92D CONGRESS
1st Session

SENATE

REPORT
No. 92-505

A PRE-WHITE HOUSE CONFERENCE ON AGING SUMMARY OF DEVELOPMENTS AND DATA

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

TOGETHER WITH MINORITY AND SUPPLEMENTAL VIEWS

NOVEMBER 1971

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[1] Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

PREFACE

To judge by official declarations, this year's White House Conference on Aging—to be conducted during the week of November 28—has had a major change in fundamental purpose.

At the start of the year, the Conference theme was "Toward a National Policy on Aging." Within recent months, however, a new Conference Chairman has talked with some urgency about the need for action, before, during, and after the Conference.

This need for action is indisputable, as earlier reports by this Committee have indicated. But the questions remain: will the action be appropriate and will it be on a scale large enough to matter?

Apparently in response to the new goals declared for the White House Conference, the Administration has taken several steps intended to allay fears about the Conference. In addition, several high-level actions have been taken in regard to long-term care, consideration of alternatives to the Administration on Aging, and establishment of a structural framework for implementation of the recommendations of the White House Conference.[1]

These late developments—and many others—have resulted in a situation far different than when the Senate Special Committee on Aging published its last annual report.[2]

To evaluate those developments and to report upon findings from recent reports and hearings by this Committee, this pre-White House Conference on Aging survey is offered to participants at that Conference and to all others who have an interest in those proceedings.

This document also serves another purpose. It has helped this Committee to organize facts and findings that will be helpful in evaluating and seeking implementation of the recommendations made by the White House Conference on Aging.

I believe that the White House Conference Chairman—former Health, Education, and Welfare Secretary Arthur Flemming—should be taken at his word when he says that he regards the Conference as an event in a process. It is certainly not the finale to all the activity and preliminary conferences which have led up to it. Instead, it will provide a foundation on which a structure can be built.

To make certain that this structure is solid and built to serve genuinely essential purposes, action should be taken in the near future to assure that implementation is based solidly upon realities and not outdated information or wishful thinking.

Mr. Flemming has already anticipated the need for new mechanisms for implementation by reporting that a Cabinet-Level Committee on Aging has been formed within the President's Domestic Council. Frankly, I see little difference between this new mechanism

[1] For additional information on the White House Conference and recent related actions, see the Introduction to this report.

[2] "Developments in Aging—1970," March 23, 1971.

and the old President's Council on Aging [3] (a body which seems to have faded away without much alarm on anyone's part).[4]

Among the complaints that can be made about the structure of the Domestic Council Committee on Aging, are many that were directed at the President's Council on Aging. Cabinet-level officers are not likely to spend hours in joint discussion of Conference recommendations; they may instead send lieutenants with varying degrees of interest or concern in aging. In addition it may be significant that the President himself did not announce, the committee but conveyed the news about the committee in a letter to H.E.W. Secretary Richardson.

A Domestic Council Committee on Aging would have far more likelihood of success if it were buttressed by several innovative measures of the kind I will soon offer in the form of legislation. Among my proposals will be the following:

1. Steps should be taken soon in 1972 to require mini-White House Conferences on Aging at approximately 2-year intervals during the decade before the next full White House Conference. These periodical Conferences should not review all the subjects reviewed at this year's full Conference. Instead, each should focus upon one major subject at a time. By far and away the most vital subject is retirement income. My legislation would call for a follow-up conference on that subject no later than November 1973, preceded by a comprehensive mobilization of essential data.

2. The Domestic Council Committee on Aging would cause considerable harm to the cause of aging if it in any way hindered efforts to establish a more potent successor to the Administration on Aging. That agency, established under the Older Americans Act of 1965, will lapse unless renewed before June 30, 1972. An Advisory Council to the Senate Special Committee on Aging has proposed major changes to supersede the AoA with much more visible and prestigious governmental arrangement.[5] As soon as the White House Conference recommendations on this subject are made, members of this Committee and others in the Congress will undoubtedly offer bills to deal with the question of continuation or replacement of the AoA. *That legislation should receive careful administration attention; it should not be balked by administration assertions that its Domestic Council Committee on Aging is developing a master plan for implementation at some distant future*

[3] The President's Council on Aging was established on May 14, 1962. Its last report covered the years of 1965, 1966, 1967.

[4] Membership in the President's Council on Aging included Secretaries of H.E.W., Treasury, Agriculture, Commerce, Labor, HUD, as well as the Chairman of the Civil Service Commission, the Administrator of Veterans Affairs, and the Director of the Office of Economic Opportunity. The new Cabinet-level Committee on Aging, as announced on October 13, has as members: Elliot L. Richardson, Secretary of Health, Education, and Welfare, Chairman; Clifford M. Hardin, Secretary of Agriculture; Maurice H. Stans, Secretary of Commerce; James D. Hodgson, Secretary of Labor; George W. Romney, Secretary of Housing and Urban Development; John A. Volpe, Secretary of Transportation; George P. Shultz, Director, Office of Management and Budget; Arthur S. Flemming, Chairman, White House Conference on Aging.

In addition, Joe Blatchford, Director of ACTION; Phillip Sanchez, Director of the Office of Economic Opportunity, and Leonard Garment, Special Consultant to the President, have been asked to serve as consultants to the Committee.

[5] See chapter 4 for details.

date. Neither should the Council Committee be accepted as the final means of implementing the White House Conference recommendations. The Cabinet-level approach has been tried before, and it does not work.

3. Soon after the White House Conference, a major administration effort should be made—by legislative direction if necessary—to compile and correlate findings from government research, demonstration projects, and experience with ongoing programs related in any way to aging *in all Federal departments.* It is a pity that such an effort was not made in advance of the Conference. It would be even more unfortunate if findings from such an information-gathering effort were not made to aid in the implementation of those recommendations.

4. A hectic-4-day White House Conference is not likely to afford sufficient time for setting priorities and for "costing-out" major recommendations. Administration representatives should be called upon by appropriate units of Congress for *cost* information soon after the Conference, and Congress should also ask for a description of *social benefits* to be derived from the major recommendations.

Added to my individual suggestions are several recommendations made by the full Committee in the body of the following report. More comprehensive recommendations will be made in the next Committee report, due for publication in early 1972.

This report does not offer definitive criticisms of the White House Conference "issues" as defined by the Background and Issues papers prepared by specialists under the direction of Technical Committees of the Conference. Despite the criticism leveled at many of the issues, largely on the grounds that they take an overly restrictive and limited view of problem areas and are too often phrased as "either/or" alternatives, the issues have served as the basis for earlier, preparatory conferences. It would be fruitless to seek redefinition at this late date, particularly in view of the fact that several Technical Committees have taken steps to permit more leeway in discussion of issues at the Conference. It is to be hoped that, in the instructions given at the first meeting of the Conference, more light can be thrown on this matter.

Once again, despite the admonitions I have just given, I find more reason for optimism than gloom about prospects for the Conference. As I said at the start of the year, the field of aging means too much to too many people to be given superficial treatment. In spite of many problems and misgivings, the way now seems clear for a good Conference and effective follow-up.

In presenting this report at this time, the Committee does not wish to give the impression that it is attempting to force major policy recommendations upon the conferees. Instead, it has a much more specific and appropriate purpose. It is merely attempting to report upon new developments which have some bearing upon committee and Conference deliberations.

Committee members and staff have made major efforts during 1971 on certain carefully selected areas. This year, in particular, the Committee was assisted by several Advisory Groups which have my heartfelt thanks for their invaluable services.[6]

Many others, including witnesses at the many hearings conducted during 1971, also have the gratitude of this Committee. Their generosity in giving of their time and knowledge may be prompted this year by the knowledge that the White House Conference should be built upon a broad foundation which includes an informed Congress. Members of this Committee, in particular, feel a special responsibility for the Conference; several of us advanced the legislation calling for it. We want a satisfactory conclusion to our beginning.

FRANK CHURCH, *Chairman.*

[6] See appendixes 4–7, pp. 155–158 for details.

CONTENTS

APPENDIXES

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NOVEMBER 19, 1971.—Ordered to be printed

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

REPORT

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INTRODUCTION

An avalanche of written material confronts participants in this year's White House Conference on Aging, as well as the many more Americans who have a direct interest in the outcome of that Conference.

This report is intended to reduce at least one demand upon those persons: it will summarize recent hearings and reports of the Senate Special Committee on Aging.[1] In addition, it will describe certain recent developments of direct relevance to the Conference.

As the preface indicates, the members of this Committee by no means regard this document as a definitive summary of all information and viewpoints that should receive attention at the Conference and elsewhere.

Instead, it deals only with recent happenings which, in the opinion of the Committee, are worthy of attention.

I. SIGNIFICANCE OF THE WHITE HOUSE CONFERENCE

As originally envisioned by the Members of Congress who introduced legislation[2] calling for a White House Conference on Aging, the Conference was to continue the process begun in 1961, when a similar

[1] See Appendix 8, p. 159, for a list of reports, committee prints, and hearings by the Senate Special Committee on Aging for December 1970-1971.

[2] On September 28, 1968, President Johnson signed a joint resolution into law (P.L. 90-526) authorizing the conference and initial funding. Several members of the Senate Committee on Aging were initial sponsors of that resolution.

convocation met for the first time.[3] The 1971 Conference was intended to evaluate progress made during the prior 10 years; and it was to stimulate action toward a unified national effort to overcome major problems, most notably inadequate retirement income.

In previous reports by this Committee, it has been pointed out that the 1971 Conference will differ markedly from the 1961 meeting. For one thing, government organization has changed. An Administration on Aging, established by the Older Americans Act of 1965, is now at work; and it has program relationships with agencies in all 50 States. Medicare has been enacted, and some progress has been made in improving Social Security protection and in providing new housing units for the elderly.

Thus, the Conference has less of a "breaking ground" function than was the case in 1961. Instead, it faces what is in many ways a more complicated task: it must extract the truly worthwhile achievements of the past, compare our present rate of progress with needs which seem to be outstripping that progress, and synthesize new strategies for short- and long-range action in the decade which follows.

If the conferees do their job well, the 1970's could be a period in which the mistakes and omissions of the past will be rectified, in which the people of this Nation will come to understand more clearly the magnitude of the challenge which confronts all of us in the form of unresolved problems relating to aging, and in which our rate of progress will accelerate markedly.

II. EARLY CRITICISM OF THE CONFERENCE

Alarmed by widespread criticisms about the Administration on Aging and its conduct of the White House Conference on Aging, the Senate Special Committee on Aging joined with the Subcommittee on Aging of the Senate Labor Committee to conduct a legislative review of the situation as it appeared earlier this year.[4] Almost unanimously, witnesses expressed deep concern about the Conference. Among their criticisms: preparation of technical papers and work books were behind schedule, members of technical committees had been subjected to political screening, and the definitions of "issues" at preliminary local and State conferences were restrictive and perhaps confusing. One witness [5] said that Conference preparations had resulted "in a moratorium that seems to have been declared on any action now."

As plans progressed, other complaints arose: no national task forces had been established to deal with the "needs-meeting" areas around which much of the conference was centered; the structural

[3] A "national meeting" on aging took place in 1950, but did not compare in size or function with the 1961 Conference.

[4] "Evaluation of the Administration on Aging and Conduct of the White House Conference on Aging":
Part 1. Washington, D.C., March 25, 1971
Part 2. Washington, D.C., March 29, 1971
Part 3. Washington, D.C., March 30, 1971
Part 4. Washington, D.C., March 31, 1971
Part 5. Washington, D.C., April 27, 1971
Part 6. Orlando, Fla., May 10, 1971
Part 7. Des Moines, Iowa, May 13, 1971
Part 8. Boise, Idaho, May 28, 1971
Part 9. Casper, Wyo., August 13, 1971

[5] William Fitch, Executive Director of the National Council on the Aging, p. 228 of hearings cited in footnote 4.

format of the Conference offers no way to resolve conflicting recommendations or to establish priorities; there appeared to be some confusion in many States about the approved procedure for arriving at policy recommendations. Representatives of several minority groups said they were under-represented (See chapter 6).

Health, Education, and Welfare Secretary Elliot Richardson—testifying at the joint hearing on April 27—said it appeared to him that the Conference was on schedule and that much of the criticism seemed to be unwarranted.

III. CORRECTIVE ACTIONS

Secretary Richardson also announced that former H.E.W. Secretary Arthur S. Flemming had agreed, a few days before the April 27 hearing, to serve as full-time Chairman for the White House Conference.

Soon after his appointment, Dr. Flemming said that "one word and concept—namely, action" would govern the Conference. He added: [6]

> Congress called for recommendations and plans for action that will achieve the objectives clearly set forth in the law authorizing the Conference. This law [7] calls for a report on plans for action not later than 120 days after the Conference concludes. It also directs that 90 days later the Secretary of Health, Education, and Welfare should submit both to the President and to the Congress his recommendations for administrative and legislative action.
>
> Unless the hopes and aspirations sure to be spelled out at the Conference lead to action, it would have been far better to have stopped with the first 1961 Conference on Aging rather than to hold a second one. A failure to translate the hopes and aspirations of our older Americans into "action programs" will simply add to their frustrations.

Dr. Flemming has since traveled extensively throughout the Nation and has announced several individual "action" efforts, including: establishment of a Cabinet-level Committee on Aging (discussed by Senator Church in the preface to this report), several related proposals intended to improve conditions in nursing homes (discussed in chapter 3) and changes in the structure of the Conference itself.

Partially in response to complaints about limitations imposed by limiting the Conference to 9 "needs area" and 5 "needs-meeting" areas, Mr. Flemming has authorized a call for 16 "special concerns" areas on the morning of December 1 (discussed in chapter 8). In addition, he has called for an "open forum" on the night of November 29 and he has established the position of "Co-chairman" for each Conference section.

The Senate Committee on Aging concurs in all decisions that will make this year's White House Conference on Aging more responsive, more representative, and better able to translate recommendations

[6] As quoted in the Bulletin of the White House Conference on Aging, June 1971.
[7] Public Law 90-526.

into action. Much will depend, however, upon the clarity of instructions given to the conferees when they assemble in Washington. Reversals of earlier decisions have not, in the opinion of this committee, been satisfactorily explained. The conferees should have no doubts in their minds as to whether they are simply to offer broad policy recommendations, or whether they are to provide recommendations that can be readily absorbed in a comprehensive action strategy.

In addition, the administration should clarify the functions of the new Cabinet-level Committee on Aging within the Domestic Council. If that committee has been established simply to re-analyze the analysis to be provided by the White House Conference recommendations or to "Plan For Planning", it could cause a moratorium on sorely-needed action.

CHAPTER 1

THE KEY ISSUE: RETIREMENT INCOME

Inadequate income, as nearly everyone agrees, is the most serious problem facing older Americans.

But, during the past 3 years, the Senate Special Committee on Aging has found it necessary to make strenuous efforts to alert the Nation to the fact that the full magnitude of the retirement income crisis is still largely unnoticed.

Our declarations on the subject were summed up in December 1970 with the publication of a report, "Economics of Aging: Toward a Full Share in Abundance." That report was based on eight working papers, 18 days of hearings, and widespread correspondence and conversation with experts in many fields.

To bring fresh perspective on the situation, the Committee Chairman asked members of the Committee's Task Force on the Economics of Aging to report on income issues facing the White House Conference on Aging.

The full text of their report appears on p. 119 of this document. But several of their conclusions should be noted here:

1. The Task Force finds that the 2½ years since publication of their first working paper "have done nothing to allay our sense of crisis."

2. In fact, says the Task Force, "*each passing year increases* the economic problems of old age." Among the complicating factors are: increasing numbers of persons who have reached their 65th birthday, together with larger proportions of the aged groups attaining the very oldest ages.

3. The "aging" of the aged population means particularly great increases in the numbers of widows and other women living alone.

4. Economic slowdown and other forces are increasing the numbers of persons who retire prior to age 65, and this "adds to the years that must be spent eking out an existence on inadequate retirement income."

5. Growing urbanization, together with decay of metropolitan centers and widespread social strife, increase the economic insecurity of the elderly, many of whom are clustered in old neighborhoods of large cities.

Underlying and complicating all such factors is the failure—in the view of the Task Force and in the view of the Senate Committee on Aging [1]—to produce the national commitment necessary for dealing with this crisis.

[1] In its last annual report, "Developments in Aging—1970," this Committee declared: "Timid tinkering or stop-gap proposals will fall far short in solving the present or future retirement income problems. Bold, imaginative and far-reaching action is needed now on several fronts." Nine minority members of the Committee, in their own assessment of the situation, said: "High priority should be given to adoption of an Older Americans Income Assurance Plan which will guarantee that our national commitment to decent standards of living with dignity becomes a reality for all the aging."

Instead, says the new Task Force summation, it would appear that the forthcoming White House Conference has sometimes been used as justification for postponing serious consideration of positive and comprehensive actions to improve retirement income. (emphasis added).

Specific suggestions to deal with the problem are advanced by the Task Force in appendix 1. In this section of the report, this Committee will report on other recent developments which are related to retirement income issues which should be considered at the White House Conference. In addition, this chapter provides a brief review of the most recent Committee on Aging recommendations in this area.

I. NEW EVIDENCE ON THE NEED FOR ACTION

In March a 10 percent increase in Social Security benefits was signed into law,[2] bringing overdue relief for 27 million recipients. For the typical retired worker, monthly benefits increased from $118 to $131. Social Security payments for the average retired couple went from $199 to $219, and for a widow from $102 to $113.

This long awaited action also provided a shot in the arm for our lagging economy, with $3.6 billion in added purchasing power to be used principally for noninflationary, everyday essentials, such as more food for the table.

But as welcome as the 10 percent raise was, it was still only a temporary measure to prevent the elderly from slipping further behind in their race with inflation. Since the last Social Security increase, which was effective in January 1970, the cost-of-living had risen by 6 percent—the most rampant inflation on an annual basis in nearly 20 years. Moreover, this stop-gap measure lacked the sizable benefit increases and comprehensive reforms to come to grips with a retirement income crisis which now affects millions of older Americans and threatens to engulf many more. Even with the 10 percent increase, Social Security benefits still fall about $300 below the poverty threshold of $1,852 for a single aged person. And 1971 statistics from the Bureau of Census provided a further grim reminder that more far-reaching action is necessary.

The overriding importance of Social Security benefits in providing income security is clear from these facts in the 1968 Social Security survey: One-fourth of the aged couples receiving Social Security benefits at the end of 1967 and two-fifths of nonmarried individuals had less than $300 per person per year other than Social Security benefits. Significantly, there had been little improvement in this respect since the survey a decade earlier.

A. Persistence of Poverty

Today more than 4.7 million older Americans fall below the poverty line. Compared with 1968, this represents approximately a 100,000 increase.

[2] Public Law 92-5 approved March 17, 1971.

TABLE I.—*Poverty thresholds (poor and near poor*) older unrelated individuals and families by location and sex, 1970*

[Weighted averages]

Location and sex	Unrelated individual 65 and over		2-person family (couple) head 65 and over	
	Poor	Near poor	Poor	Near poor
Total	$1,852	$2,315	$2,328	$2,910
Nonfarm	1,861	2,326	2,348	2,935
Male	1,879	2,349	2,349	2,936
Female	1,853	2,316	2,336	2,920
Farm	1,586	1,983	1,994	2,493
Male	1,597	1,996	1,996	2,495
Female	1,576	1,970	1,972	2,465

* Near-poor threshold is defined as 125 percent of the poor threshold.

Source: Bureau of Census.

In 1971, the likelihood of being impoverished is more than twice as great for older Americans as it is for younger Americans. One out of every four persons 65 and older—in contrast to one in nine for younger individuals—lives in poverty.

Perhaps even more disturbing is the reversal of the longstanding trend toward reducing the number of poor among the elderly. (From 1959 to 1968, poverty for older Americans declined from 6 million to 4.6 million, for nearly a 23 percent reduction, but, since 1968—as already indicated—the numbers of elderly poor are increasing.) [3]

Equally alarming, mounting evidence strongly suggests that a new class of elderly poor may be in the making unless major policy changes are instituted. From 1968 to 1970, poverty for persons 60 to 64 increased by nearly 100,000. If the present trend toward "easing" many older workers out of the work force continues, their poverty numbers may accelerate in the years ahead.

These trends, depressing as they are, represent only a portion of a very grim picture. Larger numbers of elderly persons would also be considered marginally poor. In 1970, for instance, 25 percent of all families with a head aged 65 and above were considered poor or near poor. Of this total, 16.3 percent lived in poverty, and 8.3 percent were near poor.

And the situation for elderly persons living alone or with nonrelatives was even more distressing. Nearly six out of every 10 unrelated individuals 65 and older were classified as poor or near poor.

B. LATEST BLS BUDGETS FOR RETIRED COUPLES

During 1971 Bureau of Labor Statistics updated its three budgets for urban retired couples. For couples with lower and intermediate budgets, approximately eight out of every 10 dollars of income would be spent on housing, food, transportation, and medical care. Even for the higher income budget, nearly seven out of every 10 dollars would be used for these items.

[3] For further discussion, see "Developments in Aging—1970", p. 3.

TABLE II.—*Three budgets for an urban retired couple—Preliminary spring 1970 cost estimates*

	Total budget	Food	Housing	Transportation	Medical care
Lower	$3,109	$917	$1,077	$212	$367
Intermediate	4,489	1,220	1,554	413	370
Higher	7,114	1,531	2,429	754	372

Source: Bureau of Labor Statistics.

Perhaps even more significant, nearly two out of every five aged couples in the United States have insufficient incomes to afford the intermediate budget as established by BLS. Approximately 38 percent have incomes below $4,000, and 12 percent have incomes between $4,000 and $5,000. And Social Security benefits for the typical retired couple are well below the moderate standard of living set by BLS in its intermediate budget, meeting less than three-fifths of the costs. Even the maximum benefits payable under Social Security would be more than $650 below the moderate BLS budget for an elderly couple.

For single aged persons, the situation is even more severe. Nearly 65 percent of all unrelated aged individuals living alone or with relatives have annual incomes below the BLS intermediate budget of $2,469. And their median income amounts to only $1,951—just a shade above the poverty threshold of $1,852.

C. INFLATIONARY PRESSURES

Inflationary pressures have intensified the squeeze on the elderly's limited, fixed incomes. Annual cost-of-living increases amounting to 5.4 percent in 1969 and 6 percent in 1970 represented the two sharpest rises in the Consumer Price Index in nearly two decades.

As of August 1971, the cost-of-living had registered increases for 55 consecutive months—the longest unbroken string in the 58 year history of the CPI. Compared with the base year of 1967, the CPI has increased by more than 22 percent. But, many items, which affect the elderly to a much greater degree than younger persons, have risen at even a more accelerated rate. For example, medical care increased by 30 percent during this period, and housing by more than 25 percent. And hospital daily service charges have jumped by an astounding 64 percent. If the base period 1957–1959 is considered, the increase for hospital daily service charges would amount to 204 percent.

In August, a 90-day freeze—authorized under the Economic Stabilization Act—was ordered for wages, prices, and rents. For the month of August—the first month that the freeze was in effect—the CPI increased by .3 or approximately 4 percent on an annual basis.

D. ELDERLY WOMEN: THE MOST ECONOMICALLY DISADVANTAGED

With a median income of $1,888, aged women living alone or with nonrelatives are among the most economically disadvantaged in our entire society. Nearly five out of every eight unrelated women aged 65 and older—or 63.1 percent—are classified as poor or near poor. Of the total, 50 percent have annual incomes below the poverty threshold.

Lower paying work, more frequent part-time jobs, and career interruptions because of family responsibilities have contributed to the lower benefit levels for women than for men with comparable backgrounds. According to the Survey of Newly Entitled Beneficiaries [4] during the latter half of 1969, nearly seven in 10 persons entering the retired-worker benefit rolls with minimum benefits were women.

Especially hard-pressed are aged widows who lack Social Security coverage from their own work records.[5] Their incomes are the lowest of any beneficiary group. They are also among the oldest of the elderly. And they usually receive little income other than benefits based on their deceased husband's primary insurance amount.

II. UNEMPLOYMENT IN PRE-RETIREMENT YEARS

Tempting as it might be to deal only with income problems that arise *after* retirement begins, the Senate Special Committee on Aging once again must issue this warning:

Unemployment among so-called older workers continued to increase throughout 1971. Many men and women, as a consequence, face joblessness or under-employment some years before they can qualify for retirement benefits. Nothing has occurred during this year to cause the Committee to withdraw its warnings that a new class of elderly poor may be in the making.

A. Extent of Unemployment

Widespread joblessness for all age groups continued throughout 1971 with the unemployment level averaging nearly 5 million. Compared with January 1969, the jobless rate soared from 3.4 percent to 6 percent, adding nearly 2.4 million persons to the unemployment rolls.

Throughout the year, its impact was felt in many ways—massive layoffs, shorter work weeks, smaller paychecks, reduced work forces, and steep increases in unemployment compensation payments. (From fiscal year 1970 to fiscal year 1971, for example, unemployment benefits jumped precipitously from $2.8 billion to $4.8 billion, for nearly a 71 percent increase. And this amount would undoubtedly have been considerably higher if thousands of unemployed workers had not exhausted their benefits.)

1 Million Older Workers Unemployed.—Again in 1971, middle-aged and older workers were hard-pressed by the widespread joblessness which affected every region in the Nation. In many cases, persons in their 40's and 50's found themselves in a "no-man's" land—being too young to retire, but too old to hire.

Many older workers discovered that they had lost more than their jobs. Thousands also lost their pension coverage and other fringe benefits, although they had worked most of their lives for this little "nest egg".

From January 1969 to September 1971, unemployment for persons 45 and older jumped from 596,000 to 1,057,000—for a 77 percent increase. Their long-term joblessness (15 weeks or longer) during this

[4] "Benefit Levels of Newly Retired Workers: Findings From the Survey of New Beneficiaries", *Social Security Bulletin*, July 1971, p. 26.
[5] Page 26 of article cited in footnote 4.

period rose by 196 percent, from 115,000 to 340,000. And their very long-term unemployment (27 weeks or longer) increased from 48,000 to 200,000, for a 317 percent jump.

Today, about one of every three unemployed persons aged 45 and older has been out of work for nearly 4 months. In sharp contrast, this ratio is only one out of six for younger workers. And this trend toward longer periods of unemployment continues to increase. Approximately 2½ years ago, the average duration of joblessness for an unemployed worker 45 and over was 9.9 weeks. Today the average duration has jumped to 17 weeks, for about a 72 percent increase in the length of time for being without a job.

B. Committee on Aging Hearings

In June, the Subcommittee on Employment and Retirement Incomes launched a study on "Unemployment Among Older Workers." A major purpose of the hearings was to go beyond existing statistics to hear in human terms what it means to be unemployed for several months. Additionally, the Committee sought solutions for the growing unemployment problems facing older workers. Four days of hearings were conducted in South Bend, Indiana; Roanoke, Alabama; Miami, Florida; and Pocatello, Idaho.

Throughout the hearings witnesses emphasized that the loss of a job can have a double impact for older workers. It may not only wipe them out financially when their family responsibilities are growing, but it is also likely to result in substantially reduced retirement income.

Other key findings:

—Manpower programs have largely overlooked or ignored the special problems of persons from rural areas;

—Once unemployed, the older worker runs a substantially greater risk of being without a job for a comparatively long period of time;

—Bureaucratic red tape frequently imposes insuperable barriers for the mature jobseeker;

—Age discrimination is still a real problem, even though a law [6] was passed four years ago to prohibit such practices;

—A substantial percentage of older workers, and especially those in lower paying employment, does not have any pension coverage. Others are finding coverage meaningless when they lose all rights along with their jobs.

—The concept of community service employment was enthusiastically endorsed by older persons and community leaders.

C. Nation's Stake in Employing Older Workers

Another key development in 1971 was the preparation of a working paper—"The Nation's Stake in the Employment of Middle-Aged and Older Persons"—by the National Council of Senior Citizens for the

[6] The Age Discrimination in Employment Act was signed into law on December 15, 1967, and became effective on June 12, 1968. It protects individuals 40–64 years old from age discrimination in matters of hiring, discharge, compensation and other terms, conditions or privileges of employment. Coverage under the law includes: (1) employers of 25 or more persons in an industry affecting interstate commerce, (2) employment agencies serving such employers, and (3) labor organizations with 25 or more members in an industry affecting interstate commerce. If a complaint is filed, efforts must first be made to eliminate the alleged discriminatory practice through conciliation, conference, and persuasion before legal proceedings are instituted. Only after such attempts have failed are the civil remedies and recovery procedures available for enforcement of the Act.

Committee on Aging. A major theme throughout the report was the need for special emphasis programs for meeting the unique and growing unemployment problems confronting older workers. Two major recommendations emerging from this working paper called for the adoption of an Older American Community Service Employment Act[7] and a Middle-Aged and Older Workers Employment Act.[8] Additionally, this document served as a springboard for discussion for hearings [9] on these bills by the Subcommittee on Aging of the Senate Labor and Public Welfare Committee.

D. Congressional Action to Maximize Employment Opportunities

Two employment measures with potentially far-reaching implications for the Nation's older workers were approved during the first session of the 92nd Congress. Signed into law on July 12, 1971, the Emergency Employment Act would establish a public service employment program for unemployed persons ranging from welfare recipients to jobless engineers. It was estimated that this measure would provide jobs for 150,000 to 200,000 individuals. Of special significance, the Act includes language designed to assure that middle-aged and older workers will be fairly represented in the new public service employment programs—reasonably consistent with their percentage of the total unemployment in the United States. Individuals 45 and older now constitute about 22 percent of the joblessness in the United States. Applying this percentage, mature workers could conceivably be eligible for 33,000 to 44,000 of the new public service jobs authorized under this legislation. During the fall, the Congress approved legislation extending the antipoverty programs for two years.[10] One of the key innovations in the 1971 Economic Opportunity Act Amendments was the establishment of a comprehensive child development program. Particularly significant for the elderly was an amendment, sponsored by Senator Harrison Williams, to encourage the employment of older persons in child development centers.

E. Pressures for Early or Forced Retirement

Powerful evidence of the growing trend toward earlier and earlier retirement is provided in a new Social Security Administration Bulletin, "Benefit Levels of Newly Retired Workers." Particularly noteworthy, this article revealed that nearly 85 percent of all persons awarded payable benefits in the last half of 1969 received some reductions in their primary insurance amounts because they claimed benefits before age 65. More than half of the men and two-thirds of the women claimed entitlement at age 62, As a consequence, they had nearly the full 20 percent actuarial reduction applied to their benefits.

[7] The Older American Community Service Employment Act, S. 555, was introduced by Senator Edward M. Kennedy on February 2, 1971. This measure would provide new opportunities in a wide range of community service activities—such as antipollution control, community beautification, health aides, and others—for low-income persons 55 and older.

[8] The Middle-Aged and Older Workers Employment Act, S. 1307, was introduced by Senator Jennings Randolph on March 19. 1971. This bill would establish a midcareer development services program in the Department of Labor to provide training, counseling, and special supportive services for persons 45 and older.

[9] "Employment Opportunities for Middle-Aged and Older Workers, S. 555, S. 1307, S. 1580"; Subcommittee on Aging, Committee on Labor and Public Welfare, United States Senate; 92d Congress, 1st Session; July 29 and 30, 1971. (Hearings are not yet in print.)

[10] On September 9, 1971, the Senate passed S. 2007, the Economic Opportunity Act Amendments of 1971. A similar bill (H.R. 10351) was approved by the House of Representatives on October 1, 1971. As of this date, this legislation is being considered in conference committee.

Yet, there is strong evidence to suggest that many of these older workers are leaving the work force involuntarily. As a general rule, persons claiming actuarially reduced benefits are more likely to have sporadic work patterns than individuals who can wait until age 65 to collect their Social Security. As a result, their monthly benefits are likely to be significantly lower than those received by persons waiting until 65 to retire. Moreover, large numbers are claiming actuarially reduced benefits only as an alternative to prolonged periods of unemployment or because they have already exhausted their unemployment compensation.

Consistent with this trend, pressures were mounting in 1971 for earlier retirement for Federal employees. One such measure was H.R. 8083—approved by the House of Representatives on October 4—which sets a mandatory earlier retirement age for air traffic controllers (at 56 in most cases and 61 for individuals who are retained because of exceptional skills and experience). Additionally, in July, the House Post Office and Civil Service Committee reported out H.R. 8085, which would authorize the President to establish maximum age requirements for entrance into the Civil Service when age would be a bona fide occupational qualification reasonably necessary for the performance of those duties. Under present law there is an outright ban on maximum age limits for entrance into the competitive service.

III. PENSION PLANS UNDER SCRUTINY

Increasingly, it is becoming apparent that millions of workers are losing pension benefits because of events beyond their control. Massive layoffs, plant shutdowns, company mergers, lack of vested benefits and employer bankruptcies, have all played havoc with the lives of mature workers and their families. In far too many cases, these unforeseen events have completely undercut even the most soundly conceived plans for the "golden years." All too often it means that their life styles will be changed markedly. In many cases, it also means the acceptance of a life of poverty.

Further disturbing evidence on several points was revealed in a study conducted by the Labor Subcommittee of the Senate Labor and Public Welfare Committee. This survey included 1,500 plans, which affected 60 percent of all workers covered by private pensions.

On March 31 Senator Harrison Williams, Chairman of the Labor and Public Welfare Committee, and Senator Jacob Javits, ranking Minority Member of the Committee, released a preliminary staff analysis of 87 of the retirement plans. Nearly 10 million workers had participated in these pension plans since 1950. Out of 51 plans with no vesting or requiring 11 of more years for vesting, only 5 percent of all participants who have left their jobs since 1950 have received benefits. Of the remaining 36—with 10 years or less for vesting—16 percent collected their pensions. This report also indicates that substantial numbers of individuals who lost their benefits were long-term employees.

Even though this survey is preliminary—in the sense that it does not include all of the 1,500 plans—it is sufficiently disturbing to alert the Nation to the hardships imposed upon far too many workers when they discover too late that pension coverage may turn out to be an illusory promise.[11]

IV. A GUARANTEED INCOME FOR THE ELDERLY?

With millions of older Americans now experiencing a retirement income crisis, which seems to be deepening rather than improving, important and far-reaching questions are being raised with greater and greater frequency:

—Should the Social Security program be used as the "umbrella" for lifting large numbers of elderly persons out of poverty?

—What measures should be employed to enable the aged to share in our Nation's abundance, which they have worked most of their lives to make possible?

—Should older Americans be assured of a guaranteed annual income upon reaching a certain age? What should that income be? And how should it be provided and financed?

—Should the adult categorical assistance programs be replaced with a new income supplement program, to be administered by the Social Security Administration?

Several bills now before Congress would deal with at least a few of the questions listed above. Among them:

H.R. 1.—Particularly significant is the 1971 Social Security-Welfare Reform Amendments, H.R. 1, as passed by the House of Representatives in June. (For a more detailed discussion of the provisions in this bill, see p. 23 of this report.) In addition to making major reforms in the Social Security program—such as full benefits for widows at age 65; cost-of-living adjustments; a new special minimum monthly benefit; and others—H.R. 1 would establish for the first time a new Federal income floor for the elderly. This would be achieved by replacing the existing adult categorical assistance programs (Aid to the Aged, Blind and Disabled) with a new Federal program to be administered by the Social Security Administration. Under this new program an income standard of $130 per month would be authorized for an aged person and $195 for a couple. However, H.R. 1 would make these individuals ineligible to participate in the Food Stamp program.

Church Social Security-Welfare Reform Proposal.—On April 26, Senator Frank Church introduced a comprehensive Social Security-Welfare Reform proposal (S. 1645) to eliminate poverty for 5 million older Americans and to raise Social Security benefits to more realistic levels for others. The bill would provide benefit increases for all

[11] On November 7, Senator Harrison A. Williams Jr., and Senator Jacob K. Javits released the preliminary results of a second staff analysis of 764 private pension plans studied. One of the key findings was that the median monthly payment for normal retirement is only $99 per month. For early retirement, the median monthly pension amounts to $72. And for disability retirement, it is less than $50 a month.

Social Security benefits for the typical retired couple now amount to $219 per month. On an annual basis, a typical retired couple, entitled to social security benefits and a private pension, receives slightly more than $3,800 from both of these sources. Yet, this is nearly $700 below the BLS budget of $4,489 for a retired couple living in an urban area.

Social Security recipients. However, they would be weighted in such fashion as to authorize larger dollar raises for persons who now receive lower benefits. For example, persons with monthly earnings between $150 and $200 would receive, on the average, a 21 percent increase in their benefits. Individuals with monthly lifetime earnings ranging from $200 to $300 would receive increases averaging 18 percent. Additionally, S. 1645 would increase the minimum monthly benefit from $70.40 to $120 for single persons with at least 20 years of covered employment. Moreover, the bill would authorize automatic adjustments in benefits for rises in the cost-of-living.

