the aging, plan for the appropriate services, and coordinate those which exist.

7. Research and demonstration

New funds made available for research and demonstration projects by the Federal Government have given impetus to a number of local developments. The pressures of current on-going responsibilities upon State and local public welfare departments have impeded their ability to move as quickly as desirable into research and demonstration programs. They have, therefore, not yet had an opportunity to make substantial use of the available funds. Research and demonstration projects are needed in a number of areas and efforts must be directed to select those which have the greatest potential within a community. These projects must be clearly defined, carefully implemented, competently staffed.

8. Services to nonrecipients

There has been considerable effort on the part of public welfare departments to provide services to nonrecipients which also includes OASDI beneficiaries. However, insufficient staff has made it necessary, in many instances, to limit this activity except for those acute situations which bring persons to the attention of the departments of public welfare. State and local departments of welfare hesitate to commit themselves to provision of services to nonrecipients until such a time as they are able to care for recipients of assistance. Resulting workloads would make it impossible to provide adequate services to meet the community's total need.

We are cognizant that work with older people must include cooperation on the Federal, State, and local levels, but programs and services must be conducted and offered in local communities where older people live. We have attempted to stimulate, guide, and support State and local welfare departments, while cooperating with Federal departments to incorporate sound, dynamic programs to provide services to older persons.

This brief summary, we hope, will highlight for the committee some of the continuing subject areas to which we will continue to give full attention as we serve the "older Americans."

(Mr. Roney requested and received permission to submit a supplementary statement, which follows:)

SUPPLEMENTARY STATEMENT BY JAY L. RONEY, DIRECTOR, PUBLIC WELFARE PROJECT ON AGING, AMERICAN PUBLIC WELFARE ASSOCIATION, CHICAGO, ILL.

I appreciate your invitation to submit this supplemental statement since lack of time did not permit presentation of my statement on January 16, 1964, although I was included among those scheduled.

I would like to submit two approaches in this statement: (1) those points which I would have presented had time permitted; and (2) selected statements from the 1964 Federal legislative objectives of the American Public Welfare Association which underscore public welfare's concern for older persons.

STATEMENTS IN RELATION TO THE HEARING

I would like to include in this portion the points I would have presented had time permitted my appearance. They are prompted by assertions made at the hearing by several persons who, in preceding statements, referred particularly to the field of public welfare.

Although I was invited to appear before you to describe the American Public Welfare Association's public welfare project on aging, I feel impelled to refute some statements made about "welfare" and its alleged negative connotation, particularly because this project (described in my prepared statement), supported by a grant from the Ford Foundation, is specifically directed to the area of improving and expanding services to the aged through State and local public welfare agencies. The specific services to the aged described by previous witnesses are the very services which public welfare departments over the country are encouraging—either through affording community leadership and financing or undertaking by providing these services to recipients of old age assistance. Increasingly, these are also being provided to nonrecipients. The services to which I refer are those which enable elderly persons to remain in their own

homes as long as possible or return to their own homes as quickly as possible. These include friendly visitors, described by Mrs. Maxwell; foster care, by Mr. Pikser; homemaker services, by Miss Gilroy; community centers, by Mrs. Kraft; and information and referral centers, by Dr. Furstenberg. (It is interesting to note, in view of the remarks made by the chairman of the Maryland Commission on Aging, that the Information Center in Baltimore, Md., is operated by the Health and Welfare Council, a local voluntary group.) The capacity for local public welfare to provide, support, and encourage the development of these services to recipients and nonrecipients was incorporated in the welfare amendments passed by the Congress in 1962. These progressive amendments, among many other far-reaching provisions, specifically encourage public welfare departments to provide or purchase homemaker services, through allowing 75 percent Federal financial participation of the costs.

I believe the allegations regarding the attitudes of persons concerning the word "welfare" are either open to question of fact or are greatly exaggerated. We who work in public welfare recognize that the request for help, financial or otherwise, is usually a painful experience for persons needing such help. There is perhaps a tendency in our society to escape facing the needs of our fellow men, such as the device of changing names from "Welfare Administration" to an "Office of Aging." "Poverty" is also not a pleasant word, but an attack upon it with a realistic approach did not deter the late President Kennedy nor President Johnson from coping with the problem of "our invisible poor."