Equally important, the bill would replace Old Age Assistance with a new income supplement program to be administered by the Social Security Administration. Under this new program, elderly persons below the poverty index would certify to the Social Security Administration that their incomes fall below this standard. They would then be entitled to a supplementary payment sufficient to bring their monthly income up above the poverty level. This income standard would also be adjusted automatically with increases in the poverty index.

In the wealthiest Nation in the world, it is no longer socially acceptable or economically necessary for nearly 5 million older Americans to live in poverty. The committee strongly urges that top priority attention in this year—the year of the White House Conference on Aging—should be devoted to the elimination of poverty for the elderly. Equally important, benefits under public retirement programs must be raised to a more realistic level to enable the aged to share in the abundance and growth of our economy.

The committee again urges far-reaching and comprehensive reforms on several fronts for meeting the retirement income problems now affecting millions of older Americans. Specifically, the committee recommends that:

- **—Social Security benefits be increased substantially by January 1972, but weighted to provide greater dollar raises for persons who now receive lower benefits;**
- **—The reforms in the cash benefits program advanced under H.R. 1—such as a new special minimum; automatic adjustments; full benefits for widows at age 65; liberalization of the retirement test, and other progressive measures—be adopted promptly;**
- **—Old age assistance should be replaced with a new income supplement program which would be sufficient to lift all aged persons out of poverty; and**
- **—Delegates at the White House Conference should give close and careful attention to proposed alternatives for making the Social Security payroll tax more progressive and less burdensome for low and moderate-income wage earners.**

Additionally, the committee recommends that:

- **—Legislation establishing an institute on retirement income [12] be enacted;**
- **—Increases in Railroad Retirement benefits should be commensurate with Social Security raises;**

[12] On February 19, 1971, Senator Harrison Williams introduced S. 883, which would establish an Institute on Retirement Income. The Institute would operate as a "think tank" agency for conducting intensive study and making concrete recommendations on all aspects of retirement income—including Social Security, Railroad Retirement, military retirement programs, and private pensions.

—The retirement income credit should be updated to provide comparable tax relief for Government annuitants as is now received by Social Security recipents;
—Income limitations for veterans' pensions should be adjusted to take into account increases in Social Security and Railroad Retirement benefits;
—A middle-aged and older workers employment act should be promptly enacted and fully funded; and
—A National Senior Service Corps, as envisioned in the Older American Community Service Employment Act should be established on a permanent, ongoing national basis.

CHAPTER 2

HEALTH: RISING COSTS AND REDUCED PROGRAMS

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

Complicating all such problems is a health care crisis which is receiving more and more attention in the Congress, the press, and the Executive Branch. Usually, debates about this crisis deal in the "big picture" consideration of total government outlay, reimbursement techniques, and cost-cutting techniques.

To the Committee on Aging, it is apparent that another major question must be asked:

In very concrete terms, what is happening to the people who thought that they would be better served by Medicaid and Medicare than they now are?

Vital as it is, that question is sometimes overlooked in more generalized discussion of health issues. And yet, it must be asked, and answered, not only to deal with the immediate issues of the moment, but because the answers have direct meaning and importance to the intensifying public debate over proposals to establish a national health insurance program.

I. INCREASES IN PERSONAL OUTLAY: MEDICARE

In a period marked by intense inflation, the mere passage of time compounds the problems of financing health costs for the aged. Since 1965—the year that Medicare was enacted—older Americans have received four Social Security increases. During this time their monthly benefits have increased by 53 percent. Yet, in terms of health care, they have been on an economic treadmill. The stark reality is that most of the aged's expenses for participating in Medicare have advanced as fast or faster than Social Security benefits.

The premium for Part B is up 87 percent. The cost of the Part B premium was $3.00 per month in July, 1966; on July 1, 1971, this was increased to $5.60 monthly.

The deductible on the hospital bill will increase to $68 on January 1, 1972.[1] The deductible for Part A Hospital Insurance was $40 when Medicare went into effect in 1966. This amount was later increased to $44 in 1969, $52 in 1970, and $60 in 1971.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay—as of January 1, 1972—$17 a day for the 61st through the 90th day, up from the present $15 per day.

If a Medicare beneficiary needs to draw on his "lifetime reserve" (the reserve of hospital days a beneficiary can drawn upon if he ever needs more than 90 days of hospital care in the same benefit period), he will pay—as of January 1, 1972—$34 for each day used, instead of the present $30 per day.

Doctors' fees for office and hospital visits and surgery are up more than 25 percent, and so the coinsurance which Medicare calls for (20 percent of the reasonable and customary charge) takes more dollars.

If the elderly patient goes into an extended care facility, the co-insurance he must pay—$5.00 in the initial legislation from the 21st day to the 100th day—is up 50 percent to $7.50 per day. The $225 a month that coinsurance would cost is larger than the Social Security check received by most beneficiaries. On January 1, 1972, this charge will go up to $8.50 per day.

The aged require twice as many doctor visits on the average and double the amount of hospital care and prescribed drugs as younger people so they are in "double jeopardy" from inflation of all these costs.

In 1966, an aged person spending 21 days in the hospital and 60 days in an extended care facility following an operation that cost $400 in surgeon's fees would have spent out-of-pocket $396 including his Part B premiums. The same episode would cost him $563.60 in 1971 (when the surgeon's fee is assumed to have increased to $500), an increase of 42 percent for the combined expenses of this one episode. As of January 1, 1972, this same episode will cost another $48—another $8 for the increase in the hospital deductible and an added $40 for the increase in extended care facility charges. A 1972 episode would also include whatever increase there might be in the surgeon's fee.

In fiscal 1970 a total of $10.6 billion was spent in public programs providing personal health care on behalf of the aged and $5.1 billion was spent privately. These sums come to $791 for each aged person, $534 under public programs and $257 of private payments. The public portion includes the premiums that the aged paid for Part B, equal to $63.60 per capita. If counted as private expenditures, out-of-pocket amounts would average nearly $321 per aged person per year. This amount can make a large hole in the average pension. An unavoidable

[1] This increase was announced on October 1, 1971, by Secretary of Health, Education, and Welfare Elliot L. Richardson.

Secretary Richardson stated that the increase in cost to Medicare users was caused by health care cost increases which took place before the President's wage-price freeze order of August 15, 1971.

Senator Frank Church of Idaho, Chairman of the Special Committee on Aging, on October 4, 1971, appealed to the President and Secretary Richardson to consider a postponement of this increase. Such a postponement would not be unprecedented. HEW Secretary Wilbur Cohen, on December 31, 1968, decided not to increase Medicare Part B premiums, in spite of advice given to him from the Social Security Administration. In so deciding, Mr. Cohen stated: "I want to avoid further fanning of the flames of inflation throughout our entire medical care system."

In announcing the increase to $68, Secretary Richardson stressed the need for urgent action to slow down the rising costs of hospitalization. He emphasized that policies were being developed to curtail these as a part of the administration's plans for Phase Two of its wage-price stabilization program.

Confusion reigns in another area affected by the administration's wage-price freeze. Conflicting reports have appeared on the impact of the freeze on Medicare and Medicaid reimbursements, fees, and payments. Senator Frank Church has requested that the Cost of Living Council clarify the situation.

reason for the aged spending so much themselves relates to drugs, which averaged over $73 of private costs to the aged, and would be more if all who need prescribed drugs could afford to purchase them.

Reduction of Extended Care Under Medicare

Mention has already been made of the increase—from $7.50 daily to $8.50 daily—in the coinsurance amount that an elderly patient must pay from the 21st day to the 100th day if he goes into an extended care facility. This becomes effective January 1, 1972.

This is a mere reflection of the massive cutback in the Medicare ECF program that has taken place over the past few years. In 1968 the total benefits payment amounted to $340 million and in 1969 it was $300 million. But in 1970 benefits were only $180 million. In effect, the Medicare ECF program has been cut in half.[2]

II. A NEW PROBLEM: MEDICAID FEES

Medicaid fees—charging the Medicaid recipient for benefits received—has emerged as a new problem.

In March of 1971 the Governor of California proposed co-payment charges for the welfare poor receiving Medi-Cal [3] benefits: $1 for each doctor's visit; $1 for each prescription; and $3 a day for hospital or nursing home care. The Department of Health, Education, and Welfare in Washington gave its approval to this plan in May of 1971, under a waiver of its regulations allowing States to initiate "small-scale experiments" in welfare administration.

A Medi-Cal Reform Bill was signed into law in August 1971, and it became effective October 1, 1971. The new act requires co-payment for provider services ($1 per visit) and prescription drugs (50¢ per prescription).

The Department of Health, Education, and Welfare has ruled that the Governor of California can implement on an experimental basis the co-payment plan in the reform act. The HEW ruling said California could experiment with the small payments for 18 months, beginning January 1, 1972.

The HEW approval of the California co-payment plan represents the first time a State has been allowed to impose charges on Medicaid recipients. Federal law prohibits requiring such payments, but HEW lawyers have said that the law does not bar experimenting with them, which was all that was authorized in California's case.

III. CUTBACKS IN COVERED SERVICES

A Senate inquiry specifically directed at "Cutbacks in Medicare and Medicaid" began in Los Angeles on May 10, 1971. Senator Edmund S. Muskie, Chairman of the Subcommittee on Health of the Elderly for this Committee, began the hearing by declaring:

> Recent cost-cutting cutbacks and regulations have saved money, but at the price of denying urgently needed health care to our older citizens. By placing limits on care available

[2] For a fuller discussion of the dismantling of the Medicare ECF benefit, see *Developments in Aging—1970*, a report of the Special Committee on Aging of the U.S. Senate (at pp. 43–44).

[3] Medicaid is called Medi-Cal in California.

> and by increasing costs, we have merely decreased the health and happiness of our older people. Too often, the choice for them must be made between food and medicine.

As did several witnesses, Senator Muskie warned that savings from cutbacks might prove short-lived or even illusory. He said:

> Untreated minor illnesses become major diseases. Canceled doctor visits and home care mean later expensive hospitalization. With health care primarily on an emergency-only basis, preventive medicine becomes near impossible. Without attention or drugs, many older Americans are forced to face the pain and terror of sickness alone.

A. Effects of Cutbacks in California

At the Los Angeles hearing, the Muskie Subcommittee heard compelling testimony on the impact of the cutbacks in California's Medicaid program (Medi-Cal).

In December of 1970 the Governor of California instituted severe cutbacks in the Medi-Cal program. Medi-Cal patients got reimbursement for only two visits to a doctor per month. Patients had previously been allowed to see a doctor as often as needed. Prior authorization by a State consultant was required for all hospitalizations except emergencies. Many drugs reimbursed under Medi-Cal were no longer authorized. Reimbursements to providers for all services were slashed 10 percent.

In March of 1971 the California Governor proposed benefit reductions in about one-third of the Medi-Cal medical service categories. He also proposed the Medi-Cal co-payment charges discussed earlier.

The December 1970 cutbacks are no longer in effect. The 10 percent cut in fees for providers ended July 1, 1971. A Medi-Cal Reform Bill—mentioned earlier—became effective October 1, 1971.

The precise effects of the reform act are not entirely clear at this time. It must be noted, however, that one of the major restrictions of the earlier cutbacks reappears in the new reform act: physician visits are limited to two per month or a maximum of 24 per year.

The reform act also requires—as noted earlier—co-payment for provider services ($1 per visit) and prescription drugs (50¢ per prescription). This provision is similar to an earlier cutback.

EXAMPLES OF CUTBACKS

Testimony presented to the Muskie Subcommittee in Los Angeles, documents the consequences of the cutbacks in the Medi-Cal program:

—Dr. Robert Peck, Chairman of the Los Angeles Chapter of the Medical Committee for Human Rights, called the co-payment provisions "heartless and hopeless." "And if, in fact, the doctors will attempt to collect this one dollar per visit," Peck asserted, "they will find they will spend five dollars in the collection procedure and will end up not collecting after all."

—Detailed record-keeping requirements and the prospect of not being reimbursed for their services led many doctors to refuse to see Medi-Cal patients. As a result poor people were forced to turn to county facilities and philanthropic hospitals.

—One month after implementation of the Medi-Cal cutbacks, Los Angeles County faced a backlog of 26,000 cases. Dr. John Anthony Smith, President of the Interns-Residents Association of Los Angeles County, told the Committee that the hospital where he is employed in Los Angeles saw 1,164 Medi-Cal patients in April of 1971, 218 of whom were referrals by private physicians. The 218 were a ten-fold increase over referrals of the previous month.

—Public hospitals were faced with more patients and less money to care for them as a result of the Medi-Cal cutbacks. A hospital hiring freeze was adopted by Los Angeles County due to the cutbacks. Because of the freeze anesthetists and anesthesiologists were called upon to double as operating room nurses. Dr. Smith described for the Committee the consequences of this arrangement:

> That is to say, the department of anesthesia in our hospital sort of operates the operating rooms. They are responsible for the surgical suites. This has led to inadequate personnel to staff the operating rooms and the recovery rooms and has led to potentially tragic delays in surgery.

Dr. Smith reported to the Committee that a 74-year-old woman died of peritonitis before space could be scheduled for her in an operating room. He also stated that an 89-year-old man died in the hospital from a kidney condition when there was no one available to schedule X-rays of his urinary tract.

—Another witness before the Committee, Dr. Hubert L. Hemsley, President of the Charles Drew Medical Society of Los Angeles, testified that the Medi-Cal cutbacks were depleting the poverty area of badly needed medical resources.

Dr. Hemsley asserted that only doctors with 50 percent Medi-Cal and Medicare patients would be pressed into continuing further subsidizing of the program. Those with only 10 or 15 percent Medi-Cal and Medicare patients "have already stopped seeing Medi-Cal patients rather than accept responsibility for their care and be forced by bureaucratic guidelines to render second-class medicine," he said.

The cutbacks led to the closing of neighborhood nursing homes, Dr. Hemsley said. Former patients were forced into outmoded county facilities, often remote from their communities. Emergency rooms of public and private hospitals were overflowing due to the cutbacks. Public hospitals were flooded with added cases, only emergency cases could be treated, according to Dr. Hemsley.

B. Proposed and Existing Cutbacks in New York

The Governor of New York won legislative approval of cutbacks in Medicaid in the spring of 1971. The New York cutbacks were delayed by a temporary injuction, which was later vacated by a decision of the United States Court of Appeals. Currently, the cutbacks are slated to become effective November 1, 1971.

New York welfare recipients are automatically eligible for full Medicaid benefits. This also applies—until November 1, 1971—to the "medically indigent," those with incomes insufficient to pay for the medical care they need. New York originally pegged that income at

$6,000 for a family of four. A cut to $5,000 was made in 1968. On November 1, 1971, the income limit will be reduced to $4,500.

Reductions in the income limits have led to sizable cuts in the numbers of the medically indigent. Although those on welfare still receive full benefits, the reduced numbers of medically indigent will be eligible for just the basic coverage under Medicaid. This means that the following services, among others, will no longer be received: dentistry; podiatrists; home nurses; and rehabilitation therapists outside the hospital.

The burdens of this cutback are likely to fall most heavily upon those needing medical care as well as the local government. People who need care will oftentimes not seek it because they cannot pay for it. Those requiring immediate medical attention will be turned away from doctors' offices and voluntary hospitals and forced to go to municipal hospitals and clinics.

It has been estimated that those affected by this most recent Medicaid cutback will—in New York City alone—make 32,000 outpatient visits a year, at a cost of $1.1 million; 20,000 emergency department visits costing $500,000; and will spend 80,000 hospital inpatient days, which will cost $9.9 million. Of the $11.5 million New York City expects to recover less than $7.9 million from the State and Federal governments. New York City can also expect to lose $3 million that would have come in matching funds on its existing patient load.[4]

The flood of potential problems caused by the cutbacks is not limited to this tremendous financial squeeze and the loss of needed care in many cases. The "charity medicine" stigma of public hospital gains a new life as a result of the numbers of poor people pushed out of voluntary hospitals and back into public facilities. Doctors, faced with overflowing outpatient clinics, may well be forced to devote less time to each patient.

Quality of care also may suffer in another way. Many doctors moved into poverty areas after Medicaid came into existence, believing that Medicaid payments would enable them to make a living practicing in these neighborhoods. Many such doctors now find themselves with their backs to the wall as a result of the Medicaid cutbacks. This can lead in many cases to doctors trying to survive financially by increasing their daily patient load, which means cutting down on the time spent with each patient.

Cutbacks, of course, can increase costs in many instances. A New York City Medicaid official explains it this way:[5]

> If a specialist can treat a patient in his office, and we have cut his fee from $16 to $8, he sends the patient over to the hospital, where we have to pay $40 per outpatient visit.

PROBLEMS RELATED TO LONG-TERM CARE UNDER MEDICAID

There are a number of problem areas related to long-term care under Medicaid. Charges of overutilization of long-term care facilities under Medicaid have been made by members of Congress and others. Simply being "too expensive" has been another basis for indictment of long-term care under Medicaid. Others have decried the absence in Medi-

[4] These figures are based on estimates by Paul J. Kerz, senior vice president for finance of the New York City Health and Hospitals Corporation, as reported in the *New York Times*, Oct. 17, 1971, p. E–8.

[5] Statement of Dr. Stephen N. Rosenberg, the deputy executive medical director of the New York City Medicaid program, as quoted in the *New York Times*, October 17, 1971, p. E–8.

caid long-term care regulations of any requirements for activities planning or quarterly visitations to patients by a staff member of a welfare department.[6]

IV. RESTRICTIVE PROVISIONS OF H.R. 1

Further cutbacks—in both Medicare and Medicaid—are written into the provisions of H.R. 1, the House-passed Social Security and welfare reform bill, which is scheduled to reach the Senate floor later this year or early in 1972.

A. Medicare Cutbacks in H.R. 1

H.R. 1 would increase the deductible under the Part B supplementary medical insurance program from the present $50 to $60, beginning on January 1, 1972.

H.R. 1 would also make the elderly subject to a $7.50 daily co-payment charge for each day in the hospital from the 31st to the 60th day. Under present law the patient is subject to the $60 deductible, and, after satisfying this charge, pays nothing on his hospital bill through the first 60 days.

For an elderly person in the hospital for 60 days, this daily co-payment charge could mean an extra expenditure of $225. This provision also strikes at the patient who needs help the most—the person with skyrocketing health care expenses due to an extended stay in the hospital.

B. Medicaid Cutbacks in H.R. 1

H.R. 1 contains Medicaid provisions regarded as regressive by many observers. Peter D. Coppelman, Project Director of the California Rural Legal Assistance Senior Citizens' Project, terms the H.R. 1 Medicaid changes "an open invitation to the States to slash their Medicaid programs, thereby completely disrupting medical services for the poor, just as California did in the December 1970 cutbacks." [7]

One Medicaid proposal in H.R. 1 would repeal the existing provision requiring States to have comprehensive Medicaid programs by 1977.

A second H.R. 1 provision requires maintenance of effort by the States only for the basic Medicaid services. States are thereby allowed to reduce other services without prior HEW approval or utilization control. These optional services include such items as outpatient prescription drugs, dental care, and eyeglasses.

H.R. 1—in yet another provision—would impose cost sharing on Medicaid recipients. The first two provisions discussed above would greatly reduce services, while this provision would force the Medicaid recipient to help pay for whatever services remain. This provision would require that States impose on the medically indigent a premium enrollment fee based on income. Cash assistance recipients could be faced with deductibles and cost-sharing charges for optional services. States would also be permitted to impose deductibles and co-payment features on the medically indigent, which would not have to be based on income.

[6] For a more complete discussion of problems related to long-term care under Medicaid, see *Developments in Aging*—1970, a report of the Special Committee on Aging of the United States Senate (at pp. 44–49).

[7] Letter to Senator Edmund S. Muskie, Chairman, Subcommittee on Health of the Elderly, United States Senate Special Committee on Aging, October 7, 1971.

A fourth provision in H.R. 1 is designed to encourage greater outpatient care under Medicaid. This would be accomplished through cutting back Federal matching funds for Medicaid by one-third after 60 days of care in a general or tuberculosis hospital; 60 days of care in a skilled nursing home unless the State establishes an effective utilization review program; or 90 days of care in a mental hospital. Senator Harrison A. Williams, Jr., of New Jersey, former Chairman of the Senate Special Committee on Aging, calls this provision "shortsighted" because the individuals most affected "may have a long, lingering illness requiring an extensive period in a general, tuberculosis, or mental hospital." [8] Senator Williams also points out that the financial burden caused by this provision would probably fall most heavily on the States because Medicaid patients are unable to pay for their health care costs. Most States are not able to take on this added financial burden.

Present trends toward increasing out-of-pocket expenses and cutting back health care coverage for the elderly—many of whom are already living on limited, fixed incomes—should be halted. Instead, the emphasis should be upon reorganization of the health care delivery system designed to increase the efficiency of delivered services and to control mounting costs. The importance of integrating reforms in our health care system, together with improvements in the mode of financing health services, cannot be emphasized too strongly. The alternative is to yield to the shortsighted temptation of controlling costs at the expense of the health and welfare of the elderly.

V. SHORTCOMINGS IN NATIONAL HEALTH INSURANCE PROPOSALS *

On October 19, 1971, the House Ways and Means Committee opened hearings on the national health insurance plans before the Congress. Chairman Wilbur Mills announced that 200 witnesses will be heard before Congress adjourns. In the session starting in January of 1972 the Committee will consider in executive session the 13 bills that have been introduced.

The Senate Special Committee on Aging has in recent years emphasized that one way to assure informed debate over a national health insurance program for all age groups is to perfect the Medicare program and to apply the lessons learned from this program to more general proposals.

The basic lesson learned from Medicare has been that it is not enough for the Federal government to provide only a financing mechanism for health costs; there is an attendant responsibility for assuring the delivery of high quality and effective services.[9]

In the view of the Special Committee on Aging, none of the current proposals for national health insurance deal effectively with: (1) the

[8] Congressional Record, September 21, 1971, at p. S. 14650.

*Although this section deals only with shortcomings in current proposals, the Senate Committee on Aging has supported the concept of a national health insurance program. Its December 1970 report on the Economics of Aging said: "The Committee on Aging has said, within recent annual reports, that one way to assure acceptance of a national health insurance program for all age groups is to perfect the medicare program and to apply the lessons learned from this program to more general coverage."

[9] For a fuller discussion of these points, see *Economics of Aging: Toward a Full Share in Abundance*, a report by the Special Committee on Aging of the United States Senate, December 31, 1970 (at pp. 16–17).

problem of long-term illness among older people and (2) the needs of older people for supportive health and welfare services in the community.[10]

In the decade 1960–1970, the number of persons aged 75 and over increased by 42 percent. Equally dramatic increases in the numbers of the very old are forecast for the future. As people become older they are more and more prone to conditions which require extended care at a level which few families can undertake. Current health insurance bills concentrate on skilled nursing home care with a built-in time limit. The need for cost limitations is obvious, but what about the old person whose mobility is limited after a stroke and who lives for years thereafter? Can we realistically expect the grandparent generation to assume the responsibility—financial and physical—for the great-grandparent generation? A 1962 national survey found that among the non-institutional population aged 65 and over, 32 percent were great-grandparents. That proportion is higher now.

The proportion of people 65 and over bedfast and housebound and living at home is estimated as one in every 12 Americans in this age group. These people need a full spectrum of services which are not encompassed by the Medicare term "home health visits."

Measures to enable people to live longer have considerable Congressional support. Living longer, however, means growing old—a realization of this fact must be incorporated into schemes of national health insurance.

VI. HIGH HOPES FOR HMO'S

Congress has given increased attention recently to proposals that enroll persons covered by Medicare in health maintenance organizations (HMO's), providing for comprehensive, coordinated health care through prepaid group health plans and emphasizing regular screening and other health maintenance practices. This Committee shares in the high hopes for HMO's. But we are also concerned about issues that have developed recently as HMO's receive more intense attention.

In an effort to develop background information on HMO's, the Senate Finance Committee on July 20, 1971, asked HEW a series of questions about HMO's. HEW, in replies submitted September 13, 1971, left unanswered the important query asking what guarantees were being developed to assure that an HMO does not "screen out" high-cost elderly applicants.[11]

Senator Edward M. Kennedy of Massachusetts, a member of the Senate Special Committee on Aging and also Chairman of the Health Subcommittee of the Senate Committee on Labor and Public Welfare, has held extensive hearings into HMO's. During the course of those hearings, it has been argued that effective establishment of HMO's will require careful consideration of issuses such as adequate capitalization, workable definition of the term HMO, effective devices to ensure quality of care, and assurances that population groups including the

[10] This analysis of shortcomings is based on suggestions received from Professor Ethel Shanas, College of Liberal Arts and Sciences, Department of Sociology, University of Illinois at Chicago and Dorothy McCamman, Consultant to the Senate Special Committee on Aging.

[11] See *Health Maintenance Organizations: Staff Questions With Responses of the Department of Health, Education, and Welfare;* Committee on Finance, United States Senate, September 27, 1971, at p. 10.

aged, will have the opportunity and the resources to purchase memberships in the proposed organizations.

Issues of this sort must receive the continuing attention of all those seeing HMO's as a promising development.

COMMENTS AND RECOMMENDATIONS

The Senate Special Committee on Aging recommends the following improvements in Medicare and Medicaid as essential steps to be taken now while awaiting whatever action is taken on national health insurance for the total population. In some cases we are repeating recommendations made on earlier occasions; this only underscores the urgency for prompt enactment at this time.

1. *Out-of-hospital Prescription Drugs*—We recommend that Medicare coverage be expanded to include out-of-hospital prescription drugs.

Senator Harrison A. Williams, Jr., of New Jersey, former Chairman of the Senate Special Committee on Aging, on September 21, 1971, presented compelling arguments on the floor of the Senate for this drug inclusion. Senator Williams pointed out that drug expenditures by the elderly now average three times that for younger Americans. Aged persons with severe chronic conditions—now about 15 percent of all persons over 65—spend six times as much as younger people for prescription drugs. Finally, Senator Williams indicated that drugs constitute the largest personal health care cost of the elderly, accounting for about 20 percent of their out-of-pocket health expenditures.

2. *Combining Part A and Part B of Medicare.*—On July 1, 1971, the monthly premium for Part B of Medicare—the supplementary medical insurance—was increased from $5.30 to $5.60. This increase means that the monthly premium has nearly doubled since Medicare started five years ago. Separating Medicare into Parts A and B has led to endless confusion for all involved with the program and has contributed to the massive paperwork and red tape that have unfortunately become so much a part of Medicare. We recommend that Parts A and B of Medicare be merged and that costs of Part B be financed through taxes on rising payrolls and general revenues rather than from premiums paid by aged persons living on low fixed incomes.

3. *Removing Requirement of Prior Hospitalization as Condition for Extended Care.*—We recommend that the requirement of three days of prior hospitalization be removed as a Medicare condition for extended care and home care.

The three-day requirement unnecessarily taxes our already-overcrowded hospitals. It prevents patients who really need hospitalization from getting it. It also increases costs: many patients who do not need hospitalization are now placed there solely because of the Medicare requirement for receiving extended care and home care benefits. In many instances, too, the hospitalization is for more than the required three days, to avoid any allegation of hospitalization solely to meet the Medicare condition for extended care and home care benefits.

4. *Expanded Extended Care and Home Care Benefits.*—Medicare as now constituted focuses on the acutely ill patient at the expense of the individual with one or more chronic or recurring illnesses. The elderly frequently fit into the latter category. We recommend that the coverage and benefits under Medicare for extended care and home care be expanded.

This expansion could result in considerable cost savings, as more and more people received less expensive treatment. It could also promote the well-being of the elderly by permitting them to remain—in many cases—in their own homes where they feel most comfortable. The benefits available under home care should be expanded to include homemaker services and greater use of home health aides. The current limits of 100 days in an extended care facility and 100 home health visits should be eliminated for patients needing care beyond these artificial boundaries.

5. *Retroactive Denials.*—Under Medicare, the determination of whether a patient qualifies for posthospital services is usually made after the services are rendered. This often leads to retroactive denial of coverage, which causes great hardship for all involved. Senator Frank Church of Idaho, Chairman of the Senate Special Committee on Aging, introduced legislation on May 11, 1971, designed to correct this situation. Under the Church bill (S. 1827) advance approval would be authorized for extended care services. The Secretary of HEW would establish specific periods of time after hospitalization during which a patient would be presumed to require services in a nursing home. In cases where patients failed to recover as quickly as expected, additional extended care payments beyond the presumed period would be approved. A similar measure would also apply to posthospital home health services. We recommend that this proposal be enacted into law as soon as possible.[12]

6. *Excluded Medicare Services.*—The following services—now specifically excluded under Medicare—should be included and covered in full: foot care; eyeglasses, eye refractions, and examinations for eyeglasses; hearing aids and examinations for hearing aids; false teeth; and dental care (now covered only when services involve surgery of the jaw or related structures or setting of fractures of the jaw or facial bones). These services are badly needed by many of our elderly in order to maintain minimal functioning on a day-to-day basis.

7. *Disabled Social Security Beneficiaries.*—Medicare coverage should be expanded to include disabled Social Security beneficiaries. H.R. 1 contains a provision that would extend Medicare coverage to disabled beneficiaries under age 65, provided they have been receiving disability benefits for at least two years. We urge that Medicare benefits be made available earlier in the disability when timely medical care could increase the effort at rehabilitation.

8. *Preventive Medicine and Health Maintenance.*—The current emphasis on preventive medicine and health maintenance in the national dialogue on health is welcome. Any overhaul of our health system should include reflections of this new emphasis, such as,

[12] A similar provision has been incorporated in H.R. 1, which passed the House of Representatives in June.

for example, offering patients diagnostic and referral service and other preventive medical care; opportunities to enroll in prepaid group or other capitation plans; and use of mobile health units across the Nation to make more accessible preventive medical services.

9. *Medicaid Cost Controls.*—The National Council of Senior Citizens has recommended that "Medicaid costs should be brought down through maximum use of predetermined reimbursement rates for doctors and other providers of health services and not through additional charges to the patient." This approach is superior to contrary provisions in H.R. 1.

10. *Comprehensive Medicaid Programs by 1977.*—We oppose any further weakening of the Medicaid program. We strongly oppose, therefore, the provision in H.R. 1 that would repeal an existing requirement that States taking part in Medicaid have comprehensive programs by 1977.

CHAPTER 3

NURSING HOMES: SYMBOLIC OF AN ATTITUDE?

> If there is any single institution in this country that symbolizes the tragic isolation and the shameful neglect of older Americans . . . it is the substandard nursing home.
>
> —President Richard M. Nixon, June 25, 1971

I. CONCERN AT THE HIGHEST LEVELS: HOW EFFECTIVE?

Years of mounting concern about nursing homes culminated with a Presidential directive which declared in mid-1971 that a full-scale administration crackdown would be made on deficient nursing homes.

In his June speech, President Nixon declared, "The time has come for a new attitude toward old age in America. . . . The way to do this is to stop regarding older Americans as a burden and start regarding them as a resource for America."

His comments, and his selection of nursing homes as a target of concern, echo the criticisms made within recent years by members of the Congress and others who feel that neglect in nursing homes is indeed symbolic of a careless national attitude toward the elderly. That attitude is summed up by those who say, "Why provide expensive care for a person whose life may be nearly over? Why not get by with just the minimum."

That attitude, of course, overlooks certain moral and practical considerations, including the fact that rehabilitation is quite often possible, *when the persons providing the care believe that it is feasible and important to do so.*

Several recent developments have caused some reevaluation of old attitudes. Tragic fires,[1] and a salmonella outbreak,[2] have resulted in deaths and investigations. A Ralph Nader Task Force has attracted national attention.[3] On the positive side, genuine advances have been made in care at nursing homes:[4] more caregivers are realizing that good care is possible, sometimes at less cost than traditional methods.

Another powerful goad to public interest is the sheer costliness and magnitude of long-term care in the United States today. The following table provides a perspective:

[1] See Trends in Long-Term Care, Parts 4, 5, investigation of the Marietta, Ohio nursing home fire and Part 16, investigation of the Salt Lake City nursing home fire.

[2] See Trends in Long-Term Care, Parts 9 and 10 for investigation of the epidemic.

[3] See Trends in Long-Term Care, Part 11 for Testimony of Ralph Nader and his Task Force.

[4] See study prepared for the Committee on Aging by Robert Morris of the Levinson Institute, Brandeis University entitled "Alternatives to Nursing Home Care: A Proposal," for some discussion of alternatives to institutionalization; and Trends in Long-Term Care Part 17 for Positive Aspects and Innovative Programs in the Field of Long-Term Care.

Number of nursing homes	23,000.
Type of ownership:	
Proprietory for profit	77 percent.
Private nonprofit	15 percent.
Type of support:	
Government (State and local)	8 percent.
Federal support	Over $1 billion.
State and local government	$700 million.
Private sources	$900 million.
Total revenues	$2.6 billion.

Accurate statistics on all but the generalized information given above, amazingly, are difficult to come by; but it is clear that perhaps no other industry is as wedded to and dependent on public funds.

Expenditures for nursing home care increased four times over between 1960 and 1967; the number of nursing homes more than doubled, from 9,582 to 22,993; and the number of nursing home beds more than tripled, from 331,000 to 1,099,412. Upwards of 900,000 Americans of age 65 and over are now in nursing homes.[5]

In view of the size, costliness, and social significance of nursing homes, President Nixon's new program to deal with violators of public policy is of great interest in the field of aging.

Even as the administration moved to implement his directives, however, members of Congress and others were asking questions including the following:

—If attention is directed only at violators, how will genuine improvements be made?

—How will the President get at root problems, including lack of alternatives to nursing home care?

—Will such administration efforts divert public attention from such matters as retirement income maintenance, limitations of Medicare and Medicaid, and a shortage of housing for older Americans?

In this chapter, such questions are discussed and proposals for a truly comprehensive long-term care system are once again offered.

On October 28, Senator Frank E. Moss, Chairman, Subcommittee on Long-Term Care, and Senator Frank Church, Chairman of the full Committee on Aging, called a hearing to evaluate jointly the administration's progress and commitment to the goal of eliminating substandard nursing homes. At that hearing Senator Moss characterized the administrations "gameplan" as primarily "policing" in nature in that it is primarily aimed at enforcing legislation that has been on the books since 1967. The Senator referred to the so-called Moss amendments which he sponsored and steered through the Congress but which have only haphazardly been implemented by HEW and hardly enforced at all. He also criticized the Nixon plan for failure to deal with root causes.

Details of Nixon Plan

The President's plan for action announced in an August 6 speech at a nursing home in Nashua, New Hampshire includes:

1. The extension of a program now in operation at three Universities offering a four week Federal training program for State inspectors. Some 2,000 are to be trained in the next 18 months at a cost of $1.2 million.

[5] See Developments—1970, pp. 41 and 42 for additional statistics on nursing homes.

2. Requested that the Congress provide $3.7 million for 150 new positions within the Department of HEW specifically to enforce existing standards and to provide for the assumption by the Federal government of 100 percent of the costs of State inspections.

3. Ordered that the enforcement activities of HEW relating to nursing homes be centralized so that one official would be accountable for the success or failure of enforcement activities. The official with the responsibility is Dr. Merlin K. Duval, newly appointed Assistant Secretary for Health and Scientific Affairs.

4. Directed the Department of HEW to institute short-term training of health workers in nursing homes including physicians, nurses, dieticians and social workers for which he has requested $2.4 million from the Congress.

5. Directed HEW to assist the States to set up "ombudsman" or investigative units which would respond in a constructive way to complaints made by or on behalf of nursing home patients. Some $600,000 has been requested for this purpose.

6. Asked the Secretary of HEW to undertake a comprehensive review of the use of long-term care facilities and standards with an eye toward further recommendations. One million dollars has been requested for this purpose.

7. Promised to cut off Federal Medicare and Medicaid funds to homes that fail to meet reasonable standards.

At the October 28 hearing the consensus expressed by Senator Moss and the other Senators present seemed to be that the efforts could not help but improve the system, but that their effect would be limited and definitely short-run.

II. TRENDS IN LONG-TERM CARE—A DELINEATION OF ROOT CAUSES AND PRIMARY EFFECTS

Senator Moss, Chairman of the Subcommittee on Long-Term Care of the U.S. Senate Committee on Aging, in a recent speech,[6] gave a preview of a report, now in preparation, covering a 10-year time frame from 1961 when the Committee on Aging was founded to the present. The primary focus of the report will be the 20 or more hearings conducted by the Subcommittee in 1970 and 1971.

A. A Discussion of Root Causes

The Senator listed five major causes of substandard nursing homes and the long list of abuses commonly associated with these homes. Listed in the order of descending importance, they were:

—Lack of a clear national policy with regard to the infirm elderly;
—A system of Long-Term Care with inherent or built-in financial incentives in favor of poor care;
—The absence of the physician from the nursing home setting and in general the deemphasis on geriatrics in American medicine;
—Reliance on untrained or inadequate nursing staff;
—Lack of enforcement of existing standards.