I should like to comment on the specific issue of moving responsibility for the aging in the Department of Health, Education, and Welfare from the Welfare Administration to the Secretary's level (S. 2000; H.R. 10904). Although the board of directors of the American Public Welfare Association has not acted on the reorganization aspect which applies to aging, it has given wholehearted support to the establishment of the Welfare Administration under the leadership of Commissioner Ellen Winston. This is due to the potential for the coordination of several programs relating to human need. While not contending that an aging unit on the Secretary's level cannot work, I would like consideration directed to the following points:

1. I subscribe to the principle that it is not wise to legislate detailed organizational structure. The law should provide an objective to be accomplished, appropriate and sufficient funds to carry out the objective and designate the highest level of responsibility. The Secretary of the Department, in this instance, would be responsible for prescribing the detailed administrative pattern. Moreover, the Secretary should have the necessary administrative flexibility to make changes as circumstances warrant, for purposes of cohesiveness, effectiveness, and control.

2. From a practical point of view, the present rearrangement of the Office of Aging within the Welfare Administration is so recent that no one can say, except in theory, that the alleged negative result will occur nor that it is unworkable. There is already some concrete evidence of increased effectiveness, which should continue if given a fair chance and reasonable support.

3. It would seem questionable that the mere shift of responsibility for the aging from the Commissioner of Welfare to a unit in the Office of the Secretary of Health, Education, and Welfare will accomplish what its proponents claim.

4. There is often greater strength in being attached to a strong program unit because many auxiliary services can be provided more economically and the Secretary can more appropriately request needed additional appropriations for an on-going program unit than for one directly assigned to his own office.

5. The Children's Bureau, which interests itself in all children regardless of financial status, is in the Welfare Administration. To present it conversely, all special interest areas would prefer the highest level of recognition possible. Some would undoubtedly prefer more Cabinet positions to add to the already awesome direct responsibilities of the President.

6. The exact position of aging interests in the administrative organizational structure is not as important as the implementation which occurs on State and local levels where the Federal programs finally reach the aged persons themselves.

I should like to expand on this last point as it relates to public welfare departments on State and local levels.

First, at the State level—It is significant that in a number of States the functions of the State commissions on aging have been attached to or staffed by State welfare departments. I believe a study will indicate that these units are

as effective and active as any of the State commissions that are still operating. To a great extent, independent State commissions on aging have included public welfare representation. This factor suggests the following implications:

1. Program units can effectively staff a newly assigned unit and simultaneously preserve the interests of other program areas when their administrative charge is enlarged and the administrative directives are clearly defined and maintained.
2. Social welfare departments are interested in developing needed services for the aging on a broad front; and
3. There is apparent acceptance of the welfare unit on a State level operating in the area of services.

Considerable distress was expressed by two witnesses that some State commissions had ceased to exist, but before concluding that all is lost or that there has been retrogression in these particular States, it would be advisable to review the progress which has occurred as State and local program units, representing such areas as health, mental health, education, housing, and public welfare, have initiated, expanded or improved services to the aging. These developments have occurred because of their own interests and their convictions to improve programs. It would appear that those who support a State commission on aging as the only device for improving services to the aging should consider other potentials.

Secondly, at the local level—Public welfare administrators have been concerned about the alleged public attitude toward welfare ever since the early days when financial assistance was the sole program they could provide for the great numbers of people having this primary need. In recent years a marked increase of emphasis has been given to providing a constellation of services in addition to financial aid. Increased Federal and State appropriations have facilitated these developments, but even more has been the demand from local communities for various services from the public welfare department offices in the more than 3,000 counties across the Nation. These demands have come not from persons who are recipients but from the great numbers of retired old age, survivors and disability insurance beneficiaries who, although self-sustaining, usually have low incomes; from voluntary social agencies in many urban areas who state that the volume of needs and necessary services are so great that they must be a public responsibility; and from persons at all levels in rural counties where often the public welfare office is the only social agency in the community.