[6] At the 24th Annual Conference on Aging, University of Michigan Institute of Gerontology on June 7, 1971 and in a November 2, 1971 speech before a conference on Long-Term Care sponsored jointly by AARP/NRTA and the Gerontological Society.

Problem Number One—Lack of a Clear National Policy with Regard to the infirm Elderly.—This fact should be obvious to even the most casual student in gerontology. There is no national pattern in America for the care of those who are both old and ill. Their needs have been assigned the lowest priority and the programs which have been developed are often piecemeal, inappropriate, illusory or short lived. The rhetoric speaks of care and concern but the reality resembles confusion, high costs and too often poor care or no care at all for those who need it.[7]

For examples of a lack of a clear policy one need only look to the cutbacks announced retroactively in the Medicare Extended Care nursing home program or to the lack of a broad spectrum of services in the area of long-term care.[8] States at the present time have few options, they can either place an individual in a nursing home or provide no services. The shortage of housing suitable for the needs of older Americans and the acute lack of other facilities and services which would make it possible to serve the ill elderly in their own homes has necessitated institutionalizing many Americans who do not need this kind of care.

Problem Number Two—The Existence of a System with Built-in Financial Incentives in Favor of Poor Care.—Some 77 percent of our nursing homes are for-profit institutions. Nursing homes, to make a profit, must keep their beds occupied; while the aim of society should be to move aged patients out of beds and into the community to lead as normal a life as possible.

Typically, nursing homes are compensated at a rate between $14–$15 a day or around $400 a month per patient. Commonly, reimbursement is cut back if the patient becomes ambulatory. A patient flat on his back receives the highest reimbursement rate in most States. But more importantly, each individual nursing home operator receiving, say, $14 a day can decide for himself how much he is going to allocate to patient care and how much he is going to allocate to profit. There is absolutely no accountability.

Examples of the profiteering in some nursing homes are contained in recent testimony before the Subcommittee. These include:

a. References to administrators doling out soap an ounce at a time, insufficient laundry, rationing of toilet paper, keeping the heat down in winter to conserve fuel and perhaps serving 15 pounds of hamburger for 144 patients plus the staff at the nursing home.[9]

b. Daniel Slader, Administrator of the Melbourne Nursing Home in Chicago, admitted that he received $400,000 yearly from Medicaid; that he made a profit of $185,000 and spent 54 cents a day for food while jails in the Chicago area spend 64 cents a day.[10]

c. A study conducted by the Hospital Cost Commission of the State of Connecticut indicates that the average return on investment for the State's nursing homes was 44 percent.[11]

Problem Number Three—The Absence of the Physician and the Low Place of Geriatrics in American Medicine.—One of the most consistent

[7] Developments—1970 p. 63.
[8] See Developments—1970 p. 43.
[9] Trends in Long-Term Care, Part 9, p. 776.
[10] Trends in Long-Term Care, Part 13, p. 1256.
[11] Congressional Record Speech, Frank E. Moss September 17, 1971, p. S. 14518.

assertions in hearings conducted by the Subcommittee on Long-Term Care is that physicians do not consider the nursing home part of the medical continuum.[12] President Nixon acknowledged this in his Chicago speech. He indicated that doctors don't go to nursing homes because they get depressed and feel they can't do much for the patients anyway.

But the overriding reason may be the limited interest in geriatrics as a specialty in the United States. Few Medical schools offer training in geriatrics. In this respect the United States is far behind European countries. Dr. Lionel Z. Cosin, famed English geriatrician, told the Subcommittee on Long-Term Care that this failure in American medicine is the primary reason for the existence of substandard nursing homes in the United States.[13]

The consequences of the physician's absence are that the nurses are giving medical care or that it isn't being given. With the Registered tered Nurse being increasingly tied up with supervisory duties and filling out necessary forms, it is the untrained aides that are giving medical care or it isn't being given at all.

a. Committee documentation of the absence of the physician from the nursing home setting is abundant. This issue was of particular importance during the Committee's investigation of the Baltimore salmonella epidemic. Some 44 doctors were responsible for 146 patients in the Gould nursing home. Because no one had ultimate responsibility, the existence of an epidemic was not confirmed until 5 days after it began.[12]
b. The Committee confirmed the common suspicion that in the nursing home setting the telephone is a more important instrument than the stethoscope. The Committee learned that physicians do not view the bodies of those who have died in nursing homes before signing death certificates, which makes it possible for a patient to be recorded of other than the real cause of death. Indeed the committee heard from some nursing staff that some doctors have signed death certificates in advance of death so they wouldn't have to come back to a home.[12]
c. Committee testimony is also replete with references to the misuse or lack of control of drugs because of physician indifference.[16]

The Fourth Problem—Reliance on Untrained or Inadequate Staff. — With the physician absent, the responsibility for care of patient's personal and medical needs falls upon the nursing staff. The burden is then carried by untrained aides and orderlies sometimes hired literally off the street and paid the minimum wage, at the same time asked to undertake one of the most difficult jobs imaginable. Because of reliance on these untrained and overworked individuals many abuses are likely to occur. One of the most common confirmed by the Committee is the wide usage of tranquilizers to keep patients sedated and thus cause less of a problem for the nursing staff.[17] The administrator, too, might be pleased by this practice because sedated patients being bedbound receive the highest rate of reimbursement.

a. Committee testimony in Chicago revealed that a Better Government Association official posed as a tenant in a Chicago flop

[12] Trends in Long-Term Care, Part 7, p. 563.
[13] Trends in Long-Term Care Part, 14, p. 1495.
[14] Trends in Long-Term Care, Part 10, p. 806.
[15] Trends in Long-Term Care, Part 10, p. 802.
[16] Trends in Long-Term Care, Part 10, p. 826.
[17] Trends in Long-Term Care, Part 15, Chicago—Testimony of William R. Hutton.

house to check out the story that this old hotel was used as a contact point where drunks could hire as orderlies in a nursing home. He found the story true. They were given board and room and paid $40 if they stayed the entire month.[18]

b. Also, in Chicago, a BGA investigator testified that he applied for a job as a janitor and was given a job as a nurse and within minutes after he was hired had the keys to the narcotics cabinet and was dispensing medications.[19]

c. Committee testimony also revealed that it is common practice for nurses and aides to pass medications and to prescribe drugs on their own initiative. This is particularly true for the issuance of tranquilizers. The Committee asked for a General Accounting Office Audit which confirmed that tranquilizers constituted the largest single category of drugs paid for by the Federal Medicaid program, constituting 17 percent of total drugs. Antibiotics with 8 percent were the next highest category.[20]

d. The Committee documented instances where only one nurse was on duty at night to care for 130 or more patients. It is therefore no surprise to note that aides and orderlies show a yearly 75 percent turnover rate.[21]

The Fifth Problem—Inadequate Enforcement of Standards.—Enforcement is an obvious problem; all of the Nixon nursing home initiatives aimed at providing improvement in this area. Part of the problem is the unique State-Federal relationship. The Federal government pays the lion's share of nursing home costs and issues minimum regulations, which the States interpret and enforce. In practice the Department of HEW, representing the Federal government, has not taken an aggressive role. States have been free to interpret and enforce standards as they wished. Examples of lack of enforcement by the States, documented by the Subcommittee include:

a. The State of Illinois testified that it had only closed 3 nursing homes in the last 10 years.[22] Similar patterns were documented for the States of Maryland,[23] Minnesota,[24] Oklahoma, Michigan and New York.[25] State Health departments insisted on counting nursing homes which had downgraded, say from skilled nursing homes to intermediate care facilities as an informal closure and generally protested their lack of other options.

b. Measuring enforcement by a different standard the State of Illinois admitted in Committee hearings that 50 percent of its nursing homes did not meet minimum State standards.[26] This same trend was proven by the General Accounting Office for the States of Oklahoma, Michigan and New York. The GAO audit measured frequency of physician visits, fire safety and nurse staffing provisions and found 50 percent of the nursing homes surveyed failed to meet minimum requirements in these areas.[27]

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[18] Trends in Long-Term Care, Part 12, p. 1032.
[19] Trends in Long-Term Care, Part 12, p. 1021.
[20] Senator Frank E. Moss, Congressional Record September 13, 1971, p. S. 14170.
[21] Developments—1970, p. 42.
[22] Trends in Long-Term Care, Part 12, p. 1065.
[23] Trends in Long-Term Care, Part 10, p. 814.
[24] Minneapolis Tribune, August 28, 1969, p. A. 1.
[25] General Accounting Office Audit of Medicaid Nursing Homes in Oklahoma, New York, and Michigan, May 28, 1971.
[26] Trends in Long-Term Care, Part 12, pp. 1037 and 1058.
[27] General Accounting Office Audit of Medicaid Nursing Homes in Oklahoma, New York, and Michigan, May 28, 1971.

c. The anamolous situation of the State knowing of the existance of substandard nursing homes and doing nothing about it led one Better Government Association investigator in the Chicago hearings to comment that, "There are more abuses and horrors in State health files than have ever been dreamed about by enterprising newspaper reporters." [28]

B. Primary Results and Effects of the Root Causes

The interaction of the causes listed above undoubtedly produces the unwholesome results so often described as nursing home abuses. Some discussion of these results follow below:

1. Negligence Leading to Injury and Death

Examples: Mrs. Glenda Carlson's mother's foot went unattended by staff and physicians, despite her daughter's repeated pleas for attention, until gangrene had developed and the foot had to be amputated.[29]

A patient left unattended in a Chicago nursing home was allowed to drink and smoke. She fell asleep, spilling liquor in her lap, and then dropped a lit cigarette. She became a human torch.[30]

2. Unsanitary Conditions

Typical examples include allowing patients to sit in their own wastes; this is a recurrent problem particularly where a nursing home has many incontinent or heavy-care patients. Unclean food preparation procedures are almost as common, the results of which could be a food poisoning epidemic such as occurred last year in Baltimore.

3. Poor Food

The most recurrent complaint in nursing homes is poor food. It is often said that it is all the patients have to look forward to. Causes of poor food include desire to save money, lack of properly trained food handlers and cooks and lack of dietician consulting.

4. Hazards to Life or Limb

Many hazards exist in nursing homes for patients. Because they are not ambulatory, fire presents the biggest hazard and yet 50 percent of our nursing homes do not meet minimum fire protection standards.[31] The principal reason once again being cost. A poor physical plant perhaps with steep staircases or other unclean conditions can also pose a hazard to patient life. Converted buildings pose the largest threat.

5. Lack of Dental Care, Podiatry and Psychiatric Care

Dental care in nursing homes is virtually non-existent. Testimony received by the Committee confirms this fact and that dentures belonging to patients are often lost or misplaced in the first few days of their stay in a nursing home.[32]

Podiatry or foot care is even more scarce than dental care. The Committee has documented many instances where nursing home

[28] Trends in Long-Term Care, Part 15, William Hood.
[29] Trends in Long-Term Care, Part 12, p. 999.
[30] In Committee files.
[31] General Accounting Office Audit of Medicaid Nursing Homes in Oklahoma, New York, and Michigan, May 28, 1971.
[32] Trends in Long-Term Care, Part 19.

patients have been unable to walk because their toenails have grown so long that they have turned under and were digging into the bottom of the patient's feet.[33]

Psychiatric care is also lacking. Significantly it is becoming more and more needed as States continue discharging patients by the thousands from State mental hospitals into nursing homes. The Subcommittee found this to be a common trend throughout the United States.[34]

6. Misappropriation and Theft

Theft is common in nursing homes. It seems that anything is worth stealing. Most commonly the Committee recorded instances where clothes, possessions, or small amounts of money were missing from patients. The theft of the small allowance by the State for "cigarette money" by unscrupulous operators was also recurrent. Drugs also are stolen as is food. It apparently is not uncommon for a 50 pound roast to disappear in some homes.[35]

7. Inadequate Control on Drugs

Flow of drugs through nursing homes is something very much in need of review, said Senator Frank Moss recently. The drug market for nursing homes is $240 million yearly with tranquilizers making up 17 percent and controls are extremely lax.[36] It is the easiest place an addict can find access to drugs and narcotics. The Committee found evidence of kickbacks to the nursing home from the pharmacy as well as inflation of prices for welfare medications.

8. Guardianship and Protective Services—Reprisals

The Committee has concluded that truth in advertising needs to be applied to nursing homes and has no way of knowing how many nursing home patients are promised luxurious surroundings only to find upon admission that their facility is less than adequate. Most serious in this area are reprisals which are taken out by the nursing home on the patient who complains or whose family complains to authorities. Evidence of this practice is frequent enough to suggest the need for remedial action.

9. Absence of Human Dignity

Most evident in the nursing home setting is that patients are not treated as human beings; that they were robbed of their human dignity. In an age of consumerism where things once used are discarded, the elderly in nursing homes, are viewed as having outlived their usefulness, as objects to be thrown away.

C. Positive Aspects and Innovative Programs in Long-Term Care

On October 14, 1971, an entire hearing of the Subcommittee on Long-Term Care was devoted to collecting and showing positive and innovative aspects of long-term care. Nursing home operators both proprietary and non-profit from all parts of the country appeared.

[33] Trends in Long-Term Care, Part 19.
[34] See Parts 12, 13, 15, and Report, "Mental Health Care and the Elderly: Shortcomings and Public Policy" October 1971.
[35] Trends in Long-Term Care, Part 19.
[36] Senator Frank E. Moss, Congressional Record September 13, 1971, p. S. 14170.

The proposals ran the gamut from unit-dose drug systems to bringing some efficiency into the nursing homes dispensing of drugs to a unique program to train nursing staffs.

Marshall Horsman of the Beaumont Convalescent Center in Beaumont, California, talked about his implementation of a plan of "sensitivity training" for his staff. Each member of the staff must play the role of a patient for a full 24 hours. The experience of being totally disabled and dependent on the staff for food and comforts is very helpful in causing the staff to see things through the eye of the patient and results in better care, contends Mr. Horsman.

Other testimony described an expanded role for the nursing home in the community as a subacute general hospital called a continuing care facility; still others spoke of the desirability of the ANHA sponsored program called Chronicare or in favor of Federal funded senior citizen day care centers.

These and other developments documented by the Committee have led Committee members to comment that there has been substantial improvement in the nursing home field in recent years and prospects for further progress look excellent.

III. RECOMMENDATIONS

The solutions for nursing home problems will require some attention to root problems. Those listed below are essentially the same as those suggested by the Committee in its report "Developments in Aging—1970."

1. A national policy must be established with regard to treatment of the infirm elderly. This policy should consider the total needs of the individual including medical, dental, residential, social and psychological services. The policy should look first to treating the individual in his own home with appropriate housing, congregate living facilities, home health services. Some consideration should also be given to senior citizen day care centers and for plans to subsidize the family to help them care for the elderly ill in their own homes.

2. The present system must be realigned so that greater financial rewards will be available to those nursing homes which provide exemplary care. An excellent rehabilitation program which gets individuals up and around should be rewarded. The Connecticut "points" system is one good positive example.

3. Physicians must be involved with the care of patients in the nursing home. Geriatrics must be rapidly advanced as a specialty in the United States.

4. Nursing home personnel must be trained and paid higher wages if they are expected to perform the difficult job they are given.

5. States must enforce standards and the Federal government must play an aggressive role to insure that they do.

6. Nursing home patients must be treated like human beings with intrinsic worth and be provided with a sense of human dignity. Anything less will secure for nursing homes their present labels of "elephant's graveyards" and "warehouses for the dying."

CHAPTER 4

WHAT KIND OF FEDERAL AGENCY ON AGING?

One key fact should be remembered by the delegates at the White House Conference on Aging, as well as other individuals with an interest in the field of aging: 1972 can be a year in which mounting doubts about the effectiveness of the Administration on Aging may reach a peak.

Low funding levels have already raised persistent questions about the effectiveness of the AoA. Perhaps even more important, the fundamental role of the AoA has undergone important conceptual changes as more programs were spun off to other units of government. Moreover, two Advisory Councils have been established in 1971 to assist appropriate Executive and Congressional bodies on the crucial issue of whether the AoA should be continued, strengthened, or replaced.

With the Older Americans Act scheduled to expire in only a few months (on June 30, 1972), this decision becomes all the more important.

I. REASONS FOR ALARM EARLY IN 1971

With the enactment of the Older Americans Act, 6 years ago, the AoA was charged with the responsibility for administering the title III State and Community programs on Aging, title IV Research and Development projects, and title V Training programs. Passage of the 1969 Amendments broadened its authority through the creation of Areawide Model projects and the Retired Senior Volunteer Program, "RSVP". In addition, AoA was given complete responsibility for administration of the Foster Grandparent program.

Programs Stripped Away.—Despite this strong expression of Congressional intent, AoA's role as the central spokesman for aged and aging Americans has deteriorated in recent years. Four years ago, AoA was placed within a newly created unit in HEW—the Social and Rehabilitation Service. And with this transfer, AoA lost its direct line of communication with the Secretary.

In 1970, action was initiated to transfer the research and training programs to the 10 SRS regional offices. Yet, critics charged that this realignment was in direct violation of the Act.[1]

Further disintegration occurred in 1971 with the approval of the administration's Reorganization Plan calling for a new Voluntary Agency, ACTION. With its adoption in June, two more programs under the Older Americans Act—RSVP and the Foster Grandparent program—were spun off to another agency.

The net impact of this action is that today AoA is left with only the administration of the title III community programs on aging and the area wide model projects. And its program responsibility has been reduced by two-thirds.

[1] Section 202 (3) and (4) of the Older Americans Act provides: "It shall be the duty and function of the Administration [on Aging] to:
(3) administer the grants provided by this Act;
(4) develop plans, conduct and arrange for research and demonstration programs in the field of aging".

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An Intensifying Funding Crisis.—Further downgrading occurred for the AoA when the administration submitted its budget in early 1971. At a time when it was calling for an "expansionary budget" to stimulate the economy, the proposed budget for the Older Americans Act was being cut to the bone. At a time when the cost-of-living had increased by nearly 6 percent during the past year, the recommended funding for the Act was being slashed by 8 percent. And the budgetary estimate of $29.5 million represented only 28 percent of the $105 million authorized funding level—the lowest percentage request in the history of the Older Americans Act.

TABLE A

Comparison of fiscal year 1971 appropriations for Older Americans Act and the budget request for fiscal year 1972.

	Fiscal year 1972 Congressional authorization	Fiscal year 1972 initial budgetary request	Fiscal year 1971 appropriation
Title III:			
Community grants	$30, 000, 000	$5, 350, 000	$9, 000, 000
State agency	5, 000, 000	4, 000, 000	4, 000, 000
Areawide model program	10, 000, 000	4, 000, 000	2, 200, 000
Titles IV and V:			
Title IV research	20, 000, 000	1, 800, 000	2, 800, 000
Title V Training		1, 850, 000	3, 000, 000
RSVP program	15, 000, 000	5, 000, 000	500, 000
Foster Grandparent program	25, 000, 000	7, 500, 000	10, 500, 000
Total	105, 000, 000	29, 500, 000	32, 000, 000

Comparison of the authorized funding level for the Older Americans Act and the administration's budgetary request

Fiscal year	Authorization	Budget request	Percent of authorized amount
1969	$26, 000, 000	$26, 000, 000	100
1970	62, 000, 000	28, 110, 000	45
1971	85, 000, 000	31, 000, 000	36
1972	105, 000, 000	29, 500, 000	28

II. OUTCOME OF FUNDING FIGHT

In March a joint Congressional inquiry [2] by the Senate Committee on Aging and the Subcommittee on Aging of the Labor and Public Welfare Committee was launched to consider five major issues: (1) Proposed funding cutbacks for programs under the Older Americans Act; (2) the impact of recent reorganization moves on the role and status of the AoA; (3) the proposed creation of a new voluntary agency which would incorporate RSVP and the Foster Grandparent program; (4) the conduct of the White House Conference on Aging; and (5)

[2] "Evaluation of Administration on Aging and Conduct of White House Conference on Aging", *Joint Hearings before the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Public Welfare United States Senate;* 92nd Congress, 1st Session.

whether the AoA should be continued when its mandate expires in 1972. Virtually all nongovernmental witnesses agreed that AoA was being dismantled through a siphoning away of its funds, functions and personnel. Moreover, there was general agreement that without, adequate funding, sufficient personnel, and a well-defined commitment, AoA would become a token agency for 20 million older Americans.

Three major developments emerged from the 5 days of inquiry. First, the administration rescinded its original budget estimate and proposed a $10 million increase, raising its initial recommendation from $29.5 million to $39.5 million. In July, Senator Frank Church and Senator Winston Prouty helped lead a bipartisan effort for further increases in funding for the Older Americans Act. This resulted in a $5.25 million boost in appropriations for the Act, raising the Administration's revised budget estimate of $39.5 million to $44.75 million.

Older Americans Act appropriations

[In thousands of dollars]

	Original fiscal year 1972 budget	Revised fiscal year 1972 budget	Final appropriation
Community programs	$5, 350	$9, 000	$12, 000
Planning and operations	4, 000	4, 000	4, 000
Areawide model projects	4, 000	5, 200	5, 200
Research and demonstration	1, 800	2, 800	2, 800
Training	1, 850	3, 000	3, 000
Retired Senior Volunteer Program	5, 000	5, 000	5, 000
Foster Grandparents	7, 500	10, 500	12, 750
Total	29, 500	39, 500	44, 750

Compared with the original budget request of $29.5 million, the fiscal 1972 appropriation of $44.75 million for the Older Americans Act represented a $15.25 million increase—or 52 percent more than initially recommended. Moreover, the final appropriation represented the highest funding level, by far, in the history of the act.

A second major impact of the hearings was the continuation of 21 nutrition demonstration programs, which had been funded under title IV, for an additional year. These programs had been scheduled to terminate at the end of June.

Thirdly, Nelson Cruikshank, President of the National Council of Senior Citizens, urged that a task force be formed to consider what kind of agency could serve most effectively as a visible and articulate spokesman for the elderly.

III. FURTHER QUESTIONS STILL PERSIST

Recent reorganization moves and proposed funding levels for the Older Americans Act have raised serious questions about the capability of AoA to function as a strong force for improving and enriching the lives of older Americans. Equally important, June 30, 1972 is the deadline for the Congress to act on legislative proposals to renew, modify, or replace the Older Americans Act. During this time, important and far-reaching questions must be resolved concerning what

type of Federal advocate would be most effective for representing the Nation's elderly. This decision takes on added meaning because a White House Conference on Aging will take place later this year. And, if the recommendations emerging from this Conference are to be effectively implemented, it is absolutely essential that there be a strong Federal structure for action.

A. Advisory Council on AoA or a Successor

One of the key developments in 1971 was the appointment by Senator Frank Church of a 20 member Advisory Council to consider alternatives for strengthening or replacing the AoA. A working paper, prepared by the staff of the Committee on Aging, described the policy considerations leading up to the creation of the AoA. Additionally, the report outlined the major proposals for and against several alternatives to the AoA.

In October, the Advisory Council issued its report. Among the major findings and conclusions:

—AoA falls far short of being the Federal focal point in aging sought by Congress;

—AoA's concerns are largely splintered and scattered with few clearcut goals; and

—Recent reorganizations have not strengthened Federal aging programs, but have lead to a further downgrading of an "already flawed and feeble agency." [3]

To meet these problems, the Advisory Council recommended that (1) an Independent Agency for the Aging—to be directed by an Assistant on Aging to the President—be established within the White House; (2) the AoA be headed by an Assistant Secretary on Aging in HEW; (3) appropriate departments or agencies administering programs for the elderly should establish a position of Assistant Secretary for Aging or its equivalent; and (4) an Advisory Council be created to make a comprehensive and objective annual report on the progress made during the year in resolving problems confronting older Americans.

As envisioned by the Advisory Council members, this new independent agency would have broadly based powers, including: formulating and administering policy; coordinating and monitoring programs among departments with a direct concern in matters related to aging; encouraging the development of parallel units at the State and local levels; providing funds for innovative programs to appropriate Federal agencies; and administering certain demonstration programs before transferring them to existing agencies. This new agency, in the judgment of the Advisory Council, would provide "the power and prestige to do the job wanted by the Congress and needed by the Nation." [4]

B. HEW Task Force on AoA

Another significant development was the creation of a five member Task Force on AoA by Secretary of HEW Elliot Richardson. Members of this advisory body include Mr. Garson Meyer, chairman (chairman of the President's Task Force on Aging (1970) and former president of

[3] "The Administration on Aging—Or A Successor?", A Report to the Special Committee on Aging, United States Senate; October 1971; 92nd Congress, 1st Session; p. 2.

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

the National Council on the Aging); Miss Bertha Adkins (co-chairman of the White House Conference on Aging); Mr. Hobart Jackson (president of the National Caucus on the Black Aged and administrator of the Steven Smith Geriatric Center); Governor Robert Blue (former Governor of Iowa); and Mr. John Perkins (professor at Northwestern University and former Undersecretary at the Department of HEW).

One of the key issues to be considered by the HEW Task Force is the organizational placement of AoA. Present plans call for issuing a preliminary report to provide a foundation for discussion at the White House Conference on Aging.

C. President's Task Force on Aging

In 1970, the President's Task Force had issued a comprehensive report [5] for meeting the problems and challenges of an aging population. Heading the list of 24 recommendations was the establishment of an Office on Aging within the Executive Office of the President to: (1) develop a national policy on aging, (2) oversee planning and evaluation of all Federal activities relating to the elderly, (3) coordinate activities, (4) recommend priorities cities to the President, and (5) encourage Federal agencies to undertake research and manpower preparation in the field of aging.

Several reasons were given for this "Number one concern":

—Lack of coordination at the national level constitutes a major problem for Federal agencies administering programs for the elderly.

—No agency now has authority to determine priorities, settle conflicts, eliminate duplication, identify and assign responsibility, or make other important decisions.

—The experience of the AoA "makes it abundantly clear that interdepartmental cooperation cannot be carried out by a unit of Government which is subordinate to the units it is attempting to coordinate."

Significantly, however, the Task Force did not call for an abandonment of the AoA. Instead, it called for new means of strengthening that agency. And the Task Force expressed its desire that operation of the grant programs under the Older Americans Act should remain with the AoA.

IV. 1972 A YEAR OF DECISION

A few months from now the Congress faces the crucial question of either extending the Older Americans Act, modifying it, or establishing a new and different method of achieving the objectives of this legislation. To a very large degree, all Americans, regardless of their ages, have a vital stake in this important decision. Those now old, to be sure, have a direct interest because a strong Federal advocate is a "keystone" in any national effort for making the later years the "golden years." Those now approaching retirement also have a concern because they may be unprepared for the "shock of retirement", the "threat of leisure," or a markedly reduced income. The young, too, have a stake because they can expect longer periods in retirement—perhaps a third or two-fifths of their lives.

[5] "Toward a Brighter Future for the Elderly".

Differences of opinion still exist concerning what form AoA should take or whether it should be replaced with a new agency. But, in the words of William Hutton, Executive Director for the National Council of Senior Citizens, there is agreement that "we are convinced that its current location at the bottom of the totem pole in Social and Rehabilitation Services is utterly meaningless. One more step and it will be out in the street." [6]

Existing governmental framework for meeting the problems, challenges and goals of the elderly continues, to a very large degree, to be fragmented and haphazard. A clearcut line of authority for coordinating Federal operations, programs, and activities is also lacking—as is a means for assigning priorities in the field of aging.

Because the establishment of effective governmental machinery is essential for the implementation of a long awaited national policy on aging, it is recommended that the administration submit its proposals for continuing, changing, or replacing the AoA before the White House Conference on Aging begins. It is further recommended that the delegates at the White House Conference on Aging evaluate this proposal—as well as the recommendations of the Advisory Council for the Senate Committee on Aging and any other constructive proposals—and report on the merits of implementing these measures. In addition, it is urged that appropriate Congressional units act early in 1972 on legislative proposals for amending, extending, or replacing the Older Americans Act in order that final action can be completed before the renewal date (June 30, 1972) of the existing law.

[6] Part 1, p. 57 of hearing cited in footnote 2.

CHAPTER 5

HOUSING: WHAT ARE OUR GOALS?

Clear differences of opinion about the rate of progress in meeting housing needs of older Americans sharpened in 1971.

In the view of the Department of Housing and Urban Development, "the condition of elderly-occupied housing has greatly improved over the 1960s".

To the Senate Special Committee on Aging, however, the situation is still very much the same as reported in its last annual report: [1]

—Approximately 6 million aged Americans live in unsatisfactory quarters.

—At least 120,000 federally-assisted units should be built each year if we are to have any hope at all of overcoming present and future deficits.

—The HUD decision to scrap the 202 direct loan program in favor of complete reliance on the 236 interest subsidy program is having unfortunate results.

—Little has been done to develop a full spectrum of housing options for the elderly, such as creation of "campuses" at which needs of healthy, partially disabled, and ill persons can be met.

—HUD needs an Assistant Secretary on Housing for the Elderly to assure visibility and attention to this specialized needs area.

Since publication of its annual report, the Committee has also devoted attention to two other issues: effects of crime in federally supported housing, and barriers to full use of buildings and transportation systems.

I. THE OVERVIEW

To evaluate the "Adequacy of Federal Response to Housing Needs of the Elderly" [2] the Subcommittee on Housing of the Senate Special Committee on Aging began hearings in mid-1971. As Subcommittee Chairman Senator Harrison A. Williams said in his opening statement:

> Many of the elderly were homeowners until late in life. But, because of high property taxes, inflation or other reasons, they now seek housing elsewhere.
>
> For many of them, however, there is no "elsewhere". Apartments may be either prohibitively expensive, or may not be available at all.

[1] Developments in Aging—1970, published March 23, 1971.

[2] Hearings on that subject were conducted on August 2, 3, and 4 and on October 28 and 29 in Washington, D.C.

Senator Williams said that only about 350,000 units have been made available through Federal programs, within the last 10 years, *a total roughly equal to the average net gain among people of age 65 in this Nation every year.*

> Should it be any surprise, he said, that approximately 6 million Americans of that age or older live in substandard units. It may be disheartening, but it is a fact which must be faced up to.

Administration Reply.—HUD Secretary Romney was invited by Senator Williams to testify on HUD policy at the October 29 hearing. The Secretary, however, submitted a statement responding to ten questions put to him by the Senator.

On the matter of overall need, Secretary Romney said:

> . . . it is clear that the condition of the elderly-occupied housing has greatly improved over the 1960s in terms of the two key Census housing criteria: (1) availability of adequate plumbing facilities and (2) incidence of overcrowding.

The Secretary said that in 1970, 1,605,061 or about 8.5 percent of the elderly population lived in units which lacked some or all plumbing facilities, as compared to 18 percent in 1960. Elderly overcrowding, 3.8 percent in 1960, has dropped to 2.8 percent.

> These data, said the Romney response, indicate not only that the condition of elderly-occupied housing has improved over the decade but also that the condition of such housing is, on the whole, not significantly worse than the national average.

It was pointed out at the October 29 hearing, however, that—since approximately 70 percent of the elderly own their own homes—their problems may be relatively unrelated to the criteria on which the Secretary based his argument. Plumbing deficiencies, while very real in some parts of the Nation, may not accurately gage the situation of many elderly homeowners. As for overcrowding, many of the elderly are troubled by what the White House Conference on Aging Work Book on Housing describes as *over*-housing. They may have homes that are too big to maintain or heat, that are subject to increasing tax load, and that were originally meant to house a family but now house only a couple or a widow or widower. Loneliness or isolation is more of a threat to the elderly than overcrowding.

Secretary Romney recognized "the existence of acute housing problems for many elderly Americans, including the payment of a disproportionate percentage of income for homeownership costs." He said he expects that the administration's general revenue sharing bill, if passed, would "significantly relieve elderly homeowners from the burden of rising property taxes."

In response to Senator Williams' complaints about the dearth of accurate statistical information about housing and the elderly, he said he recognized "the urgent program need for improved data on the elderly housing problem as well as the importance of such data for the forthcoming White House Conference on Aging." Consequently, he ordered a HUD-funded special 1970 Census study on elderly housing conditions. It is expected that some data will be ready prior to the White House Conference, but the Secretary added:

> Limited information on the income of elderly persons and elderly households, obtained from sample surveys conducted by the Bureau of the Census, will be shown since such data will not become available from the 1970 Census until 1972.

To Williams' question about housing goals, the Secretary said:

> To summarize our subsidized elderly housing production goals, it is expected that 1972 housing subsidy funds will support the production of approximately 72,000 units for eventual elderly occupancy.

II. THE CONTINUING DEBATE: 202 vs. 236

Much of the testimony at the August hearings dealt with the pro's and con's of two programs under which apartment housing for the elderly has been built.

Under the Section 202 program, nonprofit sponsors received direct loans to be paid back at 3 percent interest. *This program was limited solely to housing for the elderly.* Established in 1959, it resulted in construction of 45,000 units for the elderly before it was completely discontinued last year. In spite of administration hostility to the direct loan concept, Senator Williams and other members of the Senate Committee on Aging joined in a bipartisan effort in 1970 to continue funding for that program (no administration request for funds had been made that year). An appropriation of $10 million was approved.

Under the Section 236 program, a nonprofit or limited dividend sponsor pays only 1 percent interest and Federal funds pay the difference between 1 percent and the going interest rate. *This program is not limited to the elderly and, in fact, puts the greatest emphasis on housing for large families.*

Critics of 236.—Testimony on August 3 and 4 centered largely on complaints that the conversion from 202 to 236 had caused widespread confusion and even despair among nonprofit sponsors. The Right Rev. Edward E. Michelin, Executive Director of the Department of Community Services for the Diocese of Mississippi and president of several housing corporations established under 202 and other programs, gave this summary of the situation:

> For us and others, not only is 202 dead, but elderly housing also—swallowed up by 236. In addition, the same criteria for family-type housing is applied across the board, whether for family or for semi-infirm elderly. We seem to be slaves to rules and regulations covered with the mold of antiquity, instead of adapting rules to meet the needs of the people for whom they purport to serve. Such things as site locations, type of architecture, etc. cannot effectively serve such diverse needs of specialized housing with the same rules and regulations applying across the board. Involved in this is Hi-rise vs. Low-rise, inflexibility on parking areas, different social-recreational needs. 93 percent of our tenants do not have and cannot afford automobiles, yet land of sufficient volume and economical enough can only be obtained out in the country, away from shopping and other necessities. This not only creates an economic barrier but it also violates the

> social, moral concern for the elderly that demands they be kept in the mainstream of society and not be put out to pasture to die. They need now, in their declining years, to be close to their churches, stores, buses, and familiar accessible city conveniences.[3]

In addition, critics of 236 said this program costs entirely too much in Federal dollars. As Msgr. Michelin put it:

> Concisely stated, section 236 programs obligate the Federal Government to pay for up to 40 years, the difference between 1 percent and the market rate interest which the mortgage bears which in some sections of the country is as high as 12 and 13 percent.
>
> The section 202 programs cost the Federal Government only the difference between 3 percent which the mortgagor pays the Government on the loan and the rate of interest which the Government pays on its borrowings, which is substantially less than paid by mortgagors to private lenders.

Robert R. Renfrow of the Southeast Housing Consultants Inc. of St. Petersburg, Fla., pointed out that 236 also results in Federal revenue loss because of "tax breaks" made to those who invest in limited dividend corporations which are permitted in 236. Richard Fullerton of Fullerton Associates, Smyrna, Ga., said that extra fees—permissible under 236 but not paid under 202—quite often inflate the total cost of the project.

Delays in processing 236 applications and other forms have also added to costs. Several witnesses told of abandoning proposed 236 projects—or of modifying design to the point where the structure resembled bare public housing.

Later testimony by a HUD witness said that delays and a certain amount of confusion are to be expected when one program supersedes another. To this, a witness [4] at the October 28 hearing gave the following reply, based upon experience with both the 202 and 236 program:

> We were told that the 202 program was being phased-out and 236 would be utilized to provide housing for the elderly. We were told guidelines would soon be available for developing such projects under the 236 program. We were told that the responsibility would be with the area offices of FHA, where they would be close to the scene and be able to bypass the red tape battles we had known with the Regional Offices and Washington office of HUD in the 202 program. Frankly, out of my experience in trying to process 236 applications in the last three years, *I think it has been a blundering mess.* (Emphasis added.)

The Case for 236.—Eugene Gulledge, Commissioner of the Federal Housing Administration, testified on August 4 and argued that Section 236 is necessary because it can produce more housing more rapidly than 202 could possibly achieve. Only through interest subsidy mechanisms, he said, could there be any hope of meeting goals set under the Housing Act of 1968.

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[3] Similar descriptions were given by other nonprofit sponsors or consultants at the August hearing by two more witnesses in October, including the Rev. Thomas D. Ryan, Jr., speaking on behalf of the Nonprofit Housing Center of Washington, D.C.

[4] Mr. Paul B. Kennedy, Executive Administrator, the Christian Church Homes of Northern California.

As for direct loans under 202, he said:

> Under present budgetary concepts, it is not reasonable to assume that a sufficient amount of funds will be appropriated to finance a substantial volume of housing through a direct loan program.
>
> With a direct loan program, Federal funds are used to cover the entire capital cost of construction. Under the 236 approach the current annual budget impact for each unit of housing is very much smaller, that is, the payments needed to bring the effective interest rate down to 1 percent.

Mr. Gulledge said that 17,000 units for the elderly have already been funded under 236, as compared to 45,000 under 202 since 1959.

Mr. Gulledge later said that his personal feeling is that "the interest subsidy program is the wrong approach, that direct funding is the correct approach if you are trying to do the right thing."

But he also said:

> The official position with which I have to be faced when I face reality is simply this: If the Congress were considering today an appropriation bill that had enough money in it to take care of the subsidized housing needs on a direct loan basis, we would be back to producing somewhere between 50,000 and 100,000 (for all age groups) units of housing a year, because that is all we were able to generate enough steam for.
>
> These figures become so large that it simply wasn't a politically achievable job to be able to get the Congress to appropriate that much more money.

Discussing Mr. Gulledge's arguments in a Senate Floor statement on August 6, Senator Williams said:

> Perhaps his reasoning is based upon the premise that the typical taxpayer—and possibly the Congress—is less likely to notice the higher costs of 236 because those costs will be spread out over many years, whereas under 202 the expenditures have a greater immediate budgetary impact.
>
> Personally, I have more faith in the good sense of the American taxpayer and Congress. If we were too hasty in adopting the interest subsidy program, the time has now come to reconsider. Already, evidence about the inadequacies of 236 are pouring in, and we should pay some attention.

(Apparently, the prospect of cumulative increases in outlay under 236 is also causing concern within the Executive Branch. The Third Annual Housing Goals Report issued in June 1971, says: "It is . . . necessary . . . to begin undertaking a long, deep, and searching look at the basic concept of our national housing programs and policies. Present estimates suggest that by 1978 direct commitments for budgetary outlays for subsidized housing will total around $7 billion per year, and loss of tax revenues through various credits and incentives add further to this cost" (p. 3). The report went on to say: ". . . the public interest demands that the Federal Government not stand impassively at the cash register and continue to pay out whatever is necessary to feed runaway inflation of housing costs" (p. 22.)

The loss of revenues through depreciation and other tax laws also directly impinge upon the interest of the elderly since these "losses" to the Federal treasury result in less tax money that could be used for social purposes, including programs for the elderly.

III. COMPLAINTS ABOUT HUD STRUCTURE

Organizational changes within the Department of Housing and Urban Development have resulted in establishment of two new general divisions: production and management.

A Section on Housing for the Elderly and the Handicapped has been placed within the management branch of HUD, but it has suffered loss of personnel and functional powers along the way. According to testimony taken on October 29, three professional persons and one secretary now constitute its entire staff. A HUD witness [5] pointed out, however, that programs for the elderly are partially managed through regional offices, requiring fewer specialists in Washington.

Shifts made within HUD during the last 3 years, however, have caused concern among those who believe that housing for the elderly should have a highly visible advocate within the Department.

Dr. M. Powell Lawton of the Philadelphia Geriatric Center said that the early days of the low-rent housing and 202 programs had resulted in a considerable measure of success. He continued:

> Now, the hey-day of these programs came during the time when there was a Special Assistant to the Secretary on problems of housing the elderly, and when there was a program which had an ear-marked line item on the budget devoted explicitly to housing for the elderly, and a full section of individuals who were totally committed to doing well by all the aspects of living that elderly people had to do.
>
> At this point neither of those situations exist any longer, and I feel that a long-term look at where housing for the elderly is going must come up with a conclusion that this fragmentation and dissipation of the sense of commitment has to stop somewhere, and my own feeling, after looking at many aspects of the program, is that this problem can be done with only a major unit within HUD being established that is concerned only with problems of housing the elderly.

An Assistant Secretary for Elderly?—Arguing for "a high level spokesman who will assure that housing needs of the elderly will receive appropriate attention at all levels of Government," Senator Williams introduced a Housing for the Elderly bill (S. 1935) on May 24, 1971. He said that an Assistant Secretary within HUD would administer and coordinate housing programs for older Americans and that his office would serve as a clearing house of information concerning housing for aged persons. He also said:

> From an administrative standpoint, the reasons are compelling for placing these responsibilities under the authority of an Assistant Secretary for Housing programs for the elderly. An additional Secretary could provide more effective administration and coordination of housing programs for the

[5] Norman V. Watson, Assistant Secretary for Management.

elderly. Additionally, an Assistant Secretary would be in a better position to formulate a comprehensive national policy which would be responsive to the special needs of the aged. He would be able to assure that our national housing programs would be more than just bricks and mortar. Equally important are the social components of housing to provide a livable and decent environment.

This will require special attention to their nutritional, health, social, and recreational needs. And an Assistant Secretary would be in a much better position to shape these crucial considerations into a coherent national housing policy.

Several similar bills have been introduced, and statements in support of the proposal have appeared with some frequency in the Subcommittee hearings.

Asked by Williams for an official HUD position on this matter, Secretary Romney gave the following reply in his statement of October 29:

> Our department is opposed to the enactment of these provisions for the following reasons. First, we do not believe that such an additional Assistant Secretary is needed to give special impetus and coordination to HUD programs which assist the financing of housing for the elderly. The internal reorganizations of HUD have already centralized housing production in one Assistant Secretary and housing management functions in another. Moreover, other assistant secretaries in the research, community planning and management, and community development areas perform key functions relating to the elderly. All of these assistant secretaries have designated staff to deal with special elderly concerns. Moreover, the assistant secretaries for HPMC and Housing Management have offices which deal on a full-time basis with elderly housing issues. I have directed all of these assistant secretaries to closely coordinate those program areas which directly relate to the elderly and to ensure that all of their programs are sensitive to the particular needs of the elderly.
>
> To summarize, I feel strongly that fractionalization of broad program areas on the basis of the beneficiaries to be served through assignment to a separate Assistant Secretary would lead to inefficient administration and be to the detriment of all groups aided by such programs.

IV. A "CRISIS OF CRIME"

As part of its overall inquiry into the Federal response to housing needs of the elderly, the Subcommittee has begun to take testimony about the effects of crime and vandalism upon elderly tenants in federally assisted housing.

Witnesses on October 28 described murders, rapes, muggings, and terrorizing of older persons in Hartford, Conn.; Baltimore, Md.; New York City; and in Paterson, N.J.

One witness, a 72-year-old widower, had a part-time job when he was mugged just outside of his apartment house a year ago. He has since given up the job; he has gone on welfare for the first time in his life; he is still paying medical bills caused by the beating; and he has developed a nervous condition.

Senator Williams said on August 29 that such testimony has convinced him that a "crisis of crime" exists in much public housing throughout the Nation; and that it requires emergency action. Norman V. Watson, Assistant Secretary for Housing Management for HUD, told on October 29 of several steps HUD is taking to deal with crime, including a modernization program and the award of a contract on October 21 for a study design and other factors. Williams said he thought faster action is necessary: the witnesses on the previous day had spoken of unlocked windows and doors, of muggings and worse on days when Social Security checks are received; and outright day-to-day terror.

The Senator also called for these actions:

> Ways should be found to promote cooperative arrangements with local police departments. Services should be developed to make public housing more livable—and more secure—in many ways. And the Law Enforcement Assistance Administration should become more directly involved in finding solutions to this problem.

V. TOWARD A BARRIER-FREE ENVIRONMENT

Another new inquiry, this time by the full Committee, was begun on October 18 and continued during the next two days. Committee Chairman Frank Church, in his opening statement, said that the Committee was giving attention to the "impact of barriers—architectural and otherwise—upon older and handicapped Americans of today and tomorrow."

Senator Church said that the Committee was concerned not only about buildings which, in one way or another have limited usefulness to people who have varying degrees of disability. He added:

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

Our working definition of "barriers" is not limited to architectural features of structures or transportation systems.

Distance can be a barrier, particularly for the elderly. Suburban growth, attractive as it is for many, causes increasing dependency upon automobiles. Yet, only about 42 percent of Americans of age 65 and up, have driving licenses. If public transportation systems fail to serve those who do not drive, they are, in effect, marooned in the midst of metropolitan areas, and even more so in rural areas.

And there are psychological barriers, too. If an institutionalized person feels that the institution is somehow "wrong" or "cold", he experiences a barrier to whatever benefit that institution was meant to provide to him.

We must ask, therefore, whether we are building a society which is off-limits for increasing numbers of older and handicapped Americans. (Emphasis added.)

Among key points made by witnesses:

1. Estimates of the number of persons affected by barriers vary, but one Department of Transportation witness made this appraisal: "Twenty million of our citizens are 65 years of age or older. Further it is estimated that approximately 6 million Americans of all ages suffer physical handicaps which limit their mobility. To deprivate these people of transportation is to deprive them of their right to live normal and fulfilling lives. Equally important, it is to deprive this Nation of the contribution that their maturity and experience can make."

2. Many witnesses said that design improvements for the elderly will benefit many other Americans who are neither old nor handicapped. An architect told the Committee that a designer can go a long way toward making a building accessible simply by designing one entrance easily negotiated by all and also providing a usable washroom. Even multi-story buildings that don't have elevators can be made partially accessible, if necessary facilities are on the ground floor.

3. The Bay Area Rapid Transit system now nearing completion in San Francisco and environs has incorporated many design features meant to make the system more useful for the elderly and the handicapped. Similar measures are still under study in Washington, D.C.

4. The most important force for the elimination of barriers in the environment is awareness on the part of designers and builders. Schools of architecture can play a major role here. If there is a barrier in any link of the chain of mobility or accessibility, the elderly and others will be deprived in subtle or overt ways.

Suggestions for improvement in the Architectural Barriers Act, the Urban Mass Transit Act, and several other relevant statutes are now under study by Committee staff.

In addition, the Committee is also evaluating a proposal made by one witness Mr. Martin Baker, a New York City attorney who has turned his attention to the "barriers" issue.

Mr. Baker proposed that the National Environmental Policy Act of 1969—generally regarded as "anti-pollution" legislation—may have direct applicability to architects and other people designing specific facilities for the elderly:

> Section 101 of this act broadly defines the environment, declaring it to be "the continuing policy of the Federal Government . . . to use all practicable means and measures" to maintain environmental quality.
>
> Section 102(1) of this act directs that "the policies, regulations, and public laws of the United States shall be interpreted and administered in accordance with the policies of environmental quality enhancement as set forth in section 101." A clear mandate to each agency of the Federal Government which is of particular import to improving our building environment is contained in section 102(2) of that act. All agencies of the Federal Government are required by section 102(2)(A) to:
>
> . . . utilize a systematic, interdisciplinary approach which will insure the integrated use of the natural and social sciences and the environmental design arts in planning and in decision making which may have an impact on man's environment. . . .
>
> And I call your attention particularly to the terms "interdisciplinary approach" and "environmental design arts," two terms which are new to the law, which are not defined in this statute, which are not judicially defined and which it is *my thesis form the basis of the authority for Federal agencies to approach many of the problems we are talking about.* (Emphasis added.)

RECOMMENDATIONS

The Committee sees no reason to change the major recommendations made in its March 1971 report:

> **That the 1971 White House Conference on Aging should call for a major study of the housing needs of older Americans in order to determine how many need what kind of housing.**
>
> **The Conference should urge the Congress to provide the increased funding necessary to greatly expand existing housing programs at least to the point of providing 120,000 units for the elderly a year. Particular emphasis should be placed on the need to continue the FHA Section 202 program which serves middle-income elderly with units specifically designed for their special needs.**
>
> **The Conference should recommend that sponsors undertake to incorporate nursing care units within an overall plan looking toward the creation of "campuses for the elderly" which would supply the full spectrum of their housing needs.**
>
> **HUD should undertake a broad consumer information program to acquaint older Americans with the federally assisted housing programs available to them.**
>
> **That there be created a U.S. Government corporation to trade, buy, rent, sell and renovate residential property for senior citizens.**

Federal matching funds should be made available to encourage the creation on the State level of volunteer or other rehabilitation and repair programs for senior occupied housing.

The States undertake legislation to require, and that they enforce, minimum safety standards with regard to boarding houses and residential hotels occupied by the aged.

In addition, emergency action should be taken on immediate problems related to crime and vandalism in federally supported housing.

In addition, architectural and other barriers to the elderly and the handicapped should receive attention in the appropriate sections of the White House Conference.

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CHAPTER 6

MULTIPLE JEOPARDY FOR MINORITIES

All older Americans—those of age 65 and up—are members of a minority group. As can be seen from other chapters, this one-tenth of our population shares many mutual problems.

For the elderly who are also members of other minority groups, those problems may be intensified considerably. Deprivation, poor nutrition, substandard housing, and limited income have been present almost from birth to an extent far greater than for others of today's aged and aging Americans.

A few years ago, the Urban League presented a report, "Double Jeopardy," describing the deep-rooted difficulties encountered by older Americans who are both old and black. But it is becoming increasingly clear that the problem is really one of multiple jeopardy, compounded by a shortage of reliable statistical information on key matters. In fact, this "information gap" has emerged as a vital issue in all Committee on Aging research related to minority groups.

In this Chapter, the Committee presents summaries of new working papers prepared for release before the White House Conference on Aging. In addition, it draws from meetings already conducted by several Advisory Councils [1] established by Senator Church, Committee Chairman, during recent months.

I. ELDERLY BLACKS

Approximately 7 percent of the total Negro population—or 1.4 million persons—are 65 and older, compared with 10 percent for elderly whites. However, other significant contrasts were noted in Dr. Inabel Lindsay's working paper, "The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States." [2] In summarizing the status of aged blacks, Dr. Lindsay gave this assessment:

> The majority of Negroes over 65 are less well educated, have less income, suffer more illnesses and earlier death, have poorer quality housing and less choice as to where they live and where they work, and in general have a less satisfying quality of life.[3]

Poverty

One of the most striking findings in the report is that aged blacks are more than twice as likely to be poor as elderly whites. Nearly 50 percent of all Negroes 65 and older—in contrast to 23 percent for aged whites—fall below the official poverty index of $1,852 for a single person and $2,328 for a couple.

[1] For membership, see Appendixes 4–7, pp. 155–158.

[2] "The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States", A Preliminary Survey for the Special Committee on Aging United States Senate; prepared by Dr. Inabel B. Lindsay, D.S.W.; September 1971.

[3] Page vi of working paper cited in footnote 2.

And there is strong evidence to suggest that elderly blacks suffer from greater extremes in poverty. In 1969, for example, 33 percent of all Negroes 65 and older who lived alone or with nonrelatives had total annual incomes below $1,000—compared with 14 percent for elderly whites.

Perhaps the most economically disadvantaged are older Negro women. Approximately 79 percent of aged Negro women who live alone have incomes below the poverty line. Another 9 percent would be considered near poor. The net impact of these figures is that almost nine out of every 10 elderly Negro women living alone would be classified as poor or near poor.

Health

Another significant finding is that the life expectancy for blacks is markedly lower for blacks than for whites. For Negro men, it is now about 61, compared with 68 for white males. And for persons in the 45 to 64 age category, the mortality rate is nearly twice as great for blacks as it is for whites. As a consequence, many Negroes never live long enough to collect their Social Security benefits or to qualify for Medicare coverage.

Yet, utilization of medical services for blacks is less, although their health problems appear to be more intense than for whites. For example, Negroes 65 and older have approximately 58 percent more bed-disability days than do whites in this age category.

Limited financial resources, Dr. Lindsay concluded, pose a serious problem for elderly Negroes in obtaining urgently needed care. Even with Medicare, the deductible and coinsurance provisions may cause aged blacks to postpone seeking medical care until their illness has intensified.

Housing

All available evidence strongly suggests that inferior housing is disproportionately high among elderly blacks. In one study of public housing residents, for example, it was found that 63 percent of elderly Negroes, as compared with 30 percent for aged whites, occupied substandard housing before being relocated.

Equally noteworthy is the high concentrations of aged blacks in central cities. For the 55-plus age category, whites are three times as likely as Negroes to be living in the suburbs or in the surrounding areas outside of central cities.

Information Gaps

Dr. Lindsay, critical of population statistical reports, said:

> More accurate and detailed statistics regarding population distribution are also needed as a basis for more realistic and effective planning for all social programs, such as income maintenance and housing.

She also called for a more general fact-finding effort:

> Little research has been undertaken regarding this group and there is an appalling lack of information available pertinent to their situation. What does exist is fragmented or directed toward a single facet of their lives.

Advisory Council on Aging and Aged Blacks

A major recommendation in the working paper called for the creation of a task force to investigate inadequacies in present knowledge about elderly Negroes. In his preface to the report, Senator Frank Church agreed to the appointment of an Advisory Council "to build upon the excellent work initiated by Dr. Lindsay."

This 17-member Advisory Council [4] conducted its first meetings on September 20 and 21, naming Hobart C. Jackson and Dr. Jean L. Harris as co-chairmen.

Among the first actions taken by the Council were requests for greater representation of Blacks at the White House Conference on Aging and for new efforts by the Bureau of the Census to provide detailed information on certain key matters.

II. THE OLDER INDIAN

Statistics about Indians are frequently inadequate, inaccurate, or not available at all. A survey of the Library of Congress catalogue files revealed, for example, that there are approximately 417 cards on Indian legends and pottery, but none at all for "income" or "population." In fact, there is still confusion in arriving at an acceptable definition for determining who should be classified as an Indian. These conclusions were reached in a brief, but blunt, statement by the Indian Advisory Council [5] to the Senate Committee on Aging.

By whatever standard one would choose to employ, the American Indian—and particularly the aged within that group—constitute one of the most deprived segments in our population. Per capita income for Indians, for instance, is estimated to be only $1,051, only about one-third of the national average for the total population.

Underlying the Advisory Council's statement is a fundamental theme that existing programs for elderly Indians continue to be uncoordinated and fragmented. A major by-product of this dilemma is a low level of visibility for the unique problems of aged Indians. As a consequence, many Indians—the young as well as the old—never receive the full benefits of these programs. To rectify this problem, the panel called for a high level advocate for elderly Indians. Additionally, this office would coordinate and publicize all programs which are aimed at helping older Indians.

Among the other major findings, conclusions and recommendations of this panel:

Population

According to the 1970 Census data, there are nearly 792,000 Indians living on and off reservations. It is estimated by Bureau of Indian Affairs officials that there are between 45,000 and 50,000 Indians aged 65 and older, about 6 percent of the total population. A major reason for this comparatively low percentage of aged is that life expectancy for Indians is considerably lower than for the total U.S. population, averaging about 46 years.

Earlier Social Security benefits, in the judgment of the task force, is not the solution to the problem of a shorter longevity expectation.

[4] For membership, see Appendix 6, p. 157.

[5] For membership of the Council, see Appendix 5, p. 156. The Council report, "Advisory Council on the Elderly American Indian," was to be published in early November.

Instead, they maintain that the numerous factors which lead to a shorter life expectancy—such as inadequate nutrition, dilapidated housing, insufficient medical services, poor transportation systems, and others—must be dealt with immediately, forcefully, and effectively to raise the longevity expectations of Indians.

Housing

Symptomatic of their deprivation is the appalling lack of acceptable housing for Indians. According to Bureau of Indian Affairs statistics, about 48,500 Indian homes are substandard and are currently in need of replacement or renovation. Approximately 55 percent of the homes have less than 600 square feet of living space. Inadequate heating exists in 63 percent of the units and 21 percent have no electric power available.

Another problem, in the view of the task force, is that little or no consideration is given to the cultural desires of Indian tribes—such as style, location, or building materials in home construction.

Employment

Unemployment for older Indians and the Indian population in general is alarmingly high. At some reservations, the jobless rate runs as high as 80 percent, nearly 14 times as great as the unacceptable national rate of 6 percent in September 1971.

To combat this widespread problem, the Advisory Council recommends that:

—Funds should be earmarked by the Bureau of Indian Affairs for public service and community betterment projects for elderly Indians who could participate in a wide variety of capacities, such as community development officers, guides in wilderness areas, counselors, and others.

—Employment programs for older persons, such as Mainstream, should be effectively enforced to insure that aged persons participate in these projects to the extent that Congress intended.

Nutrition and Health

Hunger or malnourishment is a way of life for most older Indians. Inadequate diets and limited information about proper eating habits are two major factors for this critical problem. And the impact of malnourishment is seen in many tragic ways for aged and aging Indians—a substantially shorter life expectancy, poorer health, and an inability to work in many instances.

Moreover, present Federal programs fall far short of providing the nutritional requirements of the needy. Items in the Commodities Distribution program usually meet less than 80 percent of their caloric requirements and from 30 to 50 percent of their nutritional needs.

Poor health for Indians is further intensified by bad roads, poor communication, and inaccessible health care facilities. One outgrowth of these conditions is that many Indians, especially those in need of immediate medical attention, go to the nearest hospital rather than an Indian Health Service facility which may be many more miles away. Another problem for IHS facilities is that there is a high turnover of medical personnel. Many young doctors fullfill their military obligations by serving in these facilities, usually for a two year period.

However, the Advisory Council noted "The success of Indian Health Service in providing medical care for Indian peoples is worthy of commendation". But it also warned, "Much is left to be done, and no one can relax when the average age at death for the American Indian is 46 years."

III. ELDERLY MEXICAN-AMERICANS

Many elderly Mexican-Americans are exposed to multiple handicaps that come with being old, poor, and a member of small minority within a minority, together with a language barrier which frequently intensifies deprivation. This is often reflected in lack of information about programs which may provide vital assistance.

Despite the severity of the problems confronting older Mexican-Americans, there is still a dearth of reliable data about this group. Hearings by the Senate Committee on Aging and recent Census information have helped to unearth valuable information.[6] Yet, this profile is sketchy, and the need for further data is all too apparent.

Population Characteristics

Aged Mexican-Americans comprise only a tiny fraction of a population group that is still overwhelmingly youthful. According to 1970 Census data, there are 5 million Mexican-Americans in the United States. Of this total, only 3.3 percent (approximately 165,000) are aged 65 or older, compared with 10 percent for Anglos. (The Bureau of Census statistics are, however, under sharp attack by Mexican-American spokesmen, who say that the Bureau under-reports the total number and tends to give the impression that Mexican-Americans are to be found only in five southwestern States.)

Even if middle-aged and older persons are added to this age category, only 14.6 percent of the Mexican-American population would be 45 or older. This proportion is substantially higher for Anglos, amounting to 31.2 percent of their population.

Income

Low income, regardless of age, continues to be the number one problem confronting the Spanish origin population. For all Mexican-Americans, the likelihood of being poor is nearly three times as great as for Anglos.

In general, aged Mexican-Americans are poorer than younger persons in the population group, and considerably poorer than the Anglo aged.

The median income of $3,756 for couples is well below the $4,484 BLS Intermediate Budget for an aged couple. And it represents only about 71 percent of the median income for Anglos aged 65 or older.

Several reasons account for this widespread deprivation:

—Many worked in occupations which were not covered by Social Security;

—Large numbers, who are now covered under Social Security, still receive inadequate benefits because of low lifetime earnings;

[6] "Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans", Hearings before the Special Committee on Aging United States Senate; 90th Congress, 2nd Session and 91st Congress, 1st Session; December 17, 1968 to November 21, 1969.

—Lengthy state residency requirements have prevented potentially eligible persons from receiving old age assistance; and
—In far too many cases, aged persons are simply unaware of the existence of Social Security, Medicare, and Old Age Assistance.

Health

Many Mexican-Americans never qualify for Medicare simply because a large percentage never reach age 65. Life expectancy for Mexican-Americans is approximately 57 years, compared with about 70 years for Anglos.

Even for those who do reach age 65, limited incomes may make it necessary to delay seeking urgently needed health care. Moreover, the deductibles for hospitalization ($60) and physician services ($50) impose serious financial barriers, especially for the poor. In addition, the $5.60 monthly premium charge and the 20 percent coinsurance feature for Part B doctors' insurance add to their mounting health care costs.

For most elderly Mexican-Americans, poor health is nothing new. They have experienced deprivation and suffering throughout their lives because of limited incomes, limited health care facilities, and a shortage of trained health personnel to treat them. With advancing age, poor health may intensify and reach catastrophic proportions.

Education

In general, there is a significantly lower level of educational attainment than for most other Americans. More than 63 percent of all Mexican-Americans aged 65 and over—or five out of every eight individuals in this age category—would be classified as functionally illiterate.[7] This compares with 47 percent for all elderly persons of Spanish origin; [8] 40 percent for Negroes; and 11 percent for Anglos. For this age group, less than 7 percent have completed four years of high school, compared with 12 percent for Negroes and 31 percent for Anglos.

Employment Patterns

Low education attainment is also reflected in lower paying occupations and a substantially higher unemployment rate for Mexican-Americans. Among males 45 to 64, for example, unemployment is oftentimes three times as high as for mature Anglos. Employment for Mexican-Americans also tends to be concentrated in agricultural and other low paying jobs. Nearly 63 percent of all male Mexican-Americans aged 16 and over are employed in blue collar occupations. Another 8 percent are engaged in farm work. This compares with 44 percent and 5 percent, respectively, for Anglos. On the other hand, only 18 percent of male Mexican-Americans work in white collar jobs, in contrast with 44 percent for Anglos.

For males in the 45 to 64 age category, the labor force participation rate is very similar to Anglos, amounting to nearly 90 percent. How-

[7] Functionally illiterate is defined as five or less years of schooling.
[8] According to the Bureau of Census, Spanish origin includes Mexican-American, Puerto Rican, Cuban, Central or South American, and other Spanish.

ever, the work force participation rate is considerably lower for Mexican-American women in this age category, than for other population groups. Their participation rate, for example, is 34 percent, compared with 53 percent for Negro women and 49 percent for Anglo females.

Cabinet Committee on Opportunities for Spanish-Speaking People

In August, a measure to extend the authorization for two years for the Cabinet Committee on Opportunities for Spanish-Speaking People was signed into law (Public Law 92–122). The Cabinet Committee was originally created in 1969 to help assure that Federal programs are responsive to the needs of Mexican-Americans, Cubans, Puerto Ricans and other persons of Spanish origin. Specific functions of the Cabinet Committee include advising Federal departments and agencies concerning (1) appropriate action to be taken to help assure that Federal programs are providing the assistance needed by persons of Spanish origin and (2) the development and implementation of comprehensive and coordinated policies and programs focusing on their special needs.

Mexican-American Advisory Council

In October, Senator Frank Church appointed a 17 member Advisory Council on Aging and Aged Mexican-Americans. The Council first met on October 22, and selected Alexander S. Zermeno, Assistant Director of the Southwest Council of La Raza, as Chairman. Mr. Cipriano John Baca, Sr., member of the Economic Opportunity Board for Albuquerque-Bernalillo County, N. Mex., was elected Co-chairman. Council members were critical of preparations for the White House Conference. Mr. Zermeno said that the Conference will not grapple with issues of direct concern to Mexican-Americans, and he urged steps to increase representation for this group. He also requested the Bureau of Census to provide more detailed information than is now generally made public.

IV. ELDERLY PUERTO RICANS

Elderly Puerto Ricans—The Island and the Mainland [9]

Elderly Puerto Ricans living on the mainland and elderly Puertorricans on the island: How do they live; what are their similarities and differences? What has been the effect of the first airborne, twentieth century migration of a people, who are citizens of the United States but whose culture and traditions are so different as to make them foreign? Has the ease of traveling back and forth between the island and the mainland served to keep the culture intact or has "Americanization" on the mainland created a cultural difference between the Puerto Rican and the Puertorrican?

[9] This portion of chapter six is a summary of a report now under preparation by the Senate Committee on Aging in cooperation with officials and others in New York City and in Puerto Rico.

Older Puerto Ricans—The Mainland

Historically, large scale Puerto Rican in-migration to the mainland has been recent. The first small wave began just after World War I and lasted until the early thirties. Since 1940, there has been a steady in and out flow of persons leaving and returning to the Island.[10]

In February 1971, the Census Bureau published its November 1969 sample survey estimating that there were 1,454,000 Puerto Rican residents in the 50 States and the District of Columbia—811,000 were born on the island, 636,000 were born on the mainland.[11] About two-thirds of the total national Puerto Rican population live in New York City.[12] It is the New York City Puerto Rican population upon which this discussion will focus.

The Puerto Rican population tends to be younger than the general population. According to the 1960 Census figures, the elderly make up about 3 percent of the total Puerto Rican population living in New York City. In fact, over half of the elderly Puerto Rican population in 1960 was between the ages 65–69.[13] A major study of elderly residents (60+) in 26 poverty areas in New York City is being conducted under the auspices of the New York City Office of the Aging. Preliminary findings confirm that Puerto Rican elderly are younger than either white or black elderly; two-thirds of the Puerto Rican elderly in the sample are under 70 as compared with 58 percent of the black sample and 40 percent of the white sample.[14]

Why has the elderly Puerto Rican population not grown older within the decade? We can only speculate about the possible reasons:

—Steady travel of Puerto Ricans between the island and the mainland may indicate a return to Puerto Rico upon retirement.

—The flow of in-migration which began in 1940 and peaked in the years between 1952–1960 may indicate that Puerto Ricans may not have lived on the mainland long enough to grow old there.

—Their rate of life expectancy may be lower. Currently, there is no statistical data which would indicate a pattern of life expectancy specifically for the Puerto Rican living on the mainland.

Whatever the reasons, there is very little statistical information about the elderly Puerto Rican. Perhaps, the most important purpose of this report is to point up the large gaps and inadequacy of information and to define issues which affect the life of the elderly Puerto Rican on the mainland.

The income level of the elderly is reflected by the poverty of the total Puerto Rican population. The 1960 census figures note that the median income for a family of four in New York City was $6,091. While the median income for a Puerto Rican family of four was $3,811.[15] According to the latest census figures, 29.2 percent of the Puerto Rican population (all age groups) is living below the poverty level.[16] On a per capita basis 46 percent of the Spanish elderly sample

[10] *The Migration*, Puerto Rican Planning Board. Economic Development Administration of Puerto Rico.
[11] Bureau of the Census, P. 20, No. 213 Persons of Spanish Origin, Nov. 1969.
[12] Telephone conversation, Bureau of Labor Statistics, U.S. Dept. of Labor, Mid-Atlantic Regional Office, Mr. Benjamin, Oct. 3, 1971.
[13] Bureau of the Census, 1960-Census Trac-New York Standard-Metropolitan State Area, PHC (1-104) Part I.
[14] Cantor, Marjorie, *Elderly in the Inner City*, Study in Progress sponsored by the New York City Office for the Aging under a grant from the Administration on Aging.
[15] See footnote 13, above.
[16] Unpublished Data, Bureau of the Census.

have income under $1,500 as compared to 34 percent of the black and 22 percent of the white elderly in the New York City study mentioned earlier. Social Security payments are an important source of income to all elderly. However, only 51 percent of the Spanish sample received Social Security as compared to 70 percent of the black and 82 percent of the white elderly sample.[17]

Why so many fewer elderly Puerto Ricans receive Social Security payments is not clear. Being a younger population, they may not be entitled to Social Security or—the kinds of marginal employment available to the Puerto Rican may not be covered by Social Security. The second explanation would tend to be supported by indications that the elderly Puerto Rican sample in the study had less formal education than either black or white elderly.[18] The Puerto Rican population as a whole have generally worked at marginal jobs in the hotel, restaurant, hospital and garment industries, which pay low wages and are subject to seasonal employment. Constant migration would also not permit employment continuity or accumulation of Social Security benefits.

The Older Puertorrican—on the Island

Puerto Rico, a stricken land in 1932, has evolved into a country with rising industrial economy and an increasing concern about social, recreational, cultural and welfare needs of its population.

The 1960 Census figures indicated that there were 2,349,544 residents of which 144,800 or 5.2 percent were 65 and over. Unofficial figures of the Bureau of Vital and Demographic Statistics reveal that in June 1970 the older population had risen to almost 6 percent of the total population.

Dramatic accomplishments in the field of public health have brought about a great reduction in death rates. The life expectancy rate has increased from 46 years in 1940 to 71 years in 1960. Mortality patterns have also changed and rates in middle and old age compare favorably with corresponding rates in highly developed countries. The dramatic change can be attributed primarily to the control of infective and parasitic diseases. Tuberculosis, one of the leading causes of death has decreased from 202.1 deaths per 100,000 population in 1945 to 11.1 deaths in 1970.

Older Puertorricans like all older people have a high incidence of chronic disabling diseases. Free public medical services have generally been inadequate in terms of quality of care and numbers and location of the services. Medical services and hospitals are being rapidly developed. There continues to be however, a lack of adequate treatment and follow-up services; lack of rehabilitation homebound services; lack of adequate information about available health services; and there is no organized visiting nurse service. Rehabilitation, aimed at the total individual is a relatively new concept. But more and more of the handicapped elderly are participating in the Vocational Rehabilitation program. In 1960, 26.2 percent of the persons 45 and over in the program were between the ages of 56 and 65 years old.

Puerto Rico began participating in the Social Security program in 1950. Participation in the program is equal to participation on the

[17] See footnote 14, p. 64.
[18] See footnote 14, p. 64.

mainland, with the exception of their exclusion from "Prouty Amendment" coverage established in 1966. This exclusion does not provide benefits for uninsured individuals at age 72 residing in off-shore areas of the United States. Approximately 20,000 older people in Puerto Rico do not receive benefits because of this provision. The average Social Security benefit is $70.40.

Public Assistance payments are extremely low. The average Public Assistance payment is $18.30 which is 40 percent of the estimated minimum need. This is the lowest average grant in all of the United States and its territories. Ceilings are imposed on the amount of funds going to Puerto Rico. In addition to the ceiling, funds must be matched dollar for dollar. Puerto Rico, therefore is not able to make use of the 25–75 or other matching formulas available to those areas defined as States.

In spite of several federally sponsored elderly housing programs, no dent of real significance has been made in meeting the housing needs of the aged poor. The Puerto Rico Renewal Housing Authority continue the construction of dwelling units but for the majority of the poor such a solution is not available. Even if a sufficient number of housing units were built, many older people would not have sufficient income to afford public housing rentals.

Social services programs available to the aged are very limited. Limited funds, lack of trained personnel and even physical facilities make this impossible. Facilities for congregate living for the aged are notoriously scant and there is a limited homemaker program administered by the Department of Social Services.

Elderly Puertorricans have benefited from the Office of Economic Opportunity and Administration on Aging programs in a few cases. There are 13 components in the OEO programs (Homemakers programs and multi-service centers for the aged) and 11 multi-service centers for older people funded by title III of the Older Americans Act. These programs serve about 17 towns on the Island or less than 25 percent of the whole island.

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4. Estadisticas Vitales, 1970. Division de Registro Demografico y Estadisticos Vitales, Departmento de Salud, Estado Libre Asocido de Puerto Rico.

V. OLDER CUBANS

During the past 12 years, more than 600,000 Cubans have fled their native country to come to the United States. This mass exodus has helped to swell Miami's Cuban population to 250,000 to 300,000—making Miami the world's second largest city in terms of numbers of Cubans. According to Census Bureau figures, there are now 626,000 Cubans living in the United States.

Many of the elderly political exiles have discovered that they, like other older Americans, have also become "economic exiles." In Dade County, for example, about 61 percent of all individuals who receive welfare assistance under the Cuban Refugee Program are over 65 years of age.

Moreover, large numbers of aged Cubans are ineligible for Social Security because they do not have a sufficient period of covered employment. Even if they can meet the eligibility requirements, they are likely to have inadequate benefits because of lower lifetime earnings. As a consequence, the vast majority must depend upon relatives to exist; work to maintain even a minimum standard of living; or reluctantly accept welfare.

Profile of Older Cubans

As is the case with all minority elderly groups, information about aged Cubans is scanty, incomplete, and fragmented. However, a working paper—written by Dr. Manolo J. Reyes [19] for the Senate Committee on Aging—has helped to piece together the limited data available in a coherent and coordinated manner.

An Older Population.—One of the key findings in this working paper is that Cubans, as a group, constitute an older population. Their median age is 28.4 years, which is slightly higher than for the total U.S. population. Moreover, the proportion of middle-aged and older Cubans (individuals 45 and older) is 31 percent. This is identical to the Anglo population and nearly twice as great as for persons of Spanish Origin [20] (16 percent). Approximately 6.3 percent of the Cuban population is 65 or older, compared with 10 percent for Anglos, and only 3.3 percent for Mexican-Americans.