Depending on the need of communities, services develop in various ways. In New York City, day centers for the aged are operated by the public welfare department. In numerous rural communities, information and referral services are provided and used by all persons, including the banker, or lawyer, or doctor who wishes to know what plans he can make for his elderly parent even though financing is not a factor. The attitudes of a community toward its local department of welfare has been undertaken in a preliminary pilot study by the Minnesota Governor's Citizens Council on Aging[1] during the past year. Documentary evidence, based on this scientifically designed study, indicates that, in three selected communities, problems relating to old age were included in the concept of welfare. "* * * from this small sampling, it appears that, while society may have this stereotyped image of welfare as being negative, in individual interviews this stereotype is not confirmed since word images selected have positive connotations." In a potency scale developed, the statement is made, "* * * the local county welfare department is considered the most potent by both the citizens at large and the welfare workers."

Public welfare realizes that it is never easy to administer that portion of a program which includes a means test and, as a result, the American Public Welfare Association has, for several years, been actively supporting a health insurance program for OASDI beneficiaries through contributory social insurance. This support by public welfare is in contrast to some who profess concern for preserving the dignity of the aged but have given only lukewarm support to providing for hospital and medical needs through a universal insurance mechanism.

In conclusion, may I say that of greatest importance in relation to S. 1357 and S. 2000 is the stimulation, encouragement and added national attention which these Federal funds would provide for improved services to the aged in several

[1] "A Pilot Study To Check Techniques in Determining the Image of Welfare and Its Impact on the Development of Programs for the Aging," presented at the 16th annual meeting of the Gerontological Society, Nov. 19, 1963, by Mrs. Walter W. Walker, chairman.

areas. It is my hope that such funds would be authorized and appropriated by the Congress and put to use in State and local communities as soon as possible. In the final analysis, use of these funds constitutes the basic merit in these proposals.

SELECTED FEDERAL LEGISLATIVE OBJECTIVES

Although copies of the 1964 Federal legislative objectives of the American Public Welfare Association were presented to the committee, we should like to call your attention to various items related to the aging. In each instance, the page and numbered paragraph are cited.

Page 1, b:

"Contributory social insurance is a preferable governmental method of protecting individuals and their families from loss of income due to unemployment. sickness, disability, death of the family breadwinner, and retirement in old age; and of providing for the health costs of OASDI beneficiaries."

Page 1, c:

"Public welfare programs should be family centered and should provide effective services to all who require them, including financial assistance and preventive, protective, and rehabilitative services; these services should be available on an equitable basis to all persons without regard to race, color, creed, national origin, residence, settlement, citizenship, or circumstances of birth."

Page 2, 2:

"Federal financial aid should be available to assist States in carrying out public welfare responsibility for preventive, protective, and rehabilitative services to all who require them, irrespective of financial need."

Page 2, 9:

"Specific provision should be made for Federal financial assistance to States to stimulate and support services and facilities to promote the health and welfare of aged persons irrespective of their financial need."

Page 2, 12:

"Federal law should require the establishment and maintenance of State standards of health and safety for housing rented to assistance recipients."

Page 2, 14:

"Federal law should require that medical care for old-age assistance recipients be no less in amount, duration, and scope than medical assistance for the aged."

Page 3, 23:

"Adequate Federal funds, comparable to those for other federally supported training programs, should be appropriated for the training of State and local public welfare staff."

Page 3, 29:

"The contributory old-age, survivors, and disability insurance program, as a preferable means of meeting the income maintenance needs of people, should be strengthened. Among the needed improvements are: making benefit payments more adequate; increasing the amount of earnings creditable for contribution and benefit purposes in line with current earning levels; broadening the scope of disability insurance protection, especially by eliminating the requirement that the total disability be of long-continued and indefinite duration; and extending coverage to earners and their dependents still excluded."