Geographic Distribution.—In terms of geographic distribution, more than 50 percent of the Cubans reside in the Miami area. Unofficial estimates, according to Dr. Reyes, place this number at 320,000. Some authorities, however, estimate that there may be as many as 400,000 to 450,000 Cubans in Miami. The next largest concentration of Cubans is found in New York City and Northern New Jersey, where an estimated 135,000 have resettled. In addition, sizable concentrations are found in California, Illinois, Louisiana, Massachusetts, and Texas.

Employment Patterns.—Middle-aged and older Cubans, like other Americans in this age category, encounter difficulties in locating employment because of their advancing years. But frequently this problem is intensified by an inability to speak English fluently. As a consequence, Cuban males 45 to 64 are nearly twice as likely to be unemployed as Anglos in this age category. For those who are able to locate work, they are likely to find themselves in lower-paying employment or "dead-end" type jobs. Yet, the labor force participation rate for Cuban males and females is slightly higher than the level for Anglos who are similarly situated. Nearly 92 percent of the Cuban males in this age category and 54 percent of the Cuban females are in the work force. This compares with 90 percent and 49 percent,

[19] Dr. Manolo J. Reyes is the Latin News Director for WTVJ in Miami. He has also served as an adviser for the Cuban Refugees Program, and was appointed as a member of a task force in Miami in 1965 to develop strategy for the Freedom Flights.

[20] According to the Bureau of Census definitions, Spanish Origin includes Mexican-Americans, Puerto Ricans, Central or South Americans, and other Spanish.

respectively, for Anglo men and women. Economic necessity, according to Dr. Reyes, is the major reason for the higher work force participation rate for the Cuban family.

Income.—Even though statistics are not available by age, it is readily apparent that family incomes for Cubans tend to be slightly higher than for other Spanish-origin persons, but significantly lower than for Anglos. For example, the median income for a Cuban family is only about 67 percent of the amount earned by the total U.S. population. Considering that many Cuban families have relatives living with them, this small amount (a median income of $5,957 or $115 per week) becomes even smaller. Poverty for Cubans is also low in comparison with other minority groups, but considerably higher than for Anglos. Nearly 14 percent live in poverty—in contrast to 10 percent for Anglos and 28 percent for Mexican-Americans. Dr. Reyes warned, however, that these figures may be misleading. He pointed out that many Cubans, and especially elderly Cubans, may have incomes below the poverty threshold. But they are not classified as poor because they live in family units with an income slightly above the poverty index.

Even with the limited data available, it is readily apparent that older Cubans experience even greater deprivation than the total elderly population in the United States. They are more likely to have lower incomes, live in substandard housing, work in lower-paying jobs, and subsist in impoverished conditions.

INTERIM COMMENTS AND RECOMMENDATIONS

1. Minority groups are receiving some attention at this year's White House Conference on Aging. A major part of that attention, however, is provided in 4-hour "Special Concerns" sessions December 1. While this innovation is welcome, it was announced at a late date; and there is some question about the likelihood of its effectiveness. Special efforts should be made in implementation of conference recommendations, to provide closer working relationships with minority group organizations.

2. The Bureau of the Census should, at the earliest possible date, provide vitally needed information of direct relevance to the White House Conference and to the implementation of its recommendations.

3. While the history and present needs of each minority group in this chapter vary widely, there seems to be a common core of interest in improvements to Social Security and Medicare. The proposals made by the Senate Committee on Aging in earlier chapters would be helpful in making both programs more useful to minority groups. In addition, the Committee on Aging is giving attention to other proposals to improve these two programs.

CHAPTER 7

SOCIAL UTILITIES: HOW FAR AWAY?*

To date, no community in the United States has developed a comprehensive network of services for the aging and the aged, nor has a full range of service alternatives been developed to meet the varied and changing needs of the population.

This conclusion, reached in a recent report[1] issued by the Gerontological Society, is no surprise. Service gaps have been deplored in practically every report issued by this Committee since 1961; expert witnesses tell the Committee, in fact, that there is more gap than performance.

In this chapter, the Committee provides an exploratory discussion of a concept which is gaining greater and greater recognition among social planners and others concerned about the elderly, and that is:

Instead of providing services to limited numbers of persons through sparsely-funded individual programs, why aren't more efforts made to develop a social utility system? Exactly as we now regard a municipal water supply or a municipal transportation system as a public utility, so should we regard services for the elderly a public function, available to low-income and more fortunate persons alike.

Impressive as this concept is, it is also potentially dangerous. It could create the impression that a moratorium on all special-purpose service programs should be imposed until the master-plan is ready for implementation.

On the contrary, special-purpose programs should be sustained and broadened. Only when they are strong enough can they become working units in a broader scheme.

I. EXISTING SOURCES OF SERVICE

Social service and community programs are now funded under a variety of Federal programs, such as title III of the Older American's Act, the Office of Economic Opportunity and under Old Age Assistance.

A quick look at these programs can be deceiving if it suggests a glowing picture of elderly people receiving services. A closer look shows a picture of fragmented and haphazard services, and a multitude of unmet needs.

Older Americans Act Projects.—The title III programs are purported to have served, 1,800,000 older persons by 1,000 projects.[2] Indeed, homemaker services and home health aide services were provided as were telephone reassurance calls and friendly visitation. Home delivered and group meals, employment opportunities, and adult education programs were supported with title III funds.

*This chapter is a summary of information now being prepared for use in a forthcoming report by the Senate Special Committee on Aging. Thanks to Mrs. Roberta Brown, Chief, Office of Services to Aged, D.C. Department of Human Resources, for her help in the work thus far.

[1] Research and Development Goals in Social Gerontology. A Report of a Special Committee of the Gerontological Society. Winter, 1969, p. 55.

[2] See "Developments in Aging—1970," a report by the Senate Special Committee on Aging, March 1971, Appendix 1, Report by the Administration on Aging.

The value of the title III program can not be denied to those who received the services. The numbers of persons said to receive services however, are based upon extrapolations from limited data and do not necessarily indicate the true number of people served by the projects.

The Older Americans Act also funds title IV demonstration projects on the premise that local level funding will assume continuance of the program. But the record of continuation is poor. It must be asked: what happens to those people in need of service when the demonstration is completed?

Services for OAA Recipients.—The issuance of regulations by the Social and Rehabilitation Service on "Services for Aged, Blind and Disabled Persons", was considered a major development in 1970–71. A significant provision requires that State adult categorical assistance plans must provide for five specific supportive services by April 1, 1974, to be reimbursed at a 75-percent level by the Federal Government. Such services would include homemaker services, home maintenance, home management and personal care services for adults who are determined by the State agency to need this assistance. Forty-three States have submitted plans for reimbursement at the 75 percent level and 6 States have submitted plans to be reimbursed at the 50 percent level.

Welcome as the upgrading of social service requirements would be, it must be remembered that the regulations apply only to those 2 million elderly now receiving Old Age Assistance. In time, they may apply to perhaps as many as 10 million older people who may become recipients within the next 5 years. (Potential recipients are determined on the basis of age and the income dependency level which is set by each State.) We know, already, that nearly 5 million elderly persons fall below the poverty line and only 2 million are receiving Old Age Assistance. Can we then conclude that of the possibly 10 million potential recipients only one-half will apply for and receive the benefits provided under the new service program? Clearly, a social utility system must reach them also.

The Office of Economic Opportunity.—Under the Senior Opportunities and Services Program the elderly poor are served in a variety of ways. The major focus of SOS is on hiring the elderly to help the elderly. SOS was funded for $6.8 million in 1970. OEO's informational retrieval systems, like those of AoA, provide no truly precise figures on the number of elderly served.

Project Late Start.—A research project, sponsored by the National Retired Teachers Association and the American Association of Retired People, was based on the premise that low-income elderly people can have their problems ameliorated by a concentrated group experience of education and information. The experimental project had 650 enrollees and was located in four cities in the United States.

What was the impact of Project Late Start in terms of the elderly? According to the program evaluators, the program was generally successful in achieving its goals. A substantial number of participants showed an improvement in their knowledge and enrollment in available social services; participants made many friends and became involved in social activities. The evaluators, however, were critical of the goals of the program, which appeared to be—to help the participants make do with limited resources rather than to provide them with a larger share of resources which they so desperately needed.

The demonstration phase of Late Start is completed, but no next step appears to be in view.

Legal Services for the Elderly.—Legal Services for the Elderly (LRSE) is a national demonstration project sponsored by the National Council of Senior Citizens under an OEO grant. LRSE is a major project dealing exclusively with the legal problems of the elderly. LRSE has begun or assisted in approximately 50 lawsuits in its first year ranging over many issues including Social Security retirement benefits, Social Security disability benefits, old age assistance, health care and treatment, conservatorship, guardianships, private and public housing, consumer fraud, mental committment, private pension plans and economic development.

OEO funding for LRSE was reduced in 1970. The number of LRSE projects had been reduced from 12 to 5. This reduction in funding was made even though the program demonstrated the need for greater action to assure the elderly of competent representation.

The pattern continues: LRSE is a demonstration project which served the elderly; the need for legal services to the elderly was demonstrated; reductions were made in the funding. What will happen to the older people who were served by those 7 suspended projects? What plans are there to include legal services in a national program for comprehensive services for the elderly?

II. PROTECTIVE SERVICES

At what point is it both ethical and appropriate to intervene in an individual's life pattern? There has been increased attention in recent years on the need to re-examine and develop more realistic standards of protective care.[3] Fundamental to the concept of protective services are several basic questions: (1) Who is to be served? (2) Is it the community that is to be protected from the client? (3) Is it the individual who is to be protected from himself? (4) Or is the person to be protected from an aggressive and perhaps arbitrary action by society?

These questions are asked because a look at legal practices affecting guardianship indicates that incompetency procedures do not make sense. Studies of incompetency procedures in central New York indicate that pure incompetency rarely exists. A major need is the clear definition of "incompetency", "sanity" and "dangerous mental illness."

In almost 600 cases studied it was found that most of the persons delared incompetent spent some time in a psychiatric ward. The incompetency proceeding was developed as a means of determining inability to function in a specific area, yet the confusion in the definition of incompetency and mental illness has resulted in the likelihood of the incompetent losing not only their right to manage their own property but the right to their liberty.

There is little protection afforded a person accused of incompetency. In the cases studied, there was not one single case in which an appeal was brought in a finding of incompetency.

While in 1961, the White House Conferees saw protective services as a part of a comprehensive social service system, no strong recommenda-

[3] There are several definitions of Protective Services in current use. The specific services discussed in this report are based on the definition of Protective Services in Research and Development Goals in Social Gerontology. A Report of a Special Committee of the Gerontological Society published in Winter, 1969.

tions were made. With advancing age, the elderly may find themselves involved in complicated and baffling encounters with the legal system—yet they are forced to shift for themselves. The question of protective services for the elderly remains a large unsolved problem which must be faced by the 1971 conference.

Necessary Components of a Social Utility System

Supportive Services aid the older person to remain in his familiar environment or to retain his usual living arrangement when this is no longer possible through his own efforts. Specific services would include homemaker-housekeeper services, organized home care, chore services, home meal services, and escort services.

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

Protective Services protect the civil rights and personal welfare of older persons from the neglect and exploitation by relatives, friends, the aged individual himself, and the community. Services would be directed toward the older persons with limited mental functioning due to mental deterioration, emotional disturbance, or extreme infirmity and would focus on their inability to manage their own affairs in such areas as providing for personal and physical needs, planning and decisionmaking and handling of finances.

III. SAMPLING OF GOALS

The issues surrounding the development of a social utility system are not clear cut, nor are the answers easily come by. But if we take a look at what we know, we can more easily determine where we want to go in developing a social utility system.

We know present delivery of services to the elderly is largely fragmented and haphazard and that services are not available to all older people in every town, city or region.

We know that, viewed from the larger perspective of national policy, demonstration service programs deal with the symptoms rather than the cause of problems, that effective evaluation procedures often are not built into programs, and that there is generally no plan for the effective utilization of the evaluation where it does exist.

We know that older people are the least involved in the establishment and management of demonstration projects and they least of all understand the role of demonstration projects. We know that older people directly feel and understand the impact of cutting off of funds for service projects, but their voices are seldom heard.

The goals of social utility system should be:

Services

1. To maintain independent living to obviate the need for institutional care or costly alternatives.

   A. To reduce wide-spread mental depression among the elderly through an active community involvement program.

   B. To provide services to individuals in or near their own homes, such as homemaker, health aide, supervised foster homes, chore services, recreation and education.

2. To find and assist older people in crises to achieve a stable living situation and to continue sharing responsibility with them thereafter for their welfare while they remain in the community.
3. To provide geographically comprehensive outreach to high risk elderly.
4. To interpret to families and the community and assist them in meeting the needs of impaired elderly and facing their possible progressive decline in functioning.

Citizen Participation

1. To establish an advisory committee to include consumers of service and their representatives, relating to authorized planning agencies in each community and State.

Accountability and Quality of Service

1. To establish standards for adequate quality of service.
2. To develop methods of evaluation.

Public and Private Cooperation

1. To develop viable cooperative arrangements between the public and private service sector.

CHAPTER 8

ADDITIONAL MATTERS OF CONCERN

No attempt has been made in this report to follow the division of subject matter fashioned for the White House Conference on Aging and for the preparatory local and State conferences.

Conferees have focussed on nine "needs" areas: income; nutrition; retirement roles and activity; housing; education; spiritual well-being; health; transportation; and employment and retirement. In addition, they have considered five "needs-meeting" mechanisms: services, facilities, and programs; planning and evaluation; training; research and demonstration; and government and nongovernment organization.

In response to complaints that several major subjects had been overlooked, Conference officials announced in September that "Special Concerns" sessions would be conducted from 8 a.m. to noon on Wednesday, December 1. Subjects are: The Elderly Blind, the Older Black, Older Consumers, Emotional Problems of Aging, Older Family Problems, Homemaker-Health Aide Services, The Elderly Indian, Legal Aid for the Poor Elderly, Long-Term Care for Old People, Aging Migrants, the Poor Elderly, Rural Older People, Spanish-Speaking Mexican-American Elderly, Rehabilitation of the Disabled Elderly, Volunteer Roles for Older People, the Religious Community and the Aging, and Youth and Aging.

Several of these topics are discussed in other chapters of this report. In this chapter, certain issues have been selected on the basis of recent Committee on Aging publications, hearings, or inquiries.

I. RESEARCH AND TRAINING NEEDS IN AGING

Americans, for the most part, are very conscious of the importance of ongoing research and training. But, in the field of aging, these needs have been assigned a low priority—not only in terms of funding but also a well-defined commitment.

Many industries and governmental units now invest three to five percent of their available funds for applied research. During the past two decades, expenditures for research and development have increased more than twice as fast as our gross national product. Yet, the research investment in the field of aging is only about two-tenths of one percent.

A dearth of trained personnel also continues to be one of the most pressing problems for upgrading or providing services for older Americans. Today only one out of every five persons serving the elderly has had any formal preparation for his work. And it is projected that the requirements for trained personnel in 1980 will be at a level two and three times above the present amount.

Yet, the need for substantially stepped-up Federal efforts in research and training is all too apparent, particularly if elderly persons are to receive the services which they desperately need.

A. Wholesale Funding Cutbacks Proposed

With the submission of the Administration's budget in early 1971, proposed funding for aging research and training was cut back sharply. A 36 percent reduction was recommended for research and development projects under the Older Americans Act, trimming the funding level from $2.8 million to only $1.8 million. Even more devastating, the budget called for a 38 percent cutback for training programs under title V of the Older Americans Act, slashing appropriations from $3 million to $1.85 million. And funding for aging research and training at the National Institute of Child Health and Human Development was to be pared from $8.8 million to $7.2 million, nearly 18 percent below the previous year's appropriation.

In March, the Senate Committee on Aging and the Subcommittee on Aging of the Senate Labor and Public Welfare Committee conducted joint hearings [1] on this issue and other proposed funding reductions for programs serving older Americans. Witnesses were in virtual unanimous agreement that the proposed funding levels would seriously jeopardize existing programs.

A major argument advanced was that this decision was counterproductive, especially since the elderly population continues to grow steadily. Dr. Jerome Kaplan, President of the Gerontological Society, gave this assessment:

> Estimates for the end of the century are that we may have as many as 55 to 60 million older people. In other words, we may have three times as many older Americans as now. Therefore, we must have knowledge about the aging process, diseases, and their related behavioral components if we are to deal effectively with the needs of our people. Simultaneously, we must have the training and education programs that produce qualified professionals who provide service to our people.[2]

Reversal in Policy.—A month later, the administration made a significant reversal in policy concerning funding for programs under the Older Americans Act. Appearing at the April 27 hearing,[3] Secretary of HEW Elliot Richardson announced that appropriations for research and training would be restored to their fiscal 1971 levels. The net effect was to raise the budget estimate for research from $1.8 million to $2.8 million, and funding for training from $1.85 million to $3 million.

Church-Prouty Proposal.—Testifying before the Labor-HEW Appropriations Subcommittee in July, Senators Frank Church and Winston Prouty urged further funding increases above the administration's revised budget estimate:

—A boost in appropriations for title IV research from $2.8 million to $4.5 million;

—An additional $2 million for title V training, raising the administration's revised budget request from $3 million to $5 million; and

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[1] "Evaluation of Administration on Aging and Conduct of White House Conference on Aging," *Joint Hearings before the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Public Welfare United States Senate;* 92nd Congress, 1st Session; March 25, 1971.

[2] Page 82 of hearing cited in footnote 1.

[3] Part 5 of hearing cited in footnote 1.

—A rise in appropriations from $7.2 million to $12 million for NICHHD aging research and training.

The $4.8 million increase in funding for aging research and training at NICHHD was later approved by the Appropriations Committee and the Senate. However, in conference committee this measure was deleted.

Instead, the House and Senate Conferees decided to raise the appropriations for NICHHD by approximately $7.1 million, from $107.7 million in the House bill to $116.8 million. However, the Conferees indicated their strong intent that within this additional $7.1 million funding for NICHHD, priority should be given to research on aging.

B. Legislative Developments

Two major legislative proposals were introduced during the 92nd Congress to provide greater visibility and a more coordinated approach for research in the field of aging. Sponsored by Senator Thomas Eagleton, S. 887 would establish a National Institute of Gerontology to conduct and support biomedical, social, and behavioral research and training related to the aging process, as well as health problems and other needs of the elderly. Another proposal, S. 1925, which was introduced by Senator Harrison Williams, called for the establishment of a seven-member Aging Research Commission to be appointed by the President. The Commission would be charged with the duty of preparing a comprehensive plan for intensive and coordinated research into the biological, medical, psychological, social, and economic aspects of aging.

Hearings were conducted in June by the Subcommittee on Aging. Nongovernment witnesses unanimously supported either the separate institute or the commission concept for providing a systematic approach for a research on aging program.

The Administration, however, expressed opposition to both measures. With regard to S. 887, Stephen Kurzman, Assistant Secretary for Legislation, at HEW said, "We are supporting a respectable aging research and aging related research program within NIH. We believe that a new Institute would not be the appropriate way to further gerontological research." [4] Concerning S. 1925, Kurzman recommended that action be postponed until an HEW Task Force has examined the future status and role of the Administration on Aging.

Despite the small amount spent, expenditures for research and training have proved to be a wise investment. Research and demonstration, for example, have already shown methods of enabling older persons to continue to live independently, instead of being institutionalized at a much higher public cost.

However, the low priority assigned to research and training continue to be a major problem in the field of gerontology. Moreover, existing efforts continue to be fragmented. Program responsibility also remains scattered among many Federal agencies, causing duplication of efforts, lack of coordination, and gaps in our overall approach.

For these reasons, the Committee recommends that an entity be established—whether it be an Institute of Gerontology, aging research

[4] "Research in Aging and Nutrition Problems for the Elderly," *Hearings before the Subcommittee on aging of the Committee on Labor and Public Welfare United States Senate;* 92nd Congress, 1st Session; June 14, 1971; Hearings not yet in print.

Commission, or combine elements of both—to provide a systematic plan and centralized focus for the conduct of research in the field of aging. Additionally, the Committee endorses, in principle, the nine-point legislative program [5] recommended by the Executive Committee of the Gerontological Society and urges that it receive full attention at the White House Conference on Aging.

II. THE RURAL ELDERLY

Depressed economic conditions, a dearth of available services, and limited job opportunities have contributed to a mass exodus of nearly 6 million farm residents to cities and towns during the past decade. According to a Department of Agriculture and Bureau of Census report [6] released in 1971, the farm population in the United States declined from 15.6 million in 1960 to 9.7 million, for a 38 percent reduction.

To a very large degree, the elderly have been "left behind" by this massive migration to urban areas. For them, the pattern is all too clear. As the rural population shrinks, so does the availability of vitally needed services. With the rapid departure of doctors, druggists, nurses, dentists, and lawyers, professional services are sharply reduced and frequently become nonexistent.

Two years ago the Senate Committee on Aging launched an intensive study [7] concerning the special problems confronting older Americans in rural areas. To date, 12 hearings have been conducted throughout every region in our Nation. Although the study is not yet complete, several clear-cut preliminary findings and policy recommendations have already emerged during this study. Among the major developments:

A. Population Characteristics

Today it is estimated that approximately 5.4 million persons 65 and older, or about one out of every four older Americans, live on farms or in rural communities with a population at 2,500 or less. Compared with the Nation as a whole, the elderly constitute a higher percentage of the total population in rural areas than is the case in

[5] The Executive Committee of the Gerontological Society supports:

1. The Establishment of a National Institute of Adult Development and Aging for the purpose of conducting and supporting:
   a. Basic and applied research into the processes of aging including, therein; physical and mental health, biological and chemical changes, psychological and social relationships.
   b. Basic and applied research into the prevention, treatment and modification of changes associated with the aging process and disease.
   c. Training related to such basic and applied research and programs.
2. A budget of $12 million for the National Institute of Child Health and Human Development earmarked for research in aging.
3. Restoration of the organizational structure, position, and function of the Administration on Aging as legislated by Congress in the Older Americans' Act.
4. An appropriate budget for the Administration on Aging to include a total of $23 million for State Planning and Services, $5 million for Research and Development, and $5 million for Training.
5. $5 million in budgeted funds for the Health Services and Mental Health Administration earmarked for studies and demonstration programs on the organization and delivery of health care and health services for the middleaged and elderly.
6. Earmarked funds of $5 million for the National Institute of Mental Health for studies and programs leading to improved understanding, services, care and prevention of mental illness in the elderly.
7. The establishment of a commission to set national goals and priorities in order to improve the quality of life for the aging, with the authority and funding to insure that these goals are established.
8. The establishment of a commission to set research priorities for studies of the aging process by biological and behavioral scientists.
9. The establishment of a Congressional Commission on the Mental Illness of the Elderly.

Adopted by the Executive Committee of the Gerontological Society at its February 6-7, 1971 session in Washington, D.C.

[6] *Current Population Reports*, "Farm Population"; P-27, No. 42; August 16, 1971.

[7] "Older Americans in Rural Areas".

the cities and suburbs. *Nationally, one out of every 10 Americans is an older American. But in rural counties, that ratio is frequently one in five.*

Of the total rural population, nearly 1.1 million persons 65 and older live on farms. Another 1.2 million farmers are aged 55 to 64. During the past decade, this age group's percentage of the total farm population has risen from 18 percent to 24 percent.

B. Retirement Income

By whatever barometer one would choose to use, personal income in rural areas is substantially lower than in the cities. For the elderly, retirement income tends to be significantly less. A major reason is because their average lifetime earnings are generally lower than their urban counterparts. Moreover, very few have private pension coverage, because a large proportion has worked in jobs with no provision for retirement benefits, particularly those engaged in agriculture or some form of self-employment.

As a consequence, large numbers are dependent almost exclusively upon Social Security and whatever meager savings that they have been able to accumulate during their working years. This, in part, is a principal reason why a large proportion of the rural aged want and need to work. But, with increased mechanization on the farms and industries leaving the countryside, jobs are becoming increasingly scarce.

C. Health

Shortages of health manpower and facilities in rural America continue at an alarming level, and with no end in sight. Nowhere in the Nation is the need for health services so urgent, and nowhere is it so scarce. Approximately 30 percent of our total population lives in rural areas. But, only about 12 percent of our physicians, 14 percent of all pharmacists, and 18 percent of the Nation's nurses are located in rural localities.

In general, the Committee's study has helped to corroborate the common assumption that the rural aged are in poorer health. Approximately 87 percent have some chronic condition, compared with about 80 percent for the aged in urban areas. Their number of restricted days because of health reasons is nearly 36 percent greater than for aged persons living in metropolitan areas. Yet, elderly persons living on farms see physicians less than the aged living anywhere else.

D. Employment Patterns

Unemployment and underemployment still remain serious problems—whether for persons in their forties or those in their sixties or seventies.

Increasing mechanization and improved production techniques have made it possible now for one farm worker to grow enough food for 45 persons, compared to only 11 thirty years ago. And with technological advances many jobs have been eliminated, especially those for the unskilled.

Employment difficulties are further intensified by the seasonal nature of much of the work in rural America, particularly in agricul-

ture. And too often, there is no work to be found as industries and services move to more populated markets.

E. Housing

One of the principal by-products of low income is poor housing. With a substantially reduced income base, dilapidated housing tends to be concentrated to a much larger degree in rural areas. A major finding of the hearing was that two-thirds of all the substandard units in the Nation—or 6 million homes—are located in rural America.

Rising property taxes and maintenance costs have also intensified the economic squeeze for elderly persons living on fixed incomes. In some cases, aged homeowners were paying more than 50 percent of their total incomes for property taxes. As a consequence, many now live in ramshackle houses that are cold in the winter and steaming hot in the summer. In some localities, accessories that are taken for granted in the cities—such as indoor bathroom facilities, screened doors, and running water—are the exception rather than the rule.

F. Transportation and Isolation

In urban areas, transportation problems are, to a very significant degree, related to high costs. But in rural America, adequate transportation is frequently nonexistent. Numerous small towns are now without a public transportation system, and many communities have no taxi service.

For elderly persons who do not own and operate a car, they find themselves dependent upon relatives or friends. Routine tasks for most younger persons such as shopping, visiting friends or going to church become formidable obstacles for aged individuals without a means of transportation. In far too many cases, they just do without.

Because of the high concentrations of elderly persons in rural areas and the special problems which confront them, the Committee urges—as it did in its 1970 annual report—that these issues should receive thorough attention by the delegates at the White House Conference.

However, additional further action is necessary for building a working framework for responding to the many and intensifying problems facing the rural aged. The Committee urges that:

- **—Minimum monthly Social Security benefits be raised significantly (for a more detailed discussion of the Committee's recommendations for improvements in Social Security see chapter 1, pp. 5–16);**
- **—The retirement test be raised to a more realistic level for persons who must work to supplement their Social Security benefits;**
- **—Increased Federal funding be made available for mobile health screening units to provide disease detection and other services for persons living in rural areas;**
- **—Medicare coverage should be extended to include services performed by household aides to enable elderly patients to continue to live in their homes, rather than being institutionalized at a much higher public cost;**
- **—Legislation should be enacted to make home repair assistance available for low-income elderly homeowners who would otherwise not be able to perform these tasks themselves;**

—**Federal legislation be adopted to help defray any additional costs of rural school districts which attempt to make more effective use of their school buses during off duty hours to help meet the serious transportation problems of the aged; and**
—**Manpower training programs should be redesigned to be of more practical assistance in rural areas. Especially needed is placement in part-time work for those wishing to supplement farm income.**

III. FUNDING LEVELS FOR OFFICE OF ECONOMIC OPPORTUNITY

With the passage of the Economic Opportunity Act in 1964, our Nation launched a war on poverty. One of the principal target groups to be helped by this legislation was the elderly poor.

Yet, despite the high proportion of poverty among older persons, they have been underrepresented in OEO programs. It is estimated that only 12 percent of OEO funding is used for the aged poor, although persons 65 and older account for 20 percent of the total poverty population. And if persons 55 and older are included, this age group represents approximately 27 percent of all poverty in the United States.

Senior Opportunities and Services

Included in the 1967 Economic Opportunity Act Amendments, the Senior Opportunities and Services program ("SOS") was the result of a recommendation in the Committee on Aging's report on "Needs for Services Revealed by Operation Medicare Alert." Today there are more than 250 SOS projects in operation, serving approximately 800,000 persons 60 and older.

Some of the services rendered include outreach and referral, homemaker, home health, home repairs, employment and training, transportation, consumer education, telephone reassurances and others. In a number of evaluations by independent groups, the SOS programs have been soundly endorsed. In 1970, for example, Kirschner Associates found that SOS is an effective means for identifying and meeting the needs of the elderly. The report also noted that SOS projects (1) have a low unit cost per beneficiary and (2) have been enthusiastically accepted at the community level.

The soundness of the SOS Program has been amply demonstrated. SOS projects now generate 40 cents in local resources for every Federal dollar spent, which is the largest nonfederal share of any OEO program. The committee urges that the SOS program be fully funded.

Legal Services

Attention to the legal problems of the poor has increased dramatically under the OEO Legal Services Division. However, the elderly have received only a small fraction of the representation available under this program. Diffidence, lack of knowledge about these programs, and a lower visibility have all contributed to this problem.

But in 1968 a Legal Research and Services for the Elderly program [8] was initiated to identify issues affecting the aged and to develop solutions for their problems. During its 3 years of existence, LRSE has provided competent and forceful representation for the aged poor. Their projects throughout the Nation have constantly been in the forefront in representing elderly clients in courts of law and before administrative tribunals, developing legislation to remedy many of their problems, and providing counsel on issues of direct concern to them. Among the major examples:

Massachusetts Department of Elder Affairs.—Advocates for the Council of Elders project in Boston helped to develop legislation to create the only cabinet level department in the Nation to coordinate State programs affecting housing, health, and welfare for the elderly. This proposal became effective in April.

Rent Control.—The Legal Services Senior Citizens Center in Miami Beach drafted and helped provide support for enactment of a rent control ordinance. For elderly persons living on limited incomes, this measure can provide welcome relief. However, a suit has been filed to challenge the constitutionality of the ordinance.

Adequate Representation in Model Cities Programs.—Project attorneys in Los Angeles have successfully contended that a Model Cities program did not assure adequate participation for the elderly. As a result, the planning process has been restructured to provide greater participation by elderly residents, as well as assure greater services for their needs.

Yet, despite the successful achievements by LRSE, its funding has been cut back by nearly 25 percent, and the number of projects has been reduced by 58 percent, from 12 to 5. Moreover, the contract for the program is scheduled to terminate in April, 1972.

The Committee strongly recommends that the LRSE program be extended and expanded significantly when the existing contract is scheduled for renewal. In addition, the committee recommends that the proposed National Legal Services Corporation [9] provide for representation of the elderly poor reasonably commensurate with their proportion of the poverty population.

IV. MODEL CITIES

Adoption of the Model Cities program in 1966 represented an important step forward in directing Federal and local resources to the problems in low-income areas. It also represented a measure with potentially far-reaching implications for the elderly, since many deteriorating neighborhoods have high concentrations of older Americans.

Shortly after the program was launched, the Senate Committee on Aging initiated a study [10] to explore how this proposal could best be used to meet the problems of the elderly poor. For the most part, witnesses agreed that the Model Cities program provided great promise for improving the current living conditions of many deprived older persons. A major advantage is that it offered more than just a solution

[8] Legal Research and Services for the Elderly is sponsored by the National Council of Senior Citizens for the Office of Economic Opportunity.

[9] Economic Opportunity Act Amendments of 1971, S. 2007.

[10] "Usefulness of the Model Cities Program to the Elderly," Hearings before the Special Committee on Aging United States Senate; 90th Congress, 2nd Session and 91st Congress, 1st Session; July 23, 1968 through October 15, 1969.

for a "jobs" problem or a "transportation" problem. Instead, it provided a comprehensive approach for their economic, social or physical problems—whether they be income, employment, housing, nutrition, health, transportation or others.

However, lack of a clearcut commitment, funding difficulties, and "new directions" have seriously reduced the effectiveness of the Model Cities program as an effective force for attacking the problems of the elderly.

Full Involvement by the Elderly?

In 1971, HUD and AoA renewed their joint contract with the National Council on the Aging to assist in developing programs and services for elderly residents of Model Cities neighborhoods. A major objective of the contract is to assure that the needs of the aging are given proper attention in all Model Cities projects. In addition, NCOA is providing training and technical assistance in 15 communities located throughout the Nation.

During the past 5 years, some progress has been made in expanding services for elderly persons in Model Cities areas. However, existing programs still fall far short of assuring full and meaningful involvement for the elderly. Of 147 Model Cities surveyed by the NCOA, only 63 offered some services for the aged. Yet, persons 65 and older ordinarily comprise anywhere from 10 to 26 percent of the population in these areas. And in some of the target areas, 90 percent of the aged residents are Old Age Assistance recipients.

Because of the high concentration of older persons in Model Cities areas, it is recommended that HUD establish clearcut policy guidelines to assure that the aged residents are properly represented in the comprehensive planning process, as well as to assure that these programs are responsive to their special needs.

Funding Problems

Symptomatic of the problems confronting the Model Cities program is the difficulty in obtaining adequate funding. From fiscal year 1969 to 1972, the administration's budgetary request plummeted from $1 billion to zero. During this same period, appropriations dropped markedly from $625 million to $150 mlllion, for a 76 percent decline. In addition, the administration has not spent the $575 million which was appropriated during fiscal year 1971.

Adequate funding is essential to the success of the Model Cities program. Without sufficient appropriations, Model Cities may degenerate into nothing more than a talking and planning program—resulting in high hopes and low fulfillment. For these reasons the Committee urges significantly increased funding for the program and strong assurances from HUD and AoA that the elderly will be adequately served in selected target areas.

"New Directions"

A major new change in direction for the Model Cities program was unveiled in the President's Special Revenue Message for Urban

Community Development.[11] Drawing upon the recommendations of his Task Force on Model Cities,[12] the President called for money now going to four major programs—Model Cities, urban renewal, water and sewer grants, and rehabilitation loans—to be distributed to the cities under a formula based on population and need. Under the terms of the administration's proposal, cities would have broad authority to spend this money for "community development" purposes. In discussing the guidelines for spending, the President stated:

> Just which of these activities would be supported and what proportion of available funds would be channeled into each activity are decisions that would be made locally. No Federal approval would be required. Cities would simply be asked to indicate how they plan to use their funds and to report periodically on how the money was expended. This requirement is included merely to insure that funds would be used for eligible activities.[13]

Whether or not the administration's proposed revenue sharing for urban develpoment is adopted, the elderly—as well as other low-income groups in the central cities—can ill afford a delay in the provision of these vital services. It is therefore recommended that the Model Cities program be continued at an effective level until the Congress decides to continue, strengthen, or replace the program with something new.

V. EDUCATION FOR OLDER PERSONS: A NEGLECTED RESOURCE [14]

Educational programming for adults is usually limited to remedial instruction intended to develop skills overlooked during the years of formal education.

But the later stages of life are just as complex, problem-ridden, and subtle as adolescence or young adulthood. The older adult, too, faces a period of adjustment, accommodation to unfamiliar perils, of decision, of setting new goals for an uncertain future.

Education, however, is seldom mentioned when reviewing available resources which would be of use in meeting challenges of old age. In fact, the value of education generally is regarded as decreasing in value as a person's age advances. Even the President's Task Force on Aging, in its November 1970 report made only 4 recommendations on aging, and they were rated as 18, 19, 20, and 21 in a list of 24—nearly at the very bottom of the priority roster.

Negative attitudes toward education must be changed if its full potential is to be utilized.

The Concept of Lifelong Learning

The process of learning, the love of learning, and the skills of learning must become more important than subject matter which changes

[11] "Revenue Sharing and Urban Development, Etc.," Message from the President of the United States, 92d Congress, 1st Session; House Document 92—61; March 8, 1971.

[12] "Model Cities: A Step Towards the New Federalism," The Report of the President's Task Force on Model Cities; August 1970.

[13] Page 8 of Document cited in footnote 11.

[14] This section is adapted from Education for Older People: A Neglected Resource, a paper prepared by Dr. David Peterson, Director of Training Programs, Institute of Gerontology, University of Michigan, for the Senate Committee on Aging for publication soon after the White House Conference on Aging.

quickly. Education needs to be cumulative and anticipatory rather than remedial. It should concentrate on learning, unlearning, and relearning, a process which can be continued throughout the life span.

In this country a number of alternatives have been established which provide the opportunity for persons to continue their learning beyond the time they cease full-time studenthood. These include private and public adult schools, colleges and universities, job training or upgrading by industry, trade schools, community organizations or agencies, correspondence programs, and private study. The forest looks better than any of the trees, however. No one community can boast even half of these educational offerings, and most have very few. In some cities a church is active, in others a center, while in still others a television station has taken the lead.

It is only with this variety of educational opportunities that a community can begin to develop a positive attitude toward education in its inhabitants. Since adults are so different from each other, it is not possible to identify a need at each age that each person will have. In addition, it is not possible to identify a particular program or agency which will meet any given need for all adults. Consequently, a bewildering array of agencies, organizations, and institutions offer an astounding number of programs for the enlightenment of adults. The needs are diverse; the programs must be diverse. But the confusion that exists within a community where no one person knows all that transpires and where no coordination exists between programmers need not exist. Assurances that the gaps will be closed and duplication avoided is needed in each community. This has not yet happened and without extensive stimulation, there seems no reason to believe that it will.

Education for adults of all ages is sorely needed, but a better system of providing education must be developed in the United States.

Major Problem Areas

Problems of current programing may be attributed to lack of coordination and control, assignment of low priority to the area, and the absence of detailed models which could provide an understanding of future directions.

Coordination.—The provision of education for so diverse and numerous a population as America's older people is such a tremendous task that it cannot and should not be entrusted to any single organization or institution. But if this broad diverse approach is sure to meet existing needs, it will also cause great problems of coordination, responsibility, planning, and evaluation. As Senator Harrison Williams noted in a Senate speech on March 1, 1971:

> At least 476 different Federal programs have adult education components, yet nowhere is information available about all of them. Sharing of ideas and experiences is usually accidental. No one knows what needs are being met how well, and what needs are falling between the programs. No basis for planning exists.

Priority.—A second major problem is the low priority which is ascribed to this area by educators, the community, and older people themselves. In most cases, older persons are welcome to attend ex-

isting programs, but their unique needs and abilities receive no special attention. Programs designed for older people are assumed to be the responsibility of some other group. Older people must be shown that education works. Otherwise, they will never seize existing opportunities and the prospects for future growth will remain bleak at best. Until this happens, we can assume that education for later life will remain a small, unorganized and erratic endeavor.

Models.—A third problem in the development of education for older people is in the lack of well-defined models for communities or agencies to follow in establishing new programs. The need for this comprehensive model should be evident from the lack of coordination, responsibility, priority, and information in the field. An approach of this type could aid communities and agencies in determining needs, identifying resources, coordinating energies, stimulating participation, and evaluating the outcome of the collective efforts of a geographic area.

New Direction in Education for Older People

Education for older people must not be viewed as separate and disconnected from education for other life stages. Any attempt to disassociate education of older people from the education of the preceeding life stages will provide a distorted picture for the background will have been removed and older people will stand in isolation from the environment which has influenced them for their entire lives.

Education for older people may be viewed as being composed of four overlapping and interrelated parts. These parts must be available to older people in order for their educational needs to be met. They are (1) mass media education, (2) resources for independent study, (3) informal education organizations, and (4) formal education institutions.

Mass Media Education.—The framework of a community's education program for older people is provided by the mass media. Local and network radio and television; films; local, regional, and national newspapers; popular magazines; scholarly and professional journals, newsletters; pamphlets; and booklets provide basic information which is available to all and which is necessary to maintain the level of knowledge and understanding of older people.

A model community educational program for older people would include large segments of mass media time and space, and provide opportunity to develop non-traditional mode of learning experience.

Individual Study.—Some persons prefer independent study of printed or recorded material to group instruction and to the fleeting coverage of the mass media. A model educational community would need to provide many and varied opportunities for indivudual study at little or no financial cost. Group sessions would be provided in schools or centers where the independent students could share their fields of interest with others and, if possible, establish continuing study-discussion groups.

Informal Education Organization.—The provisions of education for older people through informal organization is at once the most difficult and most promising of the four areas identified. Their wide diversity of interest, structure, distribution and potential makes the area appear disorganized from an educational point of view.

In establishing a model community education program, adherence to one principle may assure the development of some order. This is the principle that the greater the organization's specificity, the higher its priority in that area. A typical community, then, would provide a variety of educational programs for older people. A variety of agencies and organizations would offer the type of programs which they are best suited to provide. Minimal overlap would be encouraged and program gaps might be covered by the formal educational institutions.

The encouragement of educational programing by informal educational organizations is critical in the development of a community mosiac of educational opportunities. There can be no doubt that many will, but others will either be absent from the community or will place their resources in other areas of service. It is the responsibility of the formal education institutions to insure complete coverage.

Formal Education Institutions.—The formal educational institutions have as their major responsibility the provision of education for the young. They have directed little concern and few resources for adults and older persons. The time has now come for a change. Public schools and colleges must play a crucial role in the provisions of education to adults and older people.

Although mass media, independent study, and informal educational organizations are important parts of the design and may carry the largest part of educational programing, some unit in each community must bear the leadership role for the area and be ultimately responsible for the quality and coverage of the entire educational effort. The public schools and colleges seem to be the institutions which offer the most promise of filling this role.

The role of formal education institutions must be different in two ways from that of the informal organizations. First, because the schools have a broader educational function than other organizations they must defer to the programing interests of the informal groups and offer programs only to fill the void left by others. Second, a different role for the schools would consist of its leadership in education of older people. In each community, one agency bears the final responsibility for education for aging. This agency should not be expected to provide all of the educational offerings itself, but rather encourage, assist, support, coordinate, and evaluate the communities activities.

The community school and the community college have attempted to overcome the traditional limitations of formal education in a way which makes either eminently suited to serve as the focus of education for the aging.

(1) Community school. As the concept of the community school grew, the school system became the means of providing numerous unique services and activities, not only to children, but to all residents of the community. The school became involved in the entire life of the community, and therefore, became the focus of education and services to persons of all ages. The school not only became the focus of many programs and activities, but its staff became conscious of and involved in other aspects of community life. Through reaching out and pulling in, the public schools became integrated into the community of which it is a part.

This concept could be immediately broadened to include additional educational offerings to older people and to accept responsibility for encouragement of a community-wide program of education

69-867 O-71—7

for aging. The community school then, is in an excellent position to take the leadership role in many communities.

(2) Community Colleges. Developing from the traditional junior college, the community college movement has grown rapidly in recent years. Beside providing the first two years of undergraduate instruction, these colleges also operate community service departments which provide adult education, services, and in-service education. The community college is expected to be involved in the entire fabric of the community. The newness and dynamism of the community college movement makes it a prime candidate in many areas for the leadership role.

The Adult Education Opportunity Act of 1971

Recognizing the importance of adult education both for individual fulfillment and for the social and economic well-being of the Nation, Senator Harrison Williams introduced S. 1037, The Adult Education Opportunity Act of 1971, on March 1, 1971. He said:

> The current problem of coordination and evaluation of educational efforts by hundreds of thousands of local, State, private, and voluntary programs conducted for the most part in isolation.

The Adult Education Opportunity Act of 1971 would:

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

As former Chairman of the Special Committee on Aging, Senator Williams pointed out that the Adult Education Opportunity Act would have special value to older Americans, especially those near or in retirement.

> Time and time again, well informed witnesses have told the Committee that well-being and even health of the elderly improves when those individuals are living active and stimulating lives. Education certainly would make a significant contribution toward such a goal.

The Adult Education Opportunity Act of 1971 is the first legislation recognizing adult education as a vital part of national policy.

Community School Center Development Act

In October, 1971, Senator Church introduced the Community School Development Act and described the importance of the community school concept in transforming the traditional role of the neighborhood school into that of the total community center for

people of all ages and backgrounds. Senator Church said he hopes to see the school work in partnership with other groups in the community to provide recreational, educational and a variety of other community and social services.

> "This Act will benefit all segments of our population," he said. "But, as Chairman of the Senate Committee on Aging, I want to emphasize the advantages that will accrue to our elderly through enactment of this bill. Programs of education, health, recreation, nutrition and transportation could be established through community schools. . . . . Programs of assistance and interest to the senior citizens is almost unlimited."

This Act would:

1. Provide Federal grants to strengthen and sustain existing Community Education Centers, located at colleges and universities throughout the Nation, which would train community school leaders, and in general, promote and assist the community school movement.
2. Provide Federal grants in each of the 50 States for the establishment of new community school programs and the expansion of existing ones.
3. Promote community schools through specific national programs of advocacy and education.

In attempting to establish education for older people, it is imperative that our efforts not be limited to the past. New and innovative approaches will be required if progress is to be made.

Senator Williams joined Senator Church as an initial cosponsor of the bill.

VI. CATEGORICAL VS. NONCATEGORICAL APPROACH

Assuming that the elderly need special emphasis programs, when should this approach be used? Obviously lawmakers and program administrators may prefer a more general type approach in most areas, particularly when the needs of society do not require a special solution for a particular group. But, what should be done when an identifiable group has a unique or a more severe problem calling for a different approach from the general population? And what should be done if officials in government are more interested in serving a younger clientele because they believe that Federal funding would be more prudently spent in this manner?

These are basic considerations not only for Congressmen and Senators as they draft legislation, but also for delegates at the White House Conference as they develop policy proposals. It is fundamental because it will influence, to a significant degree, the effectiveness of the national policy on aging formulated at this year's Conference. And for the elderly themselves, this issue is crucial because the resolution of this question may have a substantial impact in determining whether they fully participate in Federal programs.

Noncategorical Approach.—Supporters of noncategorical programs maintain that this approach is sounder from an administrative standpoint, and results in more efficient overall programs. A classic presentation of this view point was made by Mr. Paul J. Fasser, Deputy Assistant Secretary for Manpower and Manpower Administrator

in the Department of Labor, when he expressed opposition to the Older American Community Service Employment Act[15]—a special emphasis measure to maximize employment opportunities for low-income persons 55 and older.

> Despite the apparent success of several of the categorical programs such as the Community Senior Service program, it is clear that, as a whole, because of the multiplicity of separate and distinct programs each vying for a share, the categorical approach of recent years has not fulfilled the expectations of manpower programs for older people or for anyone else.[16]

Another key point, they contend, is that the elderly may not fare as well with special emphasis programs because an unsympathetic agency may regard categorical legislation as the only Congressional mandate which it is required to implement on behalf of the aged. Equally important, they maintain that the proliferation of narrow, categorical programs frequently leads to fragmentation, duplication of effort, and inefficiency.

Categorical Approach.—Advocates of special emphasis legislation counter by saying that the elderly have been largely overlooked or ignored under existing programs applicable to all age groups. An example frequently cited is under-representation in manpower work and training programs. For example, persons 45 and older constitute about 22 percent of the total unemployment in the United States; 30 percent of all joblessness for 15 weeks or longer; and 37 percent of the civilian labor force. Yet, they account for only 4 percent of all enrollees in the existing manpower programs.

Without a categorical approach for certain programs, the outlook for improvement, in their judgment, is not encouraging. An excellent example of this argument was made by Senator Edward Kennedy when he supported the Older American Community Service Employment program:

> We can't really tell whether the resources we are going to get will depend on the local mayor or the community. But, in terms of the legislation which is before us this morning we are sure that it is going to go with the senior citizens. And we are sure that it is going to go to the elderly.[17]

Additionally, they maintain that the elderly need a special approach because our society tends to be more youth oriented. Moreover, they contend that categorical programs are essential because the elderly's problems differ in many respects from other age groups, and require a different type of solution.

The categorical vs. noncategorical debate is a valid and important one, which has already arisen in workbooks issued for the White House Conference on Aging. The Senate Committee on Aging urges conferees to judge each and every situation on its own merits, and to allow sufficient flexibility to meet differing needs. It would be unfortu-

[15] For a more detailed discussion of the Older American Community Service Employment Act, see chapter 1, p. 11.

[16] "Employment Opportunities for Middle-Aged and Older Workers, S. 555, S. 1307, S. 1580"; Subcommittee on Aging, Committee on Labor and Public Welfare, United States Senate; 92nd Congress, 1st Session July 29 and 30, 1971; Hearings not yet in print.

[17] Statement at hearing cited in footnote 16.

nate indeed if an arbitrary, fixed attitude toward Government Administration were to sway independent judgment on widely varying needs.

VII. TRANSPORTATION NEEDS OF THE ELDERLY

Economic deficiencies may dominate most problems faced by older Americans, but certain essential services are also necessary for self-sufficiency or fulfillment in later years.

A report issued by the Senate Special Committee on Aging on December 31, 1970,[18] describes transportation as an especially essential service:

> With it (transportation) a couple or single person can more easily cope with adjustments or hardships that come with age.
>
> Without it, they may enter into what has been described as a "syndrome of deprivation". As one sociologist has said of the elderly:
>
> "You get low income; you get poor health; you get an absence of transportation facilities, and the net result of this is something that is very different than anyone of these things individually."

The Committee report declared that the transportation—or mobility—problems now encountered by many elderly citizens of this Nation have already reached the crisis stage.

> "Furthermore," declared the report, "the Committee sees a genuine possibility that today's problems are likely to be worsened by living patterns already far different than those which existed when today's elderly were young."

Urban and rural needs are described in the report, as well as recent experiments in reduced fares for the elderly and in providing specialized transportation programs for older persons and the handicapped.

Several of the report recommendations deal with existing legislation:

> 1. Action should be taken by the Department of Transportation to assure early and responsive implementation of a provision of the Urban Mass Transit Assistance Act which requires adequate consideration of provisions designed to protect social and environmental interests of residents who may be affected by any transportation project.
>
> *Discussion:* Section 14 of Public Law 91–453 requires the Secretary to assure—before approval of any transportation development grant—that "adequate opportunity was (is) afforded for the presentation of views by all parties with a significant economic, *social*, or environmental interest in the consequences of the project."
>
> Senator Harrison Williams has interpreted this provision as having special meaning for the elderly. In a speech presented at the Interdisciplinary Workshop, he said:
>
> "Under that requirement, certainly it would be mandatory that the needs of the elderly should receive special attention. It is no secret that the central urban areas of this

[18] "Older Americans and Transportation: A Crisis in Mobility," Senate Report No. 91–1529.

Nation have exceptionally high concentrations of aged and aging Americans. *If a transportation system does not serve them, it is not serving a large population with desperate need of special attention.*"

2. The Department of Transportation should report to appropriate Congressional units, by July 1, 1971, on its progress in complying with another provision of the Urban Mass Transportation Assistance Act which gives the Secretary discretion to channel approximately $46.5 million in funds into special-purpose projects of direct helpfulness to the elderly.

Discussion: An amendment—sponsored by Representative Mario Biaggi and adopted during House discussion of the mass transportation bill—was prompted by complaints that present designs of mass transit systems prevent many elderly or handicapped persons from using them. Some estimates of Americans thus precluded range as high as 44 million; one analysis indicates that more than one-half of all handicapped passengers are unable to maintain their balance when a moving vehicle starts, stops, or negotiates a sharp turn. Fear or embarrassment in large crowds caused 61 percent of the handicapped to avoid public transportation; and steps for buses and trains present difficulties for 30 percent. The Biaggi amendment declared, *for the first time:*

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

In addition, the amendment earmarked funding up to $46.5 million to be used for loans and grants so that existing mass transit systems can be modified to meet the special needs of the elderly and handicapped. A floor amendment offered by Congressman William Widnall, however, gave the Secretary of Transportation discretionary authority to set aside this amount. If the Department of Transportation utilizes the authority thus provided—especially if it acts in conjunction with other agencies for purposes described in Recommendations One and Two—its Secretary can advance the prospects of greater accessibility to transportation for millions of Americans denied, in de facto fashion, a right now guaranteed to them by law.

3. Many older Americans are now denied desperately needed health care because of inadequate or inaccessible transportation. Ambulance service—as now covered under Medicare—is limited to emergency situations. Other means and other practices may be more effective and less costly. Therefore the committee recommends that the Social Security Administration issue a report on the cost of broadening

Medicare coverage to include additional modes of transportation services for Medicare beneficiaries. The results of research and demonstration projects previously recommended should be useful to the Social Security Administration in making the report.

Discussion: As persons grow older, they tend to have more and longer hospital stays, increased doctor visits, additional days of some degree of disability, and a much greater likelihood of suffering from a chronic condition. Consequently, getting to and from health care facilities—whether it is a doctor's office, hospital or other health clinic—becomes a crucial health problem, especially for persons living on limited, fixed incomes. The strong inter-relationship between transportation and competent health care is even more apparent now, since house calls by physicians are almost nonexistent for patients today.

Quite frequently the cost of transportation precludes or inhibits an elderly person from seeking the necessary care he urgently needs. This is particularly true for low-income patients who must rely on taxi service because of the unavailability or inaccessibility of bus services.

The Committee also urged passage of legislation to authorize a special emphasis transportation services research and demonstration program for older Americans. The report pointed out that the Administration on Aging had already funded eight pilot projects on transportation, and that results had been impressive.

"However," the report added, "existing research and demonstration efforts are too limited if AoA, the Department of Housing and Urban Development and the Department of Transportation are to develop the body of knowledge to provide a coordinated approach to deal with the most pressing transportation difficulties of older Americans on a large scale."

Separate Systems for the Elderly? A firm rejection of this concept was made in the Committee report.

"This stance," said the Committee, "was taken despite the firm recommendation made 1½ years ago by a consulting firm which—after a study [19] of transportation needs of the 6 million Americans classified as 'chronically handicapped'—that 'economically viable' specialized transportation networks could be designed and put into use for the elderly and the handicapped in cities with populations of 100,000 and more."

In the view of the Committee on Aging, the most feasible form of assistance to the elderly "will be that which is also of assistance to all other Americans."

While granting that under certain circumstances, limited service systems should be offered to meet specific local needs, the Committee said that such pilot programs should be regarded as forerunners of

[19] "Travel Barriers—Transportation Needs of the Handicapped:" prepared for the U.S. Department of Transportation by Abt Associates, August 1969.

transportation-service components that ultimately will fit into more generalized networks.

A similar view was expressed by a Department of Transportation representative [20] at a recent Committee on Aging hearing.

After describing a new "people mover" [21] system in Morgantown, W. Va., the DOT witness said:

> The Department believes, however, that the solution to this problem does not lie entirely in developing separate facilities for the elderly and the handicapped, but in making all transportation facilities available to them.

After the White House Conference

The December 1970 Committee on Aging report praised AoA, DOT, and HUD for sponsoring a joint Interdisciplinary Workshop in May 1970 on Transportation and the Aging. But the Committee called for additional, similar action in the months following the November 1971 White House Conference on Aging:

> During the "implementation phase" beginning in early 1972, another Interdisciplinary Workshop should be conducted. Unlike the exploratory workshop of May 1970, the 1972 workshop should be concerned primarily with specific action proposals which, as one program, will fulfill goals of a coherent national policy on transportation and the elderly.

VIII. FLAMMABLE FABRICS AND OTHER FIRE HAZARDS

A consumer issue of some urgency emerged at a Senate Committee on Aging hearing conducted on October 12.

Committee Chairman Frank Church presented the following information about "Flammable Fabrics and Other Fire Hazards to Older Americans":

—Latest information indicates that, for overall fire involvement, the elderly constitute just under 10 percent of the population, but account for about 30 percent of the deaths by fire.

—Elderly persons suffer a disproportionate share of the 5,000 deaths and 250,000 burn cases attributed annually to clothing and apparel fires. In a 1969 survey of 23 States conducted by the Food and Drug Administration, it was discovered that 59 percent of fires related to clothing ignition involved those 65 and over.

—71 percent of fires occur in the home; for the elderly, it is an even 80 percent.

—Those who live alone are the highest risks, including—of course—many elderly widowed and others who have single occupancy quarters.

—Elderly persons quite often are ill or medicated when fire breaks out.

The Senator's appraisal of the gravity of the situation was confirmed by other witnesses, including medical practitioners who said that older persons have less capacity to deal with toxic fumes caused by fire

[20] John E. Hirten, Deputy Assistant Secretary for Environment and Urban Systems, at a hearing on "A Barrier-Free Environment for the Elderly and the Handicapped," Washington, D.C., October 20, 1971.

[21] The "people mover" is a $23 million, 100-vehicle rubber-tired, computer-drive system specially designed for the elderly and handicapped. It is on a guide-rail, and will shuttle between the community and a university.

than do younger persons, and they will readily succumb to burns that would not be fatal to younger persons.

One especially useful summary of the present situation was presented by Dr. I. Feller, Director of the University of Michigan Burn Center and Clinical Associate Professor of Surgery there, who said:

> In summary, the standards for fabric flammability in the manufacture of clothing, drapes, bedding and carpets are not effective. The existing legislation permits the continued production of unsafe consumer products and fails to give the consumer of all ages a fair chance to protect himself.
>
> In addition, I am not satisfied with the way Federal agencies are coping with problems of data collection, analysis, and dissemination in this field. What is worse, Federal funds for these purposes have not been used effectively. There is waste by duplication of effort and failure to utilize appropriate experts in a campaign to reduce the *national burn problem*. In the meantime, burn accident victims are dying and suffering needlessly.

Committee staff are now studying recommendations made at the hearings for speedier promulgation and implementation of standards under the Flammable Fabrics Act, broader educational and demonstration efforts in prevention of burn injuries, more widespread exchange of statistical and other information.

IX. ALTERNATIVES TO NURSING HOME CARE [22]

High costs of nursing home care—and the heavy public expenditure to support such treatment—have deepened awareness of the need to provide less costly alternatives.

One such proposal was explored at length in a working paper [23] prepared for the Senate Special Committee on Aging by the Levinson Gerontological Policy Institute of Brandeis University and published on October 31.

The major premise of the report is that a significant amount of the more than $2 billion spent annually on nursing home care could be eliminated by development of "personal care organizations."

The report argues that a more flexible "mix" of public assistance and Medicaid funds would make better use of the $1.8 billion in public funding that is now spent each year on long-term care.

Dr. Robert Morris, Director of the Levinson Institute, estimates in the first half of the report that between 250,000 and 500,000 persons annually end up in costly institutions for reasons other than medical need.

He also makes this criticism of current policies:

> The paradox is that our programs are designed to pay too little to keep such persons at home (a national average of $77.60 per month under Old Age Assistance) but will readily pay an average of perhaps $400 to $500 a month to keep the same persons in an institution.

The Levinson Institute study cites a 1971 study which indicates that only 37 percent of residents in Massachusetts require full-time

[22] See Ch. 3, p. 31 for a more detailed discussion of long-term care.

[23] "Alternatives to Nursing Home Care: A Proposal, (with discussion of deficiencies in federally assisted programs for treatment of long-term disabilities."

skilled nursing care. Fourteen percent needed no institutional care whatsoever for medical reasons; another 26 percent required minimal "supervised living;" and 23 percent needed limited or periodic nursing care that might, for some, be provided on a home visit basis.

In a preface to the report, Senators Frank Church and Frank Moss said the Institute had performed a timely and valuable service. They added:

> To untangle . . . problems related to long-term care of the chronically ill elderly, steps should be taken to establish what should be the first line of defense for the older person: resources that will enable him to stay at home instead of experiencing the trauma of institutionalization. This ideal is often expressed, but it is infrequently applied.

The Senators also called for "pinpointed research and demonstration" to answer certain questions raised about assumptions and conclusions reached in the Levinson report.

> "For example," they said, "Dr. Lionel Cosin and others in Great Britain—in developing substitutes for institutionalization—are relying not only upon home health care but also upon other resources such as 'day hospitals' at which patients can receive outpatient services in a congregate setting for a few hours each day."
>
> It can be argued that home health care is certain to cost more than nursing home care because it requires individual attention for one patient at a time, rather than group care.
>
> And finally, it can be said that the proposals for financing P.C.O.'s are complex and perhaps unworkable.

Nevertheless, the Senators added that the Levinson report "provides practical information about the situation in one State, and it provides the basis for widespread discussion of the applicability of similar concepts in other States."

Correspondence describing details of a pilot project in Massachusetts are provided in an appendix to the report.

X. MENTAL HEALTH AND THE ELDERLY

> Ten years after a White House Conference on Aging at which comprehensive and enlightened recommendations were offered on actions that could be taken in this (mental health) area, this Committee has been told by well-informed practitioners and administrators that progress during the past decade has been sporadic and, in some ways, perhaps even retrogressive. In addition, committee inquiry has produced information which tends to confirm the overall impression of limited achievement.

This appraisal, taken from a preface [24] to a Senate Committee on Aging report [25] published early in November 1971, sums up the mood of urgency which has emerged in recent evaluations of mental health care for older Americans.

[24] The preface was prepared by Senator Frank Church, Chairman of the Senate Special Committee on Aging, and Senator Edmund Muskie, Chairman of the Subcommittee on Health of the Elderly.

[25] "Mental Health Care and the Elderly: Shortcomings in Public Policy," a report by the U.S. Senate Special Committee on Aging.

Within the past few months, the American Psychiatric Association and the American Psychological Association have issued reports [26] calling for far-reaching action and attention in this area at the 1971 White House Conference on Aging. Last year, the Group for the Advancement of Psychiatry had made a similar plea. Another voice raised in 1970 was that of the President's Task Force on Aging, which also took a grave view of the situation.

The new Committee on Aging report said that the following facts must be faced:

—State mental hospitals, caught in a severe budgetary squeeze, may attempt wholesale "return to the community" of elderly patients without certain evidence that the transfer is beneficial.
—Unresolved questions related to Medicare and Medicaid are intensifying many problems related to mental health care.
—Community mental health centers are failing to meet the needs of the elderly.
—Some pilot projects to reduce institutionalization have been successful, but thus far the numbers served have been limited.
—Mental health needs of the elderly are given a low priority, even by practitioners, who thus ignore a growing body of evidence that reversibility of many ailments (though most certainly not all) is possible.

"In short, said the report, "public policy on mental health care of the elderly is confused, riddled with contradictions and shortsighted limitations, and in need of intensive scrutiny geared to immediate and long-term action."

The Committee regards its report as a preliminary survey, rather than a definitive study. Its recommendations, therefore, were limited to those actions which can and should be taken before the White House Conference on Aging or soon after. They follow:

1. Legislation should be introduced at an early date to call for a Presidential Commission on Mental Illness and the Elderly American, and that legislation should require the Commission to work with Administration officials who will be given responsibility for implementing recommendations made at the White House Conference on Aging. Every effort should be made to involve the private sector, including nonprofit national organizations, medical schools, and private organizations.

2. Recommendations for broadened Medicare and Medicaid coverage—advanced by the Group for the Advancement of Psychiatry, the American Psychiatric Association, the American Psychological Association, the President's Task Force on Aging of 1970, and others—should be analyzed by the Social Security Administration and other appropriate Federal agencies. Cost estimates should be produced, in time to be of assistance to participants in the White House Conference on Aging, and to assure rapid implementation of Conference recommendations.

3. Consideration should be given for institution of a national personal care corps capable of helping elderly persons remain in their homes, or be better served in hospitals and nursing homes.

4. Representatives of national organizations with an interest in aging and mental health will participate in the White House

[26] Texts of their reports are reprinted as appendix items to the report cited in footnote 2, as are the GAP and President's Task Force recommendations.

Conference on Aging, and they should use the occasion to develop a statement of mutual purpose on priority issues for the 70's.

XI. NUTRITION AND THE ELDERLY

Nutritional inadequacy has emerged as a priority problem among the elderly, so much so that it is designated as one of the nine "need areas" to be discussed at sections of the White House Conference on Aging.

On reason for the high priority given to nutrition are the conclusions reached at the 1969 White House Conference on Nutrition. A Chairman of the Panel on Aging at that conference later declared: [27]

> Selection of [nutrition and health] choices for the aged of today is a matter of national emergency requiring action of such magnitude that it can be mounted only by a dedicated Federal Government using its powers to invoke equally concerted action by State, county, and municipal authorities.

Recent Senate Committee on Aging reports [28] have provided other evidence for attention and action on nutritional needs of the elderly.

In 1971, however, debate over funding of ongoing programs—together with introduction of legislation to broaden and continue such programs—led to new arguments on the urgency and scope of the problem.

Funding of Ongoing Programs.—In 1968, Congress earmarked $2 million for a special program under the Administration on Aging to improve nutrition services for the elderly. Operated on a demonstration (title IV) basis, 10 of the AoA projects had already been completed in early 1971 and 22 others were in operation in 17 States and the District of Columbia.

AoA criteria for such projects aim at five objectives:

1. The project was to reach out into the community to locate those in need of the program.
2. It was to serve meals.
3. It was to build nutrition education into the program.
4. It was to provide a variety of related ancillary services.
5. It was to establish a mechanism for systematic and objective evaluation.

In its own evaluation of the nutrition projects, the AoA said early in 1971: [29]

> Findings . . . indicate that the meal in a group setting often is the drawing card to bring lonely and isolated elderly into a whole range of the community activities. It also becomes the occasion for acquainting them with the availability of other services, or, indeed, providing such services. In such a setting, experience indicates that food-nutrition services and social-health services become mutually reinforcing in meeting the totality of the needs of the elderly participants.

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[27] Dr. Donald M. Watkin, at the First Annual Joseph A. Despres Conference for Senior Citizens, New York City, Jan. 22, 1971.
[28] See Chapter III, Developments in Aging—1969, and Chapter V, Developments in Aging—1970.
[29] See p. 178, Developments in Aging, 1970.

At hearings [30] in April, several directors of nutrition projects said that the need for continuing the programs was in some cases a life-or-death issue.

Health, Education, and Welfare Secretary Elliot Richardson said on April 27 that HEW would not extend for 1 more year of funding the nutrition projects. He said that the funding had been on a limited, demonstration basis. Under close questioning by Senator Charles H. Percy, however, he said the decision would be reconsidered.

On June 14, at the hearing by the Subcommittee on Aging of the Senate Committee on Labor and Public Welfare, Assistant HEW Secretary for Legislation Stephen Kurzman, announced that the reconsideration had resulted in action:

> We are presently developing a plan to continue funding approximately 21 nutrition demonstrations for a fourth year. You will be pleased to know that while we are deciding the best administrative means of effecting this refunding we have also supplemented existing grants so that older persons who have been participating in projects are not denied meals until refunding is accomplished. We believe that with restructuring to include a heavy research component, most of the 21 title IV nutrition projects still operating can be made to yield additional useful data.

Legislation advanced.—Mr. Kurzman's testimony was given at a hearing on Senate bill S. 1163, which would establish a national nutrition program for the elderly. In effect, this bill would broaden and provide more constant funding for projects of the kind developed under the title IV demonstration program.

Senator Edward Kennedy, chief sponsor of the bill, said that it—and a similar bill introduced in the House by Representative Claude Pepper—would serve several purposes.

> (1) It would fund nutrition projects assuring one hot meal per day for elderly persons at least five times a week. Each meal would contain a minimum of one-third the recommended daily dietary needs for elderly persons.
>
> (2) The meals would be served in sites accessible to the majority of elderly within the community. Schools, senior citizen centers, churches, and other public and nonprofit private settings would be used.
>
> (3) Out-reach services to locate the isolated elderly would be required.
>
> (4) The sponsor would provide a setting conducive to the inclusion of other social services as a corollary to the meal itself.
>
> (5) Preference for staffing would go to the elderly.
>
> (6) The Federal Government would underwrite costs on a 90–10 basis with the States. For fiscal year 1972, $50 million is authorized. For fiscal year 1973, $100 million and for fiscal year 1974, $150 million.

[30] Evaluation of Administration on Aging and Conduct of White House Conference on Aging, joint hearings before the Special Committee on Aging and the Subcommittee on Aging of the Committee on Labor and Public Welfare.

Subcommittee Chairman Thomas Eagleton said:

> The success of these demonstration projects has been reflected in recommendations for the establishment of a permanent program.
>
> The Panel on Aging of the 1969 White House Conference on Food, Nutrition, and Health recommended that the Administration on Aging and the Department of Agriculture undertake a permanent funding program of daily meal delivery service for the aged in group settings.
>
> Similarly, the President's Task Force on the Aging, in its April 1970 report, recommended the development of a program of technical and financial assistance to local groups to provide daily meals to older people.

S. 1163 would carry out these objectives.

Opposition to S. 1163

Mr. Kurzman said, however, the administration opposed the bill on the grounds that a broad service program for the elderly—along the lines proposed in H.R. 1 is needed, not "another categorical program with a focus on only a small piece of the problem."

In spite of administration opposition S. 1163 was reported from the subcommittee on October 27.[31] There was some chance that it would be up for floor action in the Senate before 1971 ends.

[31] Approved for floor action by the full Senate Committee on Labor and Public Welfare, Nov. 16, 1971.

CHAPTER 9

RETIREES OF THE FUTURE*

Delegates at the White House Conference would be making a mistake if they assume that the needs, attitudes and expectations of the retirees of the future will be the same as those for the elderly of today. Some thought, therefore, must be given to the retirees down the road, 20 or 30 years from now.

In terms of sheer numbers, this year's White House Conference has far-reaching implications for the next generation of retirees because:

—There are now approximately 42 million Americans aged 45 to 64;

—Each year 1.4 million persons have their 65th birthday; and

—Between 45 and 50 million middle-aged persons will have become newcomers to this age group by the year 2000.

Every day the total older population grows by 1,000 but this is a net change. Of significance to the character of the future older Americans is the fact that each day 4,000 reach age 65. And about 3,000 already 65 or older die each day.

In many ways these new senior citizens differ from those already in the 65-plus age category. For example, in 1971 two-thirds of all older Americans were not yet 65 years old at the time of the last White House Conference on Aging in 1961. These two-thirds were born around 1900; were between 10 and 20 years of age during World War I; were in the middle of their family responsibilities at the beginning of the depression; and were between 35 and 45 at the start of World War II.

But there are other important reasons. It will, for example, be essential to consider the evolution of new roles for aged and aging Americans. Additionally these roles must be viewed in a larger context which has some reasonable connection with the mainstream of American society. Of major importance, greater attention must be devoted to a new type of "mixture" with regard to work and nonwork activity for all adults, especially if current trends toward increased productivity and automation continue. Instead of the "all or nothing" principle—100 percent full-time employment during the adult years and 100 percent inactivity during the retirement years—new work lifetime patterns must be considered. For instance, greater experimentation in "phased retirement", sabbaticals, and trial retirement may yield important dividends for a retirement generation which will have the greatest amount of leisure time in the history of mankind.

A rational policy to permit greater freedom of choice for tomorrow's workers must also be developed, particularly since many individuals are likely to make several career changes during their middle

*The Committee wishes to extend sincere appreciation to Herman Brotman, Assistant to the Commissioner (Statistics and Analysis), Administration on Aging, HEW, who provided much of the statistical information for this chapter.

and later working years. Even in our highly industrialized economy today, only about one person in five will remain in his same occupational category throughout his working life. And in the years ahead, this trend will probably accelerate, especially as technological advances render many skills obsolete.

I. PROFILE OF FUTURE RETIREES

A profile of aged persons in the year 2000 must be viewed against a backdrop of substantial uncertainties. Yet, given present trends, it would be safe to predict that the typical future retiree is likely to be better educated, have higher income, and, in all probability, be in better health. Today nearly half of the 65-plus population never completed elementary school; 25 percent live in poverty; and approximately 86 percent suffer from some form of chronic condition.

Additionally, the elderly of the future can expect to spend a much greater portion of their life in retirement. With the trend towards earlier retirement and a probability that the life expectancy will increase, the typical older American could conceivably spend a third to two-fifths of his life in retirement.

Numbers.—Estimates now range from 28 million to 45 million for the number of persons aged 65 and older by the year 2000. The most common prognostication, however, is around 30 million, or 10 million more than there are today.

An Older Population.—Today most older Americans are younger than age 75. The median age for the 65-plus population is now 73, and a third is under age 70. Moreover, only 1.3 million—or about one out of every 15 older Americans—are 85 or older. By 2000, there is likely to be a larger percentage of aged persons at the upper end of the age spectrum. Nearly two out of every three older Americans, or 20 million persons, will be over the age of 75.

More Women.—Most older persons are women, and this trend is expected to accelerate in the years ahead. Today there are approximately 139 women in the 65-plus age category for every 100 men. By the year 2000, this ratio is expected to increase to 150 to 100.

More Single Persons.—By the year 2000, nearly 16 million persons aged 65 and older will be single, having never married or being widowed or divorced. And nearly 9 million may be widows. Today there are more than 10 million aged persons who would be classified as single, including over 6 million widows.

Life Expectancy.—Two contrasting viewpoints emerge with regard to life expectancy. One school of thought maintains that life expectancy for adults who reach age 65 will not be much higher than it is today—approximately 13 years for men, 16 years for women, and 15 years on the average. Others contend, however, that if there are major breakthroughs in cancer, stroke, heart disease, and ailments associated with advancing age, it is conceivable that the average life expectancy at age 65 might be increased to 31 years—more than double what it is today.

Inflation.—Rising prices will continue to pose a major problem for persons living on fixed incomes. Even with a moderate increase in the cost-of-living, prices may be expected to rise by 50 percent during a typical period of retirement.

Increased Urbanization.—Older persons are expected to become increasingly urbanized. Estimates forecast that about 70 percent of their population will reside in metropolitan communities at the turn of the century. Now, about 61 percent of all aged persons live in metropolitan areas.