Page 4, 44:

"The present scope of public welfare programs reflects gaps in the social and economic fabric of the Nation. It is essential to the well-being and security of the Nation that increased emphasis be placed upon all measures to prevent poverty, including the elimination of racial and religious discrimination and the development of full and unrestricted opportunity for employment at a suitable wage, and for adequate housing, education, social, insurance, and medical care."

We are grateful that this statement will be included for the committee's review.

EXCERPTS FROM "AGING—PUBLIC WELFARE'S ROLE," A POLICY STATEMENT OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Social service requirements of older people and the concern of public welfare for meeting these requirements are direct outgrowths of significant changes in society which demand, and are now beginning to receive, serious attention.

Public welfare, as a major repository of society's concern for the general welfare of its members, must now plan definitively for the needs of the older population in the same way that it has planned for the needs of children.

Changes in society, in the recent past, have had significant impact on the older person, his role in his family, and his place in the community. These changes underlie the needs of older persons and the services essential to meet them.

SOCIAL SERVICES ESSENTIAL TO MEET THE NEEDS OF OLDER PEOPLE

While all older people need adequate income, healthy family and neighborhood relationships, proper health services, appropriate housing, meaningful activity, and a sense of continued usefulness, the ways in which these needs are met vary considerably. Traditionally, primary responsibility for meeting these needs has rested with the individual and his family. All community services for older people should be planned and organized to support and strengthen this tradition. Society has established broad measures for helping the individual and his family to carry this primary responsibility, such as social insurance, sanitation codes, building codes, health education and other such programs. There are many older people, however, whose needs cannot be met through their own or family resources, and require a wide range of community services.

Since many of these needs are social in nature, social agencies have a basic responsibility to extend their services to this group. These services are provided through casework, group work and community organization. Good community planning should include not only direct services but also the coordination of existing resources and the stimulation of other community groups to participate in the further enrichment of programs for the aging. These should include the use of the special skills and contributions of volunteer workers as well as those of professional paid staff.

Social services are for remedial and preventive purposes. Social agencies should make available direct services to the older person in order to help him identify his problem and determine a plan of action and to support him in carrying out his plans. Relatives and social agencies should be helped to recognize and understand the problems facing the older person and the special considerations that may be required to meet these needs. Social agencies also have a primary responsibility through community organization to improve, expand, and develop other resources in the community that are needed by older persons and their families.

In planning for services, it must be accepted that work with many older persons will be time consuming. It is often necessary to reach out to the aged, to help them communicate their problems, fears, and what they want for themselves, to give comfort, support, and encouragement during periods of difficulty and distress. Services for older people require more extensive collateral activities, particularly in relation to family members. Because of the multiphasic nature of the needs of older people, there is special need for development of effective cooperative working relationships with a variety of community resources.

THE ROLE OF PUBLIC WELFARE

Public welfare has a long history of activities directed toward the needs of older people. Records of public expenditures from colonial days to the present reveal the public's concern for the economic and social welfare of older citizens. Recently, public welfare agencies with offices in virtually every county in the Nation have served millions of older people through public assistance and other programs, and have acquired thereby an awareness and knowledge of the social and economic problems of older people that can be used for their benefit. Some public welfare departments have extended various services to older persons in the community without reference to eligibility for public assistance.

The role of public welfare in public assistance services

Through analysis of the needs of older people, the public agency grows in conviction as to the social services it should administer and those it should encourage other community agencies to undertake. However, public welfare staff is in a transition period in carrying out its role. A sound policy and full administrative support for direct services is essential. Public welfare administrators have a unique opportunity and a responsibility to interpret program strengths and weaknesses, and needs and resources to legislatures, boards, and citizen groups. These administrators will be expected by legisla-

tures, boards, and citizen groups to facilitate program changes within agencies and to give wise leadership in the use and development of resources, while keeping in balance the services offered to the different age groups. Basic to consideration of providing adequate social services is the matter of assistance grants which make possible a decent level of subsistence.

The role of public welfare in communitywide services

Many older persons need but are not eligible for the social services that are now available to public assistance recipients. In the future, public welfare will be increasingly concerned with a large number of people who are not in need of financial assistance, such as beneficiaries of an adequate old-age and survivors insurance or private pension benefit.