Greater Political Power.—During the 1970 Congressional elections, persons 65 and older constituted 17 percent of all votes cast. With an expanding population and an increased life expectancy, they may account for 20 to 25 percent of all votes in future elections.

II. RECOMMENDATION

At present, much more is unknown than is known about the far-reaching changes for the next generation of retirees. But, if a national policy on aging is to be developed for all aged and aging Americans, then substantially more detailed information must be unearthed to prepare for these significant changes.

The Committee again reminds the delegates at the White House Conference—as it did in its 1970 Annual Report—that less than 30 years remain for adjusting to major projected changes for the retirees in the year 2000. Moreover, the policies developed during this decade will take on added meaning because they will take us one-third of the way to a substantially different retirement life for the aged at the turn of the century. To prepare for these significant changes, the Committee recommends that well-reasoned and reliable projections should be developed after the White House Conference on Aging to prepare for the future requirements of the aged in such crucial areas as income needs, the impact of inflation, health care, housing, transportation, and more efficient social services.

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MINORITY VIEWS

MINORITY VIEWS OF MESSRS. FONG, MILLER, HANSEN, FANNIN, GURNEY, SAXBE, BROOKE, PERCY, AND STAFFORD

INTRODUCTION

Freedom of choice, satisfaction of basic physical needs, and full opportunity for involvement as persons in family, community, and national life should be the objectives of national policy toward older Americans.

Ideally we would like immediate acceptance and implementation of countless legislative proposals, Federal Executive initiatives, and basic changes in public attitudes toward aging, all of which are necessary to an enlightened policy of first class citizenship for older persons.

Elsewhere in the body of this Special Committee on Aging report are numerous recommendations. There is discussion of some specific bills in the Senate which should be considered along with numerous legislative proposals made by Minority members of this committee and others. We recognize, too, that there are other problems, such as the satisfaction of the oft-times serious needs for transportation, which deserve equally serious attention.

As a practical matter, well known to the older persons whose concern we have at heart, however, we must recognize the difficulties inherent in striving for any ideal. Intense competition for money in our complex governmental and social structure, general public attitudes, and differences of opinions as to details of programs, make it necessary that careful thought be given to priorities for action. The Nation needs help from delegates to the White House Conference in this important task.

As the delegates develop their suggestions for action, we urge them to give particular recognition to cost factors of important program improvements recommended for older Americans. Ultimate success within the Congress requires a realistic evaluation not only of the benefits of each proposal, but also the financing.

Today's older Americans—*be they men or women, aged 60, 70, 80, or 90, rich or poor*—know that full opportunity for participation in family, community and national life is the most universal want of individuals during later life, as indeed, it is in youth and middle age.

Older Americans recognize that, without adequate income safe from the erosive inroads of inflation, without decent housing, without high quality health care, without safety of person, without availability of transportation, and without satisfaction of other basic physical needs, realization of the natural and universal desire for involvement in life's mainstream is a hollow hope.

Older Americans, with a wisdom borne of experience, understand that solutions to problems as big as those now facing many of the elderly cannot be achieved easily, or overnight. They are aware that legislation and other efforts for sound social change must compete in the marketplace—the marketplace of ideas and programs—for public recognition, money, and effective implementation.

Older Americans are well aware of discrimination based on age which is practiced in what should be a classless society. They are sensitive to the validity of the appeal made by President Nixon when he said:

> The time has come for a new attitude toward old age in America. The time has come to close the gap between our older citizens and those who are not old. The way to do this, I believe, is stop regarding older Americans as a burden, and start regarding them as a resource for America.

Older Americans in attendance at the 1971 White House Conference on Aging have an opportunity to demonstrate anew their qualities of leadership and dedication which have already helped make America great. We are confident they will meet the challenges.

We look to the Conference for valuable assistance in assignment of priorities. Some have already emerged from the community forums and State conferences. We expect that the leadership thus activated at all levels will continue to offer guidance after the Conference is adjourned. Action by the national administration to date augurs well for realization of these expectations.

Republican Recommendations Summarized

Because of their importance, we believe it desirable for the Senate as well as delegates to the White House Conference to review all of the proposals, past and present, which emanate from this Special Committee on Aging.

We, as Republican members, reiterate 30 recommendations we made in the committee report "Developments in Aging—1970" which was filed with the Senate March 24, 1971. The report we are now making would be incomplete without a reaffirmation and updating of these high priority items

Because of wide distribution given to that report, it appears unnecessary to repeat all that was said in March. In essence, however, the following was said:

We recommend:

1. General increase in social security and railroad retirement benefits;

2. Congressional enactment of an older Americans' income assurance program which will provide economic support sufficient to assure that all of the elderly enjoy a decent standard of living;

3. Control of inflation—the most universal problem of retirees—through changes in congressional policies reflected in record votes against waste, extravagance, and nonessential Federal spending, which are major factors in rising living costs;

4. Vigorous efforts to expand and improve the Nation's unique private pension system;

5. Expansion of job opportunities, full time and part time, for older persons desiring employment;

6. Automatic cost-of-living increases in old age, survivors and disability insurance benefits (OASDI) under social security and in railroad retirement benefits;

7. Payment of 100 percent of primary social security benefits to aged widows instead of the present 82½ percent of amounts payable to surviving covered workers;

8. Upward adjustments, actuarially determined, in social security benefits for those who defer retirement beyond 65, so that their continuation in the work force will not be penalized;

9. Upward adjustments in social security benefits for married couples both of whom work and thus pay dual social security taxes without receiving higher payments when they became OASDI beneficiaries;

10. Extension of social security, financed from the general fund of the Treasury, to more people not covered by an adequate retirement program;

11. Further liberalization of the social security earnings test to permit social security beneficiaries to earn more money without penalty;

12. Revisions in the veterans pension program to protect the right of veterans to a fair share of higher income levels among older Americans;

13. Removal of the present requirement that a medicare beneficiary must necessarily have 3 days of prior hospitalization to be eligible for extended care;

14. Reexamination of coinsurance and deductible features of medicare to determine how best the liabilities they impose on beneficiaries may best be lightened without injury to the program's financial integrity;

15. Elimination of retroactive denials of extended care facility and home health agency benefits under medicare;

16. Prompt consideration of how best to relieve older people of excessive burdens imposed by costs of medical appliances, drugs, and needed professional services not now covered under medicare;

17. Provision of an unlimited long-term institutional medical care benefit for all persons over a specified advanced age, such as 80 years,

18. Broadening eligibility standards for admission to intermediate care facilities by transferring this program of care and services from title XI of the Social Security Act, which limits recipients to persons on welfare rolls, to the medicaid programs under Title XIX, with its broader eligibility standards;

19. Strengthening of Federal support for private elderly housing under both mortgage insurance and direct loan programs;

20. Improvement of public housing programs to make them more responsive to special needs of older persons;

21. Updating of the retirement income tax credit provisions of the Internal Revenue Code;

22. Restoration of full deductibility for medical and drug expenses, subject to a reasonable ceiling, from older persons' incomes subject to Federal taxation, as provided prior to 1967;

23. More liberal tax incentives for persons making substantial contributions to the support of needy elderly relatives;

24. Encouragement of appropriate tax relief measures for older persons at State and local government levels;

25. Adequate financing for research in the field of aging;

26. Creation of a mechanism for continuing in-depth study of economic, physiological, psychological and social factors in aging as a basis for evaluating policies and programs affecting older Americans of the present and the future.

27. Expansion of economically feasible "second career" and volunteer service opportunities for continued involvement of retirees in the mainstream of community life;

28. Development of transportation services with particular reference to special needs of older persons;

29. Better funding of State commissions on aging with special emphasis on community level programs such as senior centers, homemakers, meals on wheels and friendly visitor services, and educational, social and recreational activities designed to combat the twin fears of aging—loneliness and frustration; and

30. Upgrading of the Administration on Aging and strengthening of its ability to serve as a focal point for coordination of Federal activities and programs in behalf of older Americans.

Beyond these immediate specifics, we Republicans reaffirm our conviction that a new attitude toward aging, based on a long view into the future, which recognizes progress yet to be made, is imperative.

If our Nation is to achieve valid aspirations of today's older Americans, and acceptable roles for those who grow old in the future, there must be public consciousness of how outdated are the 19th century stereotypes of older persons which dominate too much of our public attitudes.

The needs of older Americans require much more than legislation, more than imaginative Government programs. Our Nation must go beyond these, *important as they are*, to a new understanding of the aging processes and older persons.

Implementation of humane and realistic policies will require major changes in attitudes toward aging on the part of Government, business, education and all other elements of society including older persons themselves.

Income and Inflation

Since the White House Conference is intended as a forum for citizens, it might be presumptuous of us to urge upon them any specific action. Review of statements at the 6,000 community forums held in 1970 and the various State Conferences on Aging this year, however, demonstrates wide recognition that **highest priority must be given to the need of all older persons for adequate incomes and maintenance of the integrity of incomes that older Americans already have.**

President Nixon deserves commendation, in this context, for the leadership he has provided on the high priority issue of income integrity.

The President's commitment to an unrelenting war against inflation is well known. It has been his No. 1 domestic concern. While important to all citizens, it is equally known that **unbridled rising living costs create the most universal economic enemy of retirees and others on fixed incomes.**

Less well recognized has been President Nixon's leadership in efforts to assure that all older Americans have Federal guarantees of incomes that at least approach decent standards of living.

The President's proposal that there be a minimum national income floor for all persons past 65, primarily financed from Federal general revenues, is the first serious legislative effort of this type initiated by any President in more than 30 years.

It is gratifying that the House of Representatives has accepted this recommendation from the President in its passage of H.R. 1, Social Security Amendments of 1971, as well as the President's call for automatic cost of living adjustments (first introduced in the

Senate by Senator Jack Miller) and liberalization of the earnings test under social security. Both were among Mr. Nixon's pledges in 1968.

As prime movers in these social security changes, and other improvements such as 100-percent benefits for older widows, we are pleased at the progress made. We urge the Senate to take prompt action on this important legislation including support of the general increase in benefit levels and other praiseworthy improvements.

From the time of the creation of the Senate Special Committee on Aging in 1961, its Republican members have insisted that:

1. The most serious need among the elderly is for assurance of decent incomes for all—serious because many older Americans, some of whom are ineligible for social security, are denied even the basic minimums necessary for survival.
2. The most universal economic problem of older Americans has been the rising spiral of living costs which have faced them since 1961.

We have previously commented favorably on President Nixon's proposal, in H.R. 1, for an immediate national minimum of $130 a month for each person over 65 through old age assistance. We urge the Congress to adopt this proposal—the most sweeping step forward to eliminate poverty among the aged in over 30 years—without delay.

Our Nation's President has acted with decisive leadership in this matter. He has recognized legislative realities and the temper of public opinion. In so doing, President Nixon has been less concerned with a good public image or ideological shibboleths than he has been determined to get real results. No other domestic proposal by the President has been given a higher priority by him than this legislation.

We repeat our appeal to the Senate that it join with the House of Representatives in support of the President. We feel that differences of opinion which may exist with reference to other elements in the President's family assistance plan should not be used to deny older Americans their due.

Control of inflation, absolutely essential to maintaining the integrity of incomes of older Americans, of course, has been the primary domestic concern of President Nixon from the beginning of his administration.

Rising living costs affect all income derived from lifetime savings of older persons. Only the very rich are able to protect themselves against the vicissitudes of excessive inflation. Those retirees with lowest incomes suffer the most severe hardship.

Even with his assignment of first priority to control of inflation, it has been difficult for the President to meet the problem. As observed in previous minority reports of this committee, the roots of the living cost spiral have gone deep during the past 10 years—in large measure as a result of a spending spree by those in control of the Congress.

President Nixon's absolute determination to solve this problem is reflected in his price-freeze action of August 15 and subsequent developments aimed at control of living costs. That his action, after other reasonable efforts had proven inadequate, has been productive is evident from recent national statistics on the economy covering both wholesale and retail price indexes.

Effective as the price freeze may be, however, ultimate success in the war on inflation still depends on getting at its root causes. In this it is essential that the Congress give full support to all of President Nixon's efforts to bring living costs under control.

It is appropriate, with reference to the responsibility of the Congress for inflation management, to repeat here the statement made in Minority Views of the Special Committee on Aging report, "Developments in Aging—1967" and reaffirmed ever since:

> Minority members of this committee have repeatedly taken the lead in recognizing that the most serious sources of problems among all older Americans is the massive loss of real income through inflation.
>
> We maintain, with wide support from economic experts, that control of inflation can only be achieved through Federal policies which are fiscally sound, and by rollcall votes of Members of Congress which are consistent with such policies.
>
> The record of the Republican membership measures up to these requirements.
>
> We have emphasized that a sound dollar demands cuts in unnecessary and wasteful expenditures which have characterized recent Democratic-controlled Congresses * * *. Further priorities for spending programs must be established—a basic principle of good government which has been absent.
>
> We are compelled to reiterate our concern for reduction in and postponement of unjustifiable or low-priority Federal expenditures.

Importance of Health Care

At the White House Conference on Aging community forums and State meetings, the concern of older Americans for good health care was second only to their desire for adequate incomes.

Improvements in medicare, medicaid, and other health care programs in both public and private sectors of society must be given high priority. Only those who have been inattentive to the complexities of the problems expect that they can be responsive to simple solutions. That solutions must be found, however, is imperative.

We urge prompt action on those provisions in H.R. 1 that address themselves to correcting deficiencies in health care. Even with their adoption, it is evident that further steps will be necessary if we are to achieve fully our health care goal for older Americans.

In any legislation related to delivery of medical care, it is essential that highest priority be given to the needs of older Americans, and, within that framework, to those special needs which are most critical.

Raising Nursing Home Standards

The most serious needs for quality of care and for safety in delivery of medical services, of course, are those related to nursing homes. The infirmities of many nursing home patients make it essential, on grounds of simply humanity, that public policy in their behalf and action to protect their best interest be forthright and energetic.

The high percentage of nursing home care costs borne by the Federal Government provides it with an additional reason for extraordinary interest.

President Nixon has recognized this in an eight-point program, through Executive orders and legislative requests, for immediate improvements in nursing home care.

In so doing, the President has combined an understanding of the realities of government and a compassionate belief that priority by government should be given first to those citizens least able to protect and care for themselves.

The essence of his policy deserves repetition here. His specific actions on August 6:

1. Ordered expansion of the Federal program for training State nursing home inspectors so that an additional 2,000 inspectors will be trained within 18 months.

2. Announced intention to ask the Congress to authorize Federal Government assumption of 100 percent of the cost of State inspection of nursing homes.

3. Ordered consolidation, *in a single program within HEW*, of all activities for enforcement of nursing home standards in contrast to current scattered responsibilities.

4. Announced intention to request funds to create 150 additional positions in the Federal enforcement program so as to support State enforcement efforts more effectively.

5. Directed HEW to institute short-term training of health workers regularly involved in services to nursing home patients.

6. Directed HEW to assist States to establish "ombudsman" units to act responsibly and constructively on complaints by, or on behalf, of nursing home patients.

7. Directed the Secretary of HEW to undertake a comprehensive review of long-term care facilities and standards and practices of nursing homes, and to recommend further measures for action.

8. Restated his intention that medicare and medicaid funds be cut off to nursing homes failing to meet reasonable standards.

The President's concern for the aged most in need of help again goes beyond lip service. This is reflected in actions reported by John G. Venneman, Under Secretary of the Department of Health, Education, and Welfare at an October 28 hearing of our Subcommittee on Long-Term Care.

Mr. Venneman was accompanied by other administration spokesmen, including Merlin K. Duval, M.D. Assistant Secretary of HEW, who has been given primary responsibility for implementing President Nixon's directives.

Among specific actions reported at this hearing were the following:

1. Four thousand surveys have been made to determine qualifications of nursing homes for medicare in the past 12 months; 8,000 visits have been made to assist in correction of deficiencies and improvement of services; hundreds have made significant improvements.

2. Dr. Merlin K. Duval, Assistant Secretary of HEW, *and the single official accountable for the program's success*, will be assisted by Marie Callender, former assistant professor of clinical medicine, University of Connecticut Medical School and a nationally recognized authority on nursing homes.

3. Faced with complications in maintenance of standards with two different categorical programs, medicare and medicaid—*with enforcement of standards in the latter a State responsibility*—a crash effort was begun in October to "assess the performance of State medicaid certification efforts; . . . 34 State programs have already been visited and 16 more are scheduled to be visited before November 15."

4. The program for training of 2,000 additional inspectors is well underway. Over half will be trained in the next year; the rest within 18 months.

5. Final fire and safety regulations for medicare, requiring compliance with the Fire Safety Code, have been published.

6. Because time will be required to develop programs for State "ombudsmen", Secretary of Health, Education, and Welfare Elliot L. Richardson *has ordered each of the 885 social security district and branch office managers to act now as contact points to receive and refer complaints on behalf of patients.*

7. The previously established program for training of additional personnel involved in delivery of health services within nursing homes is being accelerated by increasing from three to six the number of medical school and teaching hospital complexes involved in such educational efforts.

The 1971 White House Conference

Insistence by President Nixon that the 1971 White House Conference on Aging make a meaningful contribution to development of sound, responsive national policies toward older Americans was manifest in appointment of Dr. Arthur Flemming as full-time conference director, and Dr. Flemming's subsequent actions to assure its effectiveness.

As a former Secretary of Health, Education, and Welfare, Dr. Flemming has brought a competence and understanding to the conference which is most important. That he was HEW Secretary at the time of the 1961 Eisenhower White House Conference on Aging, has given him special insights of value to the 1971 conference.

Dr. Flemming deserves high praise for the conference building job he has done on the early foundation laid by Commissioner on Aging John B. Martin.

Commissioner Martin introduced many new ideas to the concept of White House Conferences. Among the most important innovations were the 6,000 community forums held in September 1970, and attended by over 500,000 persons. This assured a grassroots basis for the State conferences and the sessions at the end of this month in Washington, D.C.

Among the numerous contributions by Dr. Flemming in cooperation with Commissioner Martin has been attention to needs of minority racial and ethnic groups. *While there is evidence that problems for the aged within minorities cannot be dissociated from the discriminatory practices which do injury to all members of the minority group,* undoubtedly some extraordinary steps are necessary to assure such older minority persons fair treatment in policies, practices, and programs related to the elderly.

Dr. Flemming has given an administration pledge that the impact of the White House Conference will extend far beyond the November 28 through December 2 period of its formal sessions. He has announced plans for post-conference sessions in the various States and a vigorous follow-up on conference deliberations.

It is to be hoped that the Congress, too, will turn an attentive collective ear to recommendations from the conference.

Administration on Aging

Elsewhere in this report is a discussion of the Administration on Aging and the necessity for legislative action in 1972 prior to expiration of the Older Americans Act of 1965, as revised by subsequent amendments. It comments on the bipartisan concern within this committee about negative postures in the Department of Health, Education, and Welfare regarding congressional intent behind this important legislation. *It observes that this negativism has characterized HEW in both the current and previous administrations.* Appropriately, it takes note of long-term opposition by the Federal bureaucracy, beginning prior to 1965, to high visibility status and clout for activities on aging within HEW. It also reports on thoughtful recommendations by an Advisory Council to the Special Committee on Aging named by Committee Chairman Senator Frank Church, for the purpose of recommending ways to strengthen Federal Government organization as it relates to older Americans. The latter deserves careful review.

Secretary Elliot L. Richardson has also given recognition to the problems by his appointment for HEW of a Task Force on the Administration on Aging, headed by Dr. Arthur Flemming. It is worthy of special note that some of its members also serve on the Committee on Aging Advisory Council.

There is strong evidence that this question will be examined carefully by delegates to the White House Conference.

On the basis of the several recommendations which have been made and those which will be forthcoming—including what we hope will be a searching review by the Congress during coming months—we have reason to believe that, *at long last,* success may attend congressional efforts to achieve the high level coordinating activity on behalf of older Americans that was envisaged by it when it passed the Older Americans Act of 1965 without a dissenting vote.

The President's Domestic Council

President Nixon has, through activation of a cabinet-level Committee on Aging as part of his Domestic Council, clearly shown his continuing interest in the problems of older Americans, and has provided a mechanism for effective use of White House Conference products.

It is assumed that this committee will be active within the Domestic Council for a long time. It should be recognized that it can give the high level of coordination necessary to implementation of actions related to needs of older Americans.

Probably no other type of administrative review could, in fact, stimulate more positive results from the White House Conference than this committee within the President's Domestic Council.

Supplementing the Administration on Aging within HEW, and reinforcing efforts on behalf of older Americans by all Cabinet officers, the Domestic Council can and should be used as an instrument of policy on aging which easily reaches the highest levels of government. We anticipate that President Nixon will see to it that such use of the Domestic Council's resources will be made.

SUPPLEMENTAL VIEWS OF MR. GURNEY

One particular subject should, I feel, be mentioned in a discussion of any approach to the problems of the elderly. That subject is the "political football" syndrome.

Proposals for Social Security reform are like hardy perennial flowers, blossoming as election years draw close, going into dormancy as soon as the season passes. And like the flowers, at times the proposals bear no fruit.

An excellent example of this is the custom in Congress of joining other legislation to Social Security bills. Because of the universal popularity which Social Security legislation enjoys, it naturally attracts the attention of proponents of controversial and unpopular legislation. This latter group invariably seeks to seize upon Social Security reform proposals and attach them to their legislative goals. This is done to provide a sort of legislative liferaft to proposals which otherwise would quickly sink out of sight, unmissed after the passing.

Unfortunately, the result too often is that the liferaft itself, the needed social security reforms, are sunk as well.

It is my personal feeling that the time has come to stop this game which accomplishes far more injury than good to the older American.

It was this feeling of mine which prompted me to introduce S. 2512, a social security improvements bill. I introduced the bill in the firm conviction that so long as social security reforms are tied to such controversial programs as the family assistance plan, as they are in H.R. 1, presently pending, they will be enacted only after long delay.

In introducing S. 2512, all potentially controversial matters were eliminated and what I believe to be a solid and noncontroversial legislative package resulted. Many of the recommendations contained in the minority views of this report coincide with the provisions of this bill.

The provisions, which are the bare minimum necessary to the older American, include a five percent increase in benefits, and a provision for future automatic cost of living adjustments to help insulate the program from the "game" approach I have already discussed.

Also, the bill provides for an increase in widow's benefits from the present 82.5 percent of a deceased husband's benefits to 100 percent of those benefits. As is pointed out in this report, this category of person, the elderly woman, is the most economically disadvantaged in the program.

Taking both of these benefit increases together, a widow presently receiving, say, $146.70 a month in social security benefits would receive an additional $40.00 in benefits.

Another area of needed reform in the Social Security program is the present earnings limitation of $1,680 per year. This provision only encourages a trend which this report criticizes—the inactivity of the older American.

We should encourage the older American to participate fully in all aspects of life. Indeed, one of the major problems of the elderly is the exclusion from productive pursuits, their isolation from the rest of society. Such isolation can only result in depression, bitterness, and ultimately hopelessness.

S. 2512 would raise the earnings limitation to $3,000. While I personally favor removing all such limitations, past bills containing such provisions have been unsuccessful. The increase to $3,000 in the earnings limitation is a provision which I feel would be acceptable to most Members of Congress, and would go a long way toward ameliorating an inequitable situation.

Two other major provisions of S. 2512 should be noted. First, that bill provides for medicare coverage for the disabled. This group of individuals has great difficulty in finding insurance in the private sector. Yet, medical expenses are all too often an extremely large portion of their monthly budget.

I would respectfully submit that this presently unmet need is so great that legislative action can no longer be deferred.

Finally, my files are full of letters from persons in my own State of Florida who are in the unfortunate position of requiring additional assistance from State programs. What happens to these people when their Social Security benefits are increased is shocking. When these benefits are increased, State aid is decreased. S. 2512 would end this practice.

As I stated at the outset, everyone knows that Social Security reforms are needed and everyone is in favor of them. The time has come to provide these needed changes. Indeed, it arrived quite some time ago. I am confident that the upcoming White House Conference on Aging will focus attention on the need for immediate improvements in old age assistance and help encourage reasonably quick passage of legislation designed to do just that.

SUPPLEMENTAL VIEWS OF MESSRS. BROOKE AND STAFFORD

While we have signed the minority views, we find that the nature of the problem of the aged compels us to offer some supplemental views to this report.

The investigations conducted by the Special Committee on Aging brought to light several inadequacies in our societal attitudes toward old people. We commend the committee's investigation into the problems and bringing these issues to the forefront. It is our hope that the efforts of this committee, and the forthcoming White House Conference on Aging, will awaken the Nation's conscience and generate a commitment toward ameliorating the many problems confronting our senior citizens today.

The recommendations presented in the minority views represent very solid steps which the Government must take. We feel that a guaranteed annual income should be the No. 1 priority for bringing immediate and substantive change in the condition of the elderly in this country. The other 30 recommendations of the minority, if implemented, could form the nucleus of basic governmental policy to prevent economic ostracism of those members of our society who have passed the age of 65.

We feel that it is important that everyone be cognizant of the changing social values of the past two decades in which the elderly have been increasingly shunted aside to where they now occupy the lowest rung on our social value scale. It is too easy for us in this day and age to literally forget older citizens.

This trend toward exclusion of those over 65 from the benefits of our society must be reversed.

Society in general has never been noted for its long-term planning and it appears that the more we ostensibly progress, the less concern we show for the aged. At this time, when our advanced technology permits us to plan most effectively for the future, we as a nation have not used our knowledge to really cope with the problems of growing old.

It is encumbent upon Congress to produce programs for the betterment of the aged in a dedicated attempt to change the patterns of social relationships, and return the elderly to the honored positions they have held in past generations. This is an issue which should not be a partisan political battleground among Democrats and Republicans. The problems faced by the elderly need immediate solutions.

While we have said we support the recommendations of the minority report and commend the committee majority report for pointing out the shortcomings of existing attitudes and programs, we are distressed over the partisan political defense in both reports, arguing over who is right and who has done the most for the elderly.

We think it must be honestly said that we as a society and a nation have not done enough. It is our hope that the highly political nature of these reports will not turn the White House Conference on Aging into a political battleground. Such a battle would help neither the aged nor the administrators who need objective guidelines and incentives to bring about these critical changes.

Senator EDWARD BROOKE.
Senator ROBERT STAFFORD.

APPENDIXES

APPENDIX 1

A NEW APPRAISAL: ECONOMICS OF AGING

(Prepared by a Task Force to the Senate Committee on Aging for this Report)

October 15, 1971.

DEAR SENATOR CHURCH: As members of the original Task Force on the Economics of Aging: Toward a Full Share in Abundance, we welcome your invitation to express our views on the economic issues that face the White House Conference on Aging. This is a rare opportunity since we can now reassess our earlier findings in the light of developments in the last few years, developments that have been well documented in hearings and reports of the Senate Committee on Aging.

When our working paper was published by the Senate Committee on Aging in March 1969, many readers felt it had sounded an alarm to a largely unnoticed crisis—the crisis of inadequate retirement income made more acute by the lack of genuine national commitment for dealing with this crisis.

The ensuing two and one half years have done nothing to allay our sense of crisis. In fact, each passing year increases the economic problems of old age. There are not only more people who have reached their 65th birthday but larger proportions of the aged groups have attained the very oldest ages. The "aging" of the aged population means particularly great increases in the numbers of widows and other older women living alone, long since identified as an especially disadvantaged group. Retirement prior to age 65—much of it involuntary—adds to the years that must be spent eking out an existence on inadequate retirement income. Increasing urbanization, together with the decay of our cities, and the widespread strains of social strife are other factors that contribute to both the size and the complexity of the problem of economic insecurity in old age.

Nor has the passage of time produced the national commitment necessary for dealing with this crisis. Instead, it would appear that the forthcoming White House Conference has sometimes been used as justification for postponing serious consideration of positive and comprehensive actions to improve retirement income.

We therefore offer the following views on specific economic issues with the earnest hope that they will be of help to the White House Conference in developing a basic national policy on retirement income, coupled with the genuine commitment essential to carrying out this policy. The Nation can then move ahead without further delay to solve the economic problems of old age—for today's elderly as well as for those reaching old age in the future.

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RETIREMENT INCOME

In our Task Force working paper, we did not consider or recommend specific policies or legislative proposals. However, we did set forth a number of basic premises that we supported, for use as guidelines in determining public policy. We now reaffirm our support for these basic premises; we consider these sound guidelines for use by the White House Conference delegates. Any comments we wish to make are therefore in the nature of interpretations or application to the specific issues the Conference will be considering.

These were—and are—our basic premises:

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

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

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

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

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

A guaranteed level of income.—In the two and a half years since our working paper was published, there has been growing recognition that society has a responsibility for guaranteeing that older people—in fact, all our people—receive a basic floor of income. Not yet resolved are questions as to the level of the "floor", or how the guarantee should be administered and financed.

In carrying out this commitment to the aged, we believe that the guaranteed level must be no lower than the amount needed to escape poverty and that the guarantee must be delivered in a manner that truly respects the dignity of the individual. This view lends support to a federally administered and financed program of old age assistance as proposed in H.R. 1 already passed by the House. That the number of aged living in poverty has actually increased in recent years is—as the Senate Committee has said—"a disgrace in a Nation pledged to an all-out war on poverty." We seriously doubt that the problem of poverty among the aged can be solved so long as our States continue to set their own definitions of need for assistance and to establish barriers that make it difficult or impossible for older people to claim the help they need.

In administering a Federal program guaranteeing that no aged person needs to exist on income below the poverty level, optimum use should be made of the Social Security system. We say "optimum" rather than "maximum," advisedly. We are well aware of the advantages of using the administrative channels of the Social Security system with its time-tested and efficient delivery, divorced from invidious connotations of welfare. But we also are concerned that

there continue to be appropriate distinctions between a program that necessarily requires a needs test and the present social insurance system in which benefits are a matter of "right," based on past contributions. It is of utmost importance that we take no action that would weaken the support of workers now contributing to Social Security—no action that would cause them to question the value of their contributory benefits.

Social Security.—One way of preserving the distinction between contributory benefits and payments based on need is to raise the level of the contributory benefit sufficiently so that most long-term contributors are not dependent—except in very unusual circumstances—on the means test payment. That our present Social Security system falls far short of any such goal is clear from the following findings of the 1968 Social Security Survey of the Aged, made available since we prepared our working paper:

> More than one-fifth (22 percent) of the couples receiving Social Security benefits had *total* income from all sources of less than $2,020 and would therefore have been classified as poor on the basis of the 1967 income threshold developed by the Social Security Administration. Nearly three out of every five nonmarried beneficiaries had income below the poverty line of $1,600.

Increases in Social Security benefits in the period since that survey have merely caught up with rising prices; they have not significantly raised the benefit level.

Amendments now under consideration in the Congress—for example, the increase in the widow's benefit, reduction in the penalty for early retirement for men, increased benefits for postponed retirement, and automatic adjustment—while greatly to be desired as improvements in the system, do not truly go to the heart of the problem of inadequacy of retirement income. The benefit level and the wage base taxed and credited for benefits must be raised substantially if benefits are to bear a reasonable relationship to prior earnings, both for present retirees and for those retiring in the future. And thereafter, adjustment of benefits must take account of rising standards of living. It was with this in mind, that we said "The accepted level of income adequacy should be flexible enough to permit older people to share in the growth of the economy."

In recommending that the social insurance system—rather than an assistance system, no matter how improved—be the primary vehicle for assuring adequate retirement income, we are well aware that the Nation thereby undertakes a substantial commitment to future generations of retirees. There are some who will argue that we should not undertake a long-term commitment to a higher benefit level through the social insurance system because retirees in the years ahead will have much more income from private pensions. All available data indicate, however, that the existing private pension system will not solve the complex problems of extended coverage, guaranteed benefits through vesting and reinsurance, and protection of benefits against devaluation due to inflation, while at the same time providing an adequate level of benefits.

We have no reason to modify our earlier conclusion that: "Given present trends, inadequate income will still be a problem plaguing

future generations of aged people." The problem of low income in old age will not be solved by the mere passage of time. It will be solved only through affirmative actions, including Social Security benefits that are more reasonably related to the standard of living enjoyed by the working population.

Private pensions.—Events of the last year or so appear to have dampened what we consider as overly optimistic claims about the future delivery of our *existing* private pension system. There is reason to believe that we are fast approaching a plateau in the proportion of currently employed Americans covered by adequate provisions for future private pension income.

Furthermore, the work of this Committee and the study carried out by the Subcommittee on Labor of the Senate Labor and Public Welfare Committee have brought to national attention the evidence of the illusory nature of much of the private pension coverage today. Rising unemployment from plant shutdowns and cutbacks in the aerospace industry have dramatized the problem in that pension rights have been lost by managerial and professional personnel, not just the clerical and blue collar worker who regretfully has come to expect some unemployment during his worklife, especially after middle-age.

While there may be disagreement at the White House Conference as to the precise dimensions of the problem of adequacy of protection through private pensions, it can no longer be doubted that there is a problem. Obviously, the White House Conference—purposely designed as it is to provide a voice for older people—is not the means for developing the solution to such a complex and technical problem. We would hope, therefore, that it might be possible to call to the attention of the delegates some previously recommended channels for developing a solution. Specifically, the Committee's Report on the Economics of Aging recommends the establishment of an Institute on Retirement Income that could analyze proposals for expanding the coverage of private pension plans, with a view to developing a sound legislative proposal. The Report also calls attention to a recommendation of the President's Task Force on the Aging that there be established an independent Pension Commission and "that the President direct the Pension Commission, as a high priority, to enlist the ingenuity of the financial community in designing as a companion to the Social Security system a portable voluntary pension system." These recommendations (compatible rather than competing since an Institute on Retirement Income could be of great assistance in the developmental work involved in designing a portable pension system) would seem to be appropriate for consideration at the White House Conference.

EMPLOYMENT

In our Task Force Working Paper, we were not optimistic that earned income was a real potential for improving the economic situation of the aged population. Analysis of the declining labor force participation rates among older workers led us to this conclusion:

> Hence, realistic assessment of labor force conditions gives little hope that the economy will generate enough job opportunities to solve the income problem of older people, especially the oldest of them, now or in the years ahead.

Today, with over 5 million unemployed, with more than a million of them aged 45 and older, we are not only "not optimistic"; we would even question whether our Nation is prepared to undertake the commitment required to assure employment opportunities to older workers at least until they reach retirement age. The trend toward early retirement is thus not likely to be slowed, to say nothing of reversed.

Basically, we believe that functional ability, not chronological age should be the criterion for determining an individual's employability. This Committee has received ample testimony, documented by studies in the medical and behavioral sciences, on the soundness of evaluating work performance in terms of ability and not by the year of one's birth. Hopefully, the White House Conference can help in the development of an effective national manpower policy for maximum utilization of older workers, a policy that we now lack. We are not optimistic, however, about the speed with which such a policy would be accepted and implemented by industrial management, unions and the government itself. Our Nation's manpower policy will therefore continue to need special emphasis—which we think can best be carried out through categorical programs—on the employment and training of workers 45 and older. The new Emergency Employment Act should also take appropriate regard of the employment needs of older workers, with the government actively promoting—not just serving as the "employer of last resort"—the development of the public service jobs our Nation needs.

We failed, in preparing our working paper, to take account of the importance to older people of paid employment in part-time community service jobs. Fortunately, the Committee's subsequent hearings brought forth a wealth of evidence of the value of such employment, in providing both badly needed income and the psychological satisfaction of meaningful work—to say nothing of the value to the communities served. Employment opportunities of this type should be made widely available.

HEALTH COSTS

The problem of financing health costs of the aged population is considerably greater today than when our first Working Paper was prepared. This has been a period marked by extreme inflation in medical costs, especially for the elderly. This has meant great increases in expenditures through the public programs of Medicare and Medicaid and also great increases in the unpredictable costs older people still have to bear out of their small incomes.

Unfortunately, too, there has been a growing tendency to weaken the protection of the public programs by expecting the sick person to pay more of his own costs. Under Medicare, the payments that the patient in a hospital or extended care facility must make have gone up—as well as the premium payments. Additional coinsurance and deductibles are proposed in H.R. 1. Under Medicaid, a number of States have introduced charges for medical services formerly furnished without cost to needy sick persons. Proposed amendments to the Medicaid law would require States to impose a premium enrollment fee on the medically indigent and would authorize deductible and copayments for them and for cash-assistance recipients. Medicaid would be further weakened by repealing the provision which now requires States to have comprehensive Medicaid programs by 1977.

In our judgment—concerned as we are with economic security in old age—steps like these take us down the wrong path. They aggravate rather than solve the medical cost problems that put an intolerable strain on limited financial resources; they can defeat other efforts to improve the income position of the aged.

On the brighter side, the past few years have awakened hopes that our Nation will embark on a course of action to deal with the health cost problems faced by people of all ages, thus reversing the trend toward the unrealistic concept of separate and multiple systems of protection for just the highest risk segments of our population. New emphasis is being placed on the potentials of timely and continuous services for health maintenance in reducing the high costs of sickness and institutional care.