Public welfare has a responsible role to assume in the provision of services to older people throughout the community having social service needs which may or may not include economic want. At the present time, public welfare should further identify through research and demonstration the areas of need of older persons, the identification of resources to meet those needs, including family and individual strengths as well as agency services, and the ways of mobilizing these resources to bear upon specific needs.

Public welfare has the responsibility to orient administrators, boards, and executives to the needs of older people, particularly as they relate to other individuals and groups, so that they may evaluate and foster coordination of existing services and proceed to develop additional services to meet those needs. It is important that services for older people are developed within the framework of the total responsibilities facing public welfare boards and departments.

This, in turn, is closely related to the continuing function of informing the public about the needs of older people and the services required to meet those needs in order to establish a climate of acceptance.

Specific responsibilities of public welfare

Within this framework of acceptance public welfare should take the initiative in developing for the community-at-large of older persons services to encourage independent living, individual counseling, information, and referral services, help for the aged mentally ill who return to their communities, help of various kinds with unmet medical and housing needs, and protective services. Public welfare must consider which of these services public welfare departments should and can provide at the present time, and what priorities will be for the addition of new services. Essential, too, is the development of plans for the progressive addition of services in accordance with community assessment and planning. This planning should recognize the need for involving the physical planners as well as social planning groups. The development of new programing can only be considered in conjunction with the strengthening of existing services.

Pilot projects

Significant contribution can be made by public welfare departments through demonstration or special projects. These may include self-care or social rehabilitation projects, home medical care programs, homemaker service, family care, volunteer services, and special casework programs. When appropriate, cooperation with existing medical programs and voluntary agencies should be undertaken in such demonstrations.

Leadership role

Finally, public welfare has a duty as well as a continuing responsibility to provide community leadership in concerted action to consolidate all community resources toward an effective operating program for the aged. It has its basis in law, and in fact in experience and in depth of organization; and in knowledge, understanding, compassion, and conviction to support it in carrying out such a role.

Senator KENNEDY. The Chair is advised that the General Federation of Women's Clubs will submit a statement. It will be received and inserted in the record at this point.

(The statement referred to follows:)

STATEMENT BY MRS. LEONARD E. OLIVER, KANSAS CITY, MO., CHAIRMAN OF GERONTOLOGY, GENERAL FEDERATION OF WOMEN'S CLUBS

INTRODUCTION

The General Federation of Women's Clubs, with its headquarters at 1734 N Street NW., Washington, D.C., was organized in 1890 and was incorporated by an act of Congress March 3, 1901. The purpose of the General Federation of Women's Clubs as stated in its charter of 1891, is: "To unite the women's clubs and like organizations throughout the world for the purpose of mutual benefit, and for the promotion of their common interest in education, philanthrophy, public welfare, moral values, civics, and fine arts."

Its membership comprises 11 million women in 16,000 clubs in the 50 States, and 53 countries and territories.

The work of the general federation is promoted through its appointed department and divisional chairmen, each with a counterpart in the 50 States. Each State chairman directs the program and projects through the State organization.

In Mrs. Dexter Otis Arnold's installation message, June 29, 1962, "Assignment for the Sixties," she said: "To study and act in the field of gerontology is to bring hope and comfort and intelligent understanding in an area where misunderstanding flourishes."

"The goals for this administration are 'to strengthen the arm of liberty' through positive programs that recognize the ability, dignity, and experience of the elderly, and to correct the outdated image of aging."

ACCOMPLISHMENTS

The inability to submit a full report on the accomplishments of this administration is due to the fact that the State biennial reports are not due until March 1, 1964. However, the summary from the 1963 reports indicate that the work done with and for older people has been gratifying.

The local clubs have shown great interest in alerting their members on better housing for the elderly. A special feature, of the 72d annual GFWC convention, held in Milwaukee, Wis., June 10–14, 1963, was a tour of St. John's Old People's Home. This building has been described as one of the most suitable homes of its type in the United States. It was designed by Architect Charles Haeuser of Milwaukee. Twenty States were represented in the tour.

A majority of the States reported an increased interest in the organization of councils for studying and dealing with problems of the aging. It is worth noting that State federations had representation on these councils, and in most cases took the initiative, and with the approval and support of State health and welfare departments are now in charge of implementing such programs.

The reports indicate an informed interest in the work of this division with an increase in the number of programs and special projects in certain areas—education, health, safety, employment studies, low-cost housing, recreation and social services.

The phases of the program devoted to "Preparation for a Dynamic Maturity" and "Your Retirement Finances" have elicited much response.

Perhaps this 1963 annual report from one State—(contributed $10,972.00—12,661 gifts—36,928 hours of service and 39,669 transportation-miles) multiplied by 50 States can, in a small measure, show the interest and accomplishments for the year 1962–63. Correspondence with State chairmen indicates far greater results will be given in the 1964 reports.

ASSISTANCE BY FEDERAL GOVERNMENT

The Department of Health, Education, and Welfare, through Secretary Anthony J. Celebrezze, has been of invaluable service to the organization in promoting the program.

The U.S. Office of Aging, through Dr. Donald P. Kent, Director, and Mrs. Ada Stough, specialist in voluntary organizations, has been working closely with the headquarter's office of the General Federation of Women's Clubs, in providing copies of available publications, giving program guidance, and the publication of 18,000 copies of a brochure on safety and accident prevention for older persons—

"Free the Added Years From Accidents." This publication is in the final drafting stage and will soon be available to the local clubs.

The U.S. Public Health Service, Division of Accident Prevention through Dr. Paul V. Joliet, and Dr. Irmagene N. Holloway, safety program specialist, provided the General Federation with four safety programs included in the brochure, "Free the Added Years From Accidents."

These programs were designed for those aged 65 and over. Dr. Irmagene Holloway and Mr. Thomas C. Klapperich, regional consultant, Chicago, Ill., office. were present when the safety program was initiated during the 72d annual convention, June 12, 1963, in Milwaukee, Wis. Dr. Holloway assisted in launching the "Free the Added Years From Accidents" program at a Kansas City metropolitan area meeting September 30, 1963. She was interviewed by Kansas City, Mo., WDAF radio, in a 1-hour conversation program September 30, launching the program over a 5-State area.

The nine regional accident prevention consultants have assisted the State and local Gerontology chairmen through their State and local health departments.

The nine regional representatives on aging have given valuable service to State and local organizations.

Miss Amelia A. Wahl, U.S. regional (VI) representative on aging, and Mr. John H. Hove, U.S. regional consultant (VI), Accident Prevention Division, Public Health Service, have been very cooperative in assisting the chairman.

The U.S. Treasury Department through the Kansas City office of the Missouri U.S. Savings Bonds Division assisted with the program by providing copies of the pamphlet "Now, Build Your Own Retirement Program with U.S. Savings Bonds" for State and district meetings, and for letter enclosures.

The U.S. Veterans' Administration, Department of Medicine and Surgery through James H. Park, Director, Voluntary Service Staff, contributed VA Pamphlet 10–17 "Senior Citizens—We Need You," for letter enclosures.

RECOMMENDATIONS FOR FEDERAL ACTION WHICH WOULD HELP THE GENERAL FEDERATION PROVIDED MORE AND BETTER SERVICES TO THE AGED

1. Use our members on citizens councils and committees to advise the Government on problems of aging.
2. Alert the organization to trouble spots or advise it of specific needs which it could follow through.
3. Enact legislation which will provide demonstration grants for community planning and action programs in the areas of education and social participation. If such grants were available any number of special action programs might be sponsored by local clubs of the General Federation of Women's Clubs; or the clubs might well stimulate other nonprofit organizations to assume responsibility in this area.
4. Provide speakers for State conventions and regional conferences; printed material and filmstrips for local programing.
5. Participate in seminars and workshops at State conventions and regional conferences.
6. Use a greater percentage of "retired persons" in the Peace Corps program.

Senator KENNEDY. This hearing is now adjourned, subject to the call of the Chair.

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