Our experience with Medicare and Medicaid has contributed significantly to the knowledge needed for formulating a national health insurance program for the total population. As the Committee's expert witnesses have pointed out, we have learned that "it is not enough for the government to provide only a financing mechanism for health costs; there is an attendant responsibility for assuring the delivery of high quality and effective services." Immediate steps to strengthen Medicare and Medicaid by implementing this "attendant responsibility" would be of immeasurable help to those who will continue to depend on these essential programs while awaiting protection for people of all ages.

Proposals for national health insurance, designed as they are for the total population, almost necessarily give insufficient attention to the long-term care needs of the elderly. Here again we see a hopeful sign in increasing awareness of the potentials of personal or social care arrangements which make it possible for the elderly to live independently instead of in expensive institutions. As members of the Task Force on the Economics of Aging, we would stress that such living arrangements—quite aside from the human values and satisfactions derived therefrom—save many so-called "health dollars," otherwise provided from public funds or through needless drains upon the incomes of elderly individuals and their families. But awareness of the value of personal care programs is not enough. We need to move ahead without further delay to develop and finance such programs—programs that also provide real opportunities for elderly people to supplement inadequate incomes with part-time earnings as homemakers or home health aides.

In conclusion, we wish to thank you for this opportunity. It has been a privilege and pleasure to serve as the Senate Committee's Task Force on the Economics of Aging during the past three years. We know that the work of the Senate Committee has contributed significantly to the deliberations leading up to the White House Conference on Aging. We are glad to have had a share in the Committee's report to the delegates to the Conference.

Sincerely,

DOROTHY MCCAMMAN, *Consultant.*
JUANITA M. KREPS, Ph. D.
AGNES W. BREWSTER
JAMES H. SCHULZ, Ph. D.
HAROLD SHEPPARD, Ph. D.

APPENDIX 2

SUMMARY OF MAJOR PROVISIONS IN H.R. 1 (CASH BENEFITS AND ADULT CATEGORICAL ASSISTANCE PROGRAMS)

Benefit Increases.—More than 27 million recipients would be entitled to a 5-percent across-the-board increase in benefits, effective in June 1972.

Special Minimum.—A new special minimum monthly benefit, ranging from $75 to $150, would be authorized for persons who have worked at least 15 years under Social Security. This benefit would be equal to $5 multiplied by the number of years of covered employment, up to a maximum of 30 years.

Automatic Adjustments.—Benefits would be adjusted annually according to rises in the cost-of-living, provided (1) the Consumer Price Index increased by at least 3 percent; and (2) legislation increasing Social Security benefits had neither been enacted nor had become effective during the previous year.

Full Benefits for Widows.—Widows and widowers aged 65 and older would be entitled to benefits equal to 100 percent of their spouses' primary insurance amount.

Liberalization of the Retirement Test.—H.R. 1 would raise the annual earnings limitation from $1,680 to $2,000. For earnings in excess of $2,000, $1 in benefits would be withheld for each $2 of earnings.

Increased Benefits for Persons Delaying Retirement.—Benefits would be increased by 1 percent for each year a worker does not receive benefits because he is working after age 65.

Additional Dropout Years.—One additional year of low earnings for each 15 years of covered work, in addition to the five years provided under present law, would be dropped in computing benefits.

Age-62 Computation Point for Men.—The method of computing benefits for men would be based on working years up to age-62 (the same as now exists for women), instead of the current 65 year requirement.

Working Wives.—A working couple would be able to combine their wages for purposes of computing benefits if this would result in higher payments, provided they each had at least 20 years of covered earnings after their marriage.

Old Age Assistance.—The existing Federal-State adult categorical assistance programs—Aid to the Aged, Blind, and Disabled—would be replaced by a new Federal program which would be administered by the Social Security Administration. The income standard authorized under H.R. 1 would be $130 a month for an aged person and $195 for a couple. However, elderly persons receiving assistance under this new program would be ineligible to participate in the Food Stamp program.

APPENDIX 3

STATEMENTS OUTLINING POSITIONS ON WHITE HOUSE CONFERENCE ISSUES

ITEM 1. "A PLATFORM FOR THE SEVENTIES FOR ALL OLDER AMERICANS," PUBLISHED IN NOVEMBER 1971 BY THE NATIONAL COUNCIL OF SENIOR CITIZENS WITH 10 ENDORSERS [1]

To the Delegates—

The 3,400 delegates to the 1971 White House Conference on Aging will participate in almost 100 meetings scheduled by sub-sections of the 14 sections that make up the Conference. They will be called upon to deal with a wide range of topics.

The endorsers of this presentation believe it will be helpful to all participants in the Conference to have available a handy guide outlining goals for all Conference sections followed by a position taken on each of the issues posed in Conference Workbooks.

Over the decade since the first White House Conference on Aging, the endorsers believe a foundation has been built for formulation of a sound public policy in the field of aging—and this is outlined in the statement of guiding principles which have been set forth in this special publication.

We hope these principles will be supported by all who wish this Conference to be meaningful in terms of action for and on behalf of the elderly—and not just an exercise in rhetoric.

Although the issues as stated in the Conference Workbooks are not included here, the materials for each Conference Section follow closely the order in which these issues are listed in the Workbooks.

The recommendations in this special publication are significantly addressed to the problems and needs of all older persons. However, we want to underline the importance of and necessity for programs geared to special and unique needs of minority groups—blacks, Indians and the Spanish-speaking.

Racial discrimination, unemployment and/or low paying jobs and educational deficiencies have condemned substantial numbers of minority elderly to low levels of income and inadequate health provisions. Too often, these minority groups of the elderly have not had

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Harold Hagen, Washington Representative, American Public Welfare Association.
Hobart Jackson, Administrator, Stephen Smith Geriatric Center, Philadelphia, Pa., and President, National Caucus on the Black Aged.
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the resources or capacity to stand up for their rights, nor have governmental agencies and senior citizens organizations adequately served as advocates for them.

We can and must demand that government fulfill its advocacy role for this group of the poorest of the elderly poor and we seek the fullest involvement of the disadvantaged in all action-geared senior citizens organizations.

GUIDING PRINCIPLES

The Foundation for Sound Policy on Aging

1. A Nation as wealthy as ours can afford to do more for its older people without decreasing its efforts for the younger population.

This is not a matter of "either/or." Gains for the elderly should not be at the sacrifice of young people. We must avoid the misleading cost/benefit type of analysis that usually leads to the conclusion that the benefit to the public is less with public programs to help the elderly than with programs to help other segments of the population.

2. Where the needs of the elderly are essentially universal, the responsibility for financing and for assuring adequate administration and delivery of such programs belongs to the Federal Government.

Income maintenance and protection against health costs, for example, are basic needs of all older people, with little or no regional significance. Responsibility is thus properly lodged at the Federal level.

3. An adequate and equitable contributory social insurance system is based on tripartite financing—employee and employer payroll taxes and Federal general revenues.

Appropriate use of general revenues is a more equitable way of sharing the tax burden that now bears heavily on workers through regressive payroll taxes.

The argument which seeks to stigmatize as "welfare" the use of general revenue funds to pay part of the cost of a social insurance program is false because—unlike welfare programs—the Social Security beneficiary has a right to the benefits without undergoing a means test.

4. Government has the duty and the responsibility to serve as a strong advocate for the beneficiaries of the programs it provides.

In a representative democracy, government at all levels is the servant of the people. For older people, with their special problems of income loss and health, government must be the guarantor that older people have a fair share of our Nation's income.

5. While adequate income is the first priority for elderly people, a program of appropriate services is also essential and necessary.

Even in the unlikely event that all older people had adequate income, there would remain the problem of the availability of services. Adequate income does not solve the transportation needs of older people living in areas that lack transportation services. It does not provide an answer to the nutritional and social needs of an older person living alone. Nor is more income the answer to the problem of the infirm elderly who are forced into institutions simply because our society lacks the services that would make it possible for them to live independently.

6. Voluntary non-profit agencies and organizations—membership organizations of seniors and direct service agencies—are essential components of a well balanced and adequate system of programs and services for seniors.

However, such agencies should remain free to act as constructive critics of public programs of services and benefits to seniors.

7. Appropriate identification of programs and funds for the aged is necessary.

To the maximum extent possible, older people desire and should participate on equal terms in programs for the total population. But there will always remain areas requiring that older people be singled out for the special consideration that takes account of their greater needs (for example, the extra heavy burden of health care, especially for long-term illness or their lesser ability to compete with younger people in the job market).

8. The Time to Act is NOW.

We can no longer postpone action in the hope that the problems associated with old age are transitional problems that will solve themselves, given sufficient time. The evidence is all too clear that without positive and immediate action the situation of people already old will deteriorate still further.

Moreover, we now know that future generations will face many of the same problems facing today's elderly when they in turn reach old age. The Nation should therefore immediately embark on the course of action that will meet the needs of today's older population and at the same time provide assurance to those still young of a brighter future in old age.

INCOME

GOAL: Every American should have enough income to live on in comfort and dignity and to participate fully in the life of the community. As an immediate step toward this goal, the Federal Government must provide a guarantee that no one need live in poverty.

Standard of adequacy. Achievement of this goal for the elderly requires a standard no lower than the Bureau of Labor Statistics moderate level—a level which is adequate to maintain health and enables an individual to be self-sufficient. (In 1969, it would have cost elderly couples living in cities at least $4,192 to maintain this modest but adequate standard.) The standard must be periodically updated (not just repriced to take account of purchasing power) to assure that older people share in the Nation's rising standard of living and there is a better balance between pre-retirement and post-retirement income.

Providing a floor above the poverty level. Society's responsibility for assuring that no one need live in poverty should be implemented through a federally financed and administered system of assistance to supplement Social Security benefits and any other sources of income.

This Federal guarantee, financed through general revenues, should apply to the young as well as the old, differing only in how the guarantee is administered. For the aged, blind and disabled—for whom employment is not the means of escape from poverty—appropriate

use should be made of the Social Security system to determine eligibility and pay assistance in a manner that respects the dignity of the individual.

States that have already recognized their responsibility for doing more for their needy than merely to lift them from poverty should continue this effort with Federal help.

Social Security benefits. The level of Social Security benefits should be raised substantially. For the short run, a meaningful increase is necessary to give proper recognition to past coverage under the contributory system. For the long run, a meaningful increase is necessary in order that benefits bear a more reasonable relationship to pre-retirement earnings.

The level of earnings taxed and credited for benefits must be raised to reduce the regressivity of the tax and to permit replacement of more of the earnings of workers with higher wages.

Thereafter, adjustments—whether automatic or through Congressional action—should ensure that Social Security benefits keep pace with rising standards of living (not just rising prices).

Federal sharing in Social Security costs. As is the case in other industrialized countries, general revenues should help support the costs of this nation's social insurance program, thus reducing the heavy burden of regressive payroll taxes on today's workers. There is no validity in the argument that general revenue sharing in social insurance costs causes the program to take on characteristics of a welfare program. The Social Security beneficiary is and should be entitled to benefits without a means test.

We believe that the contribution from general revenue should be predetermined by formula specified by law and that a reasonable share over the long run is one-third—approximately the cost resulting from paying benefits to workers already old when first covered, many of whom would otherwise have been dependent on public assistance.

Social Security retirement test. We recognize that the retirement test which results in a loss of Social Security benefits for those who earn more than the designated amount sometimes serves as a barrier to the employment of workers past retirement age.

But we also recognize that the test conserves funds for payment to beneficiaries who are unable to supplement low retirement incomes with earnings. Elimination would place unfair higher tax burdens on younger workers for the purpose of paying full retirement benefits to the comparatively few who continue to work at full earnings.

We therefore recommend that the basic principles of the test be retained, not eliminated. We also recommend that the test be reexamined periodically for purposes of liberalization (such as raising the dollar limit and perhaps lowering the age at which the test is no longer applicable) as well as for purposes of seeking various methods of offsetting penalties under the test.

Financing of health costs. The Nation will continue to fall short of a reasonable goal of income security so long as heavy and unpredictable health costs threaten fixed incomes.

We believe that our elderly population's best hope of adequate protection against health costs is through enactment at the earliest

possible date of a national health insurance system for the total population, with the government assuming responsibility for improving the organization and delivery of comprehensive services as well as for the financing mechanism.

Until enactment of national health insurance legislation, we urge improvements in Medicare and Medicaid to extend protection and to reverse the trend toward heavier copayments and deductibles (out-of-pocket payments required of the beneficiary).

Medicare—and the proposed national health insurance program—should be financed through payroll taxes and general revenues, not through premiums and other heavy out-of-pocket costs paid by retirees living on fixed incomes.

We also urge special attention to the need for long-term home care arrangements as an alternative to unnecessary institutional care.

Property tax relief. In many parts of the country, the local property tax on the older person's home takes such a large share of limited income as to threaten continued ownership.

Because this is a problem not likely to be solved locally, we urge the development of a Federal program to reimburse States that extend relief to low-income householders—whether owners or renters—who are overburdened by property taxes.

Private pensions and Federal responsibility. Under present trends, only a minority of the retirees of the future will have private pensions and other income which, in combination with Social Security benefits, is sufficient to maintain a reasonable standard of living.

We recommend early Federal legislation to improve the protection of private pension plans through appropriate vesting, provision for survivors' benefits, reinsurance or other methods of guaranteeing pension funds, and to assure fiduciary responsibility.

To make possible pension protection for employees of small firms as well as for individual investors, we recommend that the government exercise vigorous leadership in the development of a national portable pension system as a companion to the Social Security system.

HEALTH

GOAL: High quality, comprehensive health services should be available to every American as a matter of right regardless of age, income, race or religion.

Need for special consideration. The delivery of health services for the elderly must be fully integrated with care for the general population in order to assure optimum treatment of the elderly person's acute illnesses.

Health services for those with chronic physical and mental impairments—regardless of chronological age—must be adjusted to the medical and social needs of the individual and may require specialized personnel and facilities.

In planning, coordination and financing of health services, special consideration should be directed to the aged because of the framework in which their illnesses occur—for example, inadequate income, forced retirement, poor housing, lack of mobility and social isolation.

Coordinated care as an integral part of the total system. A system of comprehensive, coordinated personal health services for both th short-term and long-term care of the ill, infirm or disabled aged should be developed as an integral part of the Nation's health care system. The comprehensive and coordinated services should include the full range of preventive, maintenance and rehabilitative services needed to promote health and reduce expensive institutionalization.

Goal is National Health Security. We support the proposal for national health security as the method of reorganizing the present chaotic health care system into a system with national standards and public accountability for delivery and quality as well for efficiency and economy of services.

Immediate improvements in Medicare and Medicaid. Until the Nation has achieved health security for all Americans, the protection afforded by Medicare and Medicaid should be strengthened—not weakened as is contemplated in legislation now before the Congress.

To the extent possible, the principles of cost control and public accountability that are basic to a national health security program should be incorporated into Medicare and Medicaid. Co-payments and deductibles should be eliminated and benefits expanded to include the full range of services needed for optimum health care.

Medicare should be financed through contributions from earnings and through Federal general revenues—not through ever higher premiums paid by the aged out of low incomes. Federal responsibility for Medicaid should be extended to assure adequate and equal health services regardless of the State of residence.

Long-term care. The Nation must move ahead immediately to meet the long-term needs of chronically ill persons, including the aged, under a policy that the sponsorship and operation of services and facilities in this area shall be primarily through non-profit private and governmental agencies.

We urge special attention to the development of personal care programs in reducing the need for institutionalization, thus conserving health care dollars.

Our public policy must be to keep the older person functioning to his maximum physical and mental capacity within the community—not separated from it in an institution. When it becomes necessary for medical reasons, the care then provided—whether for a few days or a longer period—must be in a facility capable of providing comprehensive medical and social services and geared to a rehabilitation philosophy—the concept of a geriatric hospital with a wide-open admission policy.

Responsibility. Responsibility for the entire spectrum of health services for the aged belongs in the public sector at the Federal level. Maximum implementation of the planning process, delivery of services and evaluation should remain at State and local levels.

An educational program. A national continuing educational program for the general public should be initiated for the joint purpose of promoting a more positive attitude among younger people about old age and health and informing them about specific health issues that affect individuals regardless of chronological age (rather than setting aging apart in a way which stigmatizes the elderly).

Specialization in geriatric problems. While the development of specialization in geriatric problems is desirable, all appropriate health professionals should be given adequate education on the physical and mental health problems of the elderly. This should be part of the education of health workers at all levels of training and on a continuing basis.

Allocation of funds. In view of the critical need to provide more direct services to the physically and mentally ill elderly, much more funding must be put into these services. At the same time, additional funds must be provided to finance more basic and applied research and to develop increased health manpower and facilities.

EMPLOYMENT/RETIREMENT

Goal: Functional ability, not chronological age, should be the test of employability. On reaching "normal" retirement age, individuals should have a choice of continuing to work as long as they are able or retiring on adequate income with opportunities to pursue meaningful activity.

Reversing the trend toward early involuntary retirement. Achievement of this goal requires that we reverse the trend toward *involuntary* retirement on permanently reduced income. To lower the normal retirement age merely compounds the problem, making it increasingly difficult for older workers to continue in gainful employment as well as being costly to the economy. The solution lies instead in an action program to end discrimination based on chronological age and to provide more job opportunities for middle-aged and older workers.

Extended unemployment benefits. The duration of unemployment benefits should be extended for older workers so that workers faced with long-term unemployment do not become so discouraged they drop out of the labor market.

Categorical manpower programs. All experience indicates that is it insufficient merely to promulgate policies for improved employment opportunities for older workers. Adequate funds must be earmarked for special placement, training and job assistance programs for the elderly.

Limits upon employer's action. Basic to any effort is an active educational program among employers, workers, and the general public. Also basic is strict enforcement of existing anti-discriminatory legislation accompanied by a removal of the upper age limit of 65 in current legislation. We also favor requirements for listing of job vacancies, scrutinizing of dismissal from employment and early warning systems that may be necessary to eliminate age-employment problems even if such requirements impose limits upon the employer's actions.

Public service employment. We need much more than the actions implied in the phrase, "government as the employer of last resort." We believe that the government should actively *promote*—not just underpin—the development of public services not generally available but which are so urgently needed by the Nation and so appropriate for the employment of older persons (including part-time employment

after retirement). The Emergency Employment Act of 1971 and similar legislation should be amended to prohibit discrimination on the basis of age.

Social Security retirement test. See statement on this issue under discussion relating to Income Section (page 130).

A nationwide program of community service. Even if we were to attain our goal of adequate retirement income, many elderly people would want the psychological satisfaction of continuing activity. For them, broader opportunities for volunteer services are needed. Others, especially widows with little or no employment experience to help them compete in the regular labor market, need a source of income while waiting to be eligible for old-age benefits. Special employment programs are essential if their talents are to be used and if they—and those with inadequate retirement income—are to have an alternative to dependency on welfare or relatives.

We therefore recommend immediate enactment of a nationwide Community Service program—modeled on such outstanding demonstrations as Senior AIDES and Green Thumb—to provide part-time paid community service employment for the low-income elderly, administered through the Labor Department as a special employment program for the elderly.

[Senior AIDES is a community service employment program operated by the National Council of Senior Citizens for the U.S. Labor Department. It is a demonstration program providing community service jobs for 1,150 men and women age 55 or over with low incomes in 20 communities across the Nation. AIDES in Senior AIDES means Alert, Industrious, Dedicated, Energetic Service.

[A similar program is operated by the National Council on the Aging for the Labor Department.

[Green Thumb provides jobs for the low income elderly in beautification and improvement of the environment on public property including highways. This program is operated by the National Farmers' Union for the Labor Department.]

Reduction of "normal" retirement age. Pressures to reduce the so-called normal retirement age of 65—whether for workers generally or in special circumstances—should be strongly resisted as part of a national policy to make chronological age immaterial to employability.

Institutionalizing a given age as normal for retirement makes it harder for workers close to that age to get jobs. A lower retirement age would be costly to the economy in terms of the burden of supporting the nonproductive segment of the population and in terms of dissatisfaction among the displaced elderly with a life of inactivity.

Workers forced to retire prematurely. To help workers forced to retire before the "normal" retirement age because of health problems or job displacement (caused by technological change or jobs requiring early retirement), we recommend new national policies accompanied by publicly and privately supported programs in existing agencies that have responsibility for dealing with these problems.

Specifically, the Labor Department should administer a continuously funded program especially designed to maintain economic security during the transitional period while the unemployed worker is being retrained and educated for reemployment or while resources are being mobilized for a meaningful retirement.

The Social Security system should be liberalized to provide disability payments for workers forced into retirement by disability not severe enough to meet present definitions.

Private pensions and Federal responsibility. Under present trends, only a minority of the retirees of the future will have private pensions and other income which, in combination with Social Security benefits, is sufficient to maintain an adequate standard of living.

We recommend early Federal legislation to improve protection of all private pension plans through appropriate vesting, provision for survivors' benefits, reinsurance or other methods of guaranteeing pension funds and for assuring fiduciary responsibility.

To make possible pension protection for employees of small firms as well as for individual investors, we recommend that the Federal Government exercise vigorous leadership in the development of a national portable pension system as a companion to the Social Security system.

Pre-retirement education. Society should assume greater responsibility for helping people (the spouse as well as the worker) to prepare for the retirement years. We believe that organized pre-retirement educational programs should be made available on a voluntary basis through local industrial and educational channels, with Federal assistance in the development of program materials.

HOUSING

GOAL: In keeping with the inherent dignity of the individual, older people are entitled to suitable housing—individually selected, designed and located with reference to special needs and available at a cost which older people can afford.

Federal, State and local funds should be earmarked to provide adequate housing for the elderly.

Guiding Principle No. 7 calls for "an appropriate identification of programs and funds for the aging . . ."

The needs of the elderly for housing have been submerged by the Department of Housing and Urban Development in a program of meeting the housing needs of the low income group generally to the serious neglect of the millions of elderly who are poor or close to the poverty level.

Thus, while there is a need for over 3 million units, less than 40,000 units a year are being constructed. Legislative authorization for a program providing at least 120,000 housing units per year is essential and must be obtained.

Eligibility for housing. Housing designed to meet the special requirements of the elderly should be available to all elderly who need such housing at a cost proportionate to the individual's income. Housing charges or rentals should not exceed 20 percent of the person's income, with further consideration given to the costs of special services due to poor health or other handicaps.

Importance of Federal leadership and funding. Vigorous Federal leadership and adequate funding are essential to the provision of adequate housing for the elderly. Accordingly, there should be established the position of Assistant Secretary for Housing for the Elderly in the Department of Housing and Urban Development with statutory

69-867 O-71—10

authority to initiate, review and implement housing programs for the elderly.

Housing funds now impounded by the administration should be released and the highly effective Section 202 of the Housing Act, with its special guidelines related to space, design, construction and particulary favorable financing, restored.

Consideration must also be given to the rehabilitation of housing units inhabited by older people which are being ruined by deterioration and decay, upward revision of eligibility for low-income and moderate-income housing, and the provision of professional security protection for elderly citizens in housing projects.

Maintaining the option of independent living. Given the option, the great majority of older people would choose independent living to even the most benign type of custodial care.

This argues for a range of services—social, health, rehabilitative, recreational, nutritional, protective and counseling—that would enable the older person to live in his own home or with his children or grandchildren or with a small group of other older persons or in a residential facility.

We maintain that too many nursing homes are not living arrangements but custodial facilities to which an elderly person is committed until death.

U.S. public policy must be to keep the older person functioning to his maximum physical and mental capacity in the community—not separated from it in an institution. When it becomes necessary for medical reasons, the care of the elderly—whether for a few days or for a longer period—must be in a facility capable of providing comprehensive medical and social services and geared to a rehabilitation philosophy.

We believe there should be essential supportive services for the elderly organized, administered and delivered on a community-wide basis and made available to all elderly living in the community. This, we argue, is the most humane and economical housing policy for the elderly.

Relief from property taxes. We support property tax exemption for homesteads because steadily rising property taxes have increasingly adverse effects on elderly persons living on low fixed incomes.

As a parallel proposal, we support also a homestead tax rent refund which would provide relief for elderly renters.

We also maintain that the time has come to view the cost of education, which takes up half to two-thirds of the local property tax, as the obligation of both the Federal and State governments. The recent finding of the California Supreme Court that the local property tax for schools is unconstitutional since it discriminates against the poorer communities adds a powerful argument for the re-examination of how universal education for all children should be financed.

Because securing State and local action is a slow process and the financing of education controversial, consideration should be given to the development of a Federal program to reimburse the States that extend relief to low-income householders—whether owners or renters—who are overburdened by property taxes.

TRANSPORTATION

GOAL: Transportation services in every community should be sufficient to enable older people to have access to the basic services of their community and to support their needs and their right to participate in social life.

Federal action. Transportation problems in general and those of the elderly in particular are so critical that vigorous action by the Federal Government is required. Only by massive Federal aid and the concentration of that aid into selected transportation problem areas will the elderly and the general public be assured adequate transportation services. This means:

- **A substantial portion of revenues from Federal gas, oil and motor taxes be earmarked for improvement of mass transit services.**
- **Action be taken by the Interstate Commerce Commission and the Civil Aeronautics Board, either by regulation or through new legislation where required, to provide for reduced fares for elderly rides on planes, buses and trains.**
- **Federal action is essential to guarantee the right of older motorists to buy car insurance and there is an urgent need for a prohibition against denials solely on the basis of age.**
- **Federal legislation be enacted setting up a national system of no-fault car insurance that would provide for payment of most accident claims without the expense of legal action and would make available a greater share of the car insurance premium dollar to pay claims.**

Integrated services. Separate transportation systems should not be devised solely for the elderly. The most fruitful approach for resolving the mobility problems of the elderly is through a more effective transportation system for people of all ages. The elderly do require certain specialized transportation services but in the long run such services should operate within more generalized networks. Specialized transportation efforts for the elderly can and should provide impetus for improved transportation services for the general population.

Program requirements for transportation. Achievement of improved transportation services for the elderly would be enhanced if the problem remains the responsibility of all units of government—Federal, State and local. It is appropriate, however, for the Federal and State governments to provide leadership by requiring, for example, that transportation be an integral part of any social services program for the elderly. But these efforts should mesh with similar activities at the community level.

Individualized transportation. The Federal Government should act vigorously on behalf of individualized transportation for the elderly for such activities as shopping and religious worship. At the same time, it must be recognized that Federal action is not enough. A successful program will require the energies of local government and volunteer community groups. A variety of mechanisms are required such as low cost car insurance, volunteer driver programs and demand activated services. In short, there should be a wide spectrum of services which can only be achieved by a mix of Federal, local and private efforts.

Safety and convenience. A more active role by the Federal Government in the setting of standards is required in the areas of safety and convenience for the elderly as pedestrians, drivers and users of transportation systems. State and local efforts in these areas are frequently fragmented, uncoordinated and inconsistent. Adoption of legislation now pending in Congress which would make it a Federal offense to deny an elderly motorist car insurance solely on the basis of age is an example of an appropriate Federal standard. The diverse needs of older people in these areas will require the traditional involvement of State and local governments, which are best equipped to handle the day-to-day details of such programs.

NUTRITION

GOAL: The nutritional well-being of the Nation's elderly should be improved but at the same time there should be programs to help meet social needs of the elderly.

Research and services. Both research and services are important and financial support for both should be increased. However, increased funding for one area should not be at the expense of funding in another area. Programs must be based on the best information and research currently available. The victims of malnutrition among the aged have made their contribution to society. Society must see that no aged person's nutritional needs are neglected.

Higher standards. State and local governments have had ample opportunity to raise standards for institutional food services but generally have not done so. Federal action is essential to raise standards and the most effective approach would be to require institutions and home care agencies to meet higher standards as a condition for receiving funds under Federal programs.

Educational programs. There is a need for governmental sponsorship of nutritional education programs designed for the elderly. These programs should involve the mass media, voluntary and public agencies, national and community organizations, and the training of professional and semi-professional workers in nutrition and gerontology. The cost of this educational effort should not be at the expense of the nutritional needs of the elderly. It would be a cruel hoax to provide nutritional education but at the same time deny the elderly utilization of this knowledge through a lack of income or the lack of services or programs to meet their needs.

Group meals vs. home-delivered meals. Experience demonstrates that a meal service program is more effective when meals are provided in a group setting which encourages social interaction and facilitates the involvement of other services which directly relate to adequate nutrition. The objective should be not only to provide food but to meet social needs as well. However, such programs, to the extent possible, should include home-delivered meals, nutritional education and appropriate auxiliary services for shut-ins.

Federal responsibility. The responsibility of the Federal Government to promote adequate nutrition was documented by the 1969 White House Conference on Food, Nutrition and Health.

A major emphasis should be to raise the inadequate incomes which now prevent so many older Americans from eating nutritious meals.

But inadequate income is only one of several causes of malnutrition among the elderly. Programs should be devised which not only provide proper nutrition but at the same time combat the social isolation and other problems faced by so many elderly.

Safety and quality of food supply. All levels of government must act vigorously to protect older persons who, because of low income and greater incidence of poor health, are very often victims of price gouging on food items.

Congress should provide the redirection and funding to make government more responsive to the needs of the consumer. There must be a rededication by Federal protection agencies, including the U.S. Department of Justice, the Federal Trade Commission and the Food and Drug Administration, to consumer needs with special emphasis on the safety and quality of the Nation's food supply.

RETIREMENT ROLES AND ACTIVITIES

GOAL: The retirement years should be satisfying years—a time to deepen and widen relationships with friends and relatives—a time to be of service to others—years filled with a sense of usefulness and worth—a time of recognition of the individual's contribution to society.

For the retirement years to be meaningful and satisfying, older people must be assured adequate income, housing and health care.

Governmental responsibility to provide opportunities for gainful employment and also volunteer employment programs. Age or compulsory retirement (the latter described by many older people as being fired rather than retired) should not mark the watershed between a useful and contributory role in the community and a life of inactivity. The average older person wants to continue to work at socially useful tasks, be part of the larger community and have a meaningful choice as to how he shall spend his later years.

The Federal Government has a responsibility to provide community service programs which not only provide income for the low income elderly but also afford them the opportunity to make a further contribution to society.

Elderly persons can and do derive great personal satisfaction from being of service to others—through churches, unions, community social welfare organizations, senior citizens centers and programs to help the needy—but these volunteers very often need to be compensated for out-of-pocket expenses as is provided for under the new Federal program, Retired Senior Volunteer Program (RSVP).

No means test for services programs. Except for programs clearly designed to provide income supplementation, eligibility for service programs—protective, homemaker, etc.—for the elderly, should be based on the need for the service and not on the person's income. Historically, programs for the poor have become "poor" programs.

As a Nation, we possess the resources not only to eliminate poverty among the elderly but to provide them with a level of income that would permit them to live in comfort and dignity and to participate fully in the life of the community. As Guiding Principle No. 5 indicates, "While adequate income is the first priority for elderly people, a program of appropriate services is also essential and necessary."

Preparation for retirement. Public support is needed to prepare the aged for the inevitable changes that occur along the life-span so that their quality of life may be enriched and their effectiveness as contributors to society enhanced.

Supportive services for the elderly and their families. The maintenance of strong familial ties is of great importance to both the elderly and their families. This provides older people with a significant sense of dignity and security. Of equal importance, this familial relationship can and does enhance and strengthen family ties and family life.

To strengthen the older person's sense of independence and prevent his or her fear of becoming a heavy burden and source of concern to the family, supportive services—protective, homemaker, nutritional—should be available to meet critical emergencies and to supplement the family's obligation to the elderly.

For the unattached individual or the older person whose family is widely scattered or unresponsive, an outreach service functioning in a substitute family role—backed up by a wide range of supportive services—is essential.

How a senior citizens organization can affect public attitudes toward the elderly. Organizations of, by, and for seniors, democratically governed and dedicated to promoting the welfare of older persons, can and do make important contributions to the general welfare.

Such organizations make possible:

- Satisfying and significant roles for older people in managing the affairs of the organization and in conducting service programs for the elderly.
- Action programs designed to secure legislation benefiting not only the elderly but their children and grandchildren, such as extension and improvement in Old Age, Survivors and Disability Insurance and a national health security program designed to provide comprehensive health services for persons of all ages.

Such organizations promote responsible citizenship by supporting progressive candidates and issues. They share with other groups a common concern for the Nation's welfare.

EDUCATION

GOAL: Older people should have the right to participate in educational activities that will enrich their lives and enhance their contribution as citizens. This guarantee must be accompanied by adequate services to ensure a dignified and secure old age; otherwise most educational efforts, no matter how well formulated, are certain to prove futile.

Education as a right. Every American, including the elderly, should have the right to the finest possible educational opportunities and that right should be based on the concept of the individual worth of every human being. This concept should not be subject to modification by cost/benefit considerations based on age.

National commitment. There should be a national commitment to educate the elderly and this commitment should be reflected in increased public expenditures and efforts to include education as an integral part of all programs designed for the aged. A national policy to implement this commitment should include:

• High priority for funding and staffing educational activities that will better enable older people to cope with urgent problems related to health, income, housing, employment and other necessities related to daily living.

• Public support for programs to prepare the elderly for retirement during pre-retirement years so that the quality of their life in later years will be greatly improved and their effectiveness as participating citizens enhanced.

Responsibility and leadership. Responsibility for initiating, supporting, conducting and coordinating programs in education for older people should be vested in the established educational system and should include:

Involvement of State educational agencies, universities, community colleges, local school districts, as well as specialized agencies, private and voluntary institutions, organizations and groups serving older people.

An overall leadership role for the U.S. Office of Education and establishment within that agency of a Unit of Education for Aging, headed by an Assistant Commissioner of Education, and a National Center for Life Long Learning.

Increased effectiveness and status for the Administration on Aging in securing educational and other needs for the elderly by making it an independent agency or by transferring it to the Executive Office of the President.

Flexible education. Education is a life-long process and the educational system should offer all groups in the population—youths, adults and retirees—equal opportunities to participate based on their needs and interests. The system should be flexible enough to see that the education of older persons, when necessary, can be conducted apart from the education of persons of other ages.

A variety of educational activities should be available ranging from vocationally-oriented to culture- and leisure-oriented programs in order to provide maximum opportunity for the elderly to gain all they can from their learning experience and at the same time enable them to contribute from their experience and wisdom to other age groups in the population.

Research versus program needs. There should be increased funding for research and for innovation of improved educational opportunities not provided by the traditional educational system and for expansion of existing programs of demonstrated effectiveness. Maximum progress in expanding and improving educational services for the elderly can be best achieved through a balanced deployment of resources in support of both these objectives.

Political education. National educational policy should stress the importance of the political process as a means of improving the well-being of older people and should educate them to make more effective use of their collective influence in achieving that objective. An integral part of this effort should be educational programs which will enable older persons to participate more effectively as individuals in the political process.

Special programs. Special outreach programs should be developed to encourage older persons to participate in educational services. Included in such programs should be special efforts to involve older

persons difficult to reach by reason of social, economic, health, or racial characteristics.

Criteria for educational services. It is imperative that the needs of older persons, and not institutional needs, be the basis for provision of educational services to older persons and that this be the basis for determining educational priorities. In order to achieve this objective, there should be full participation of the elderly at every level of policy formulation and implementation.

SPIRITUAL WELL-BEING

GOAL: The individual's religious beliefs can be a sustaining force throughout his lifetime. The later years with their changes in physical strength and health and the losses of relatives and friends place demands on the inner resources of mind and spirit of the older person for which the supportive services of a religious ministry are often essential.

Relationship of government and religious bodies in providing for the welfare of the elderly. There are various and complementary roles in the development and protection of the individual's spiritual well-being appropriate to government, religious organizations, community, family and friends. Each must assume a responsibility and recognize their limitations.

Government can assist chiefly in providing the underpinning of economic security so essential to peace of mind and assuring the conditions of a free society essential to the fulfillment of the spirit.

The community can provide the environment necessary to a healthy life, while church, family and friends can be supportive of the individual's efforts to meet and master the problems of advancing years.

Older persons have special religious needs. The needs of older people, while often reflecting the needs of the whole society, are of such special nature that it is appropriate there be special programs designed to meet their needs with particular effort devoted to involving the isolated older person without family ties.

Religious organizations should serve both spiritual and temporal needs. Religious organizations need not restrict themselves solely to the spiritual sphere but can rightfully be concerned with both the spiritual and temporal concerns of the elderly based on the concept of serving the whole man who is composed of body and soul.

Religious organizations can rightfully be concerned about the various social needs which relate to the elderly such as housing, nutrition, mental and physical health care, and other needs. The various religious bodies can effectively serve as advocates together with the elderly in order to effect an improvement in the lives of senior citizens.

Religious organizations should approach the needs of the elderly ecumenically. Religious denominations often maintain a ministry on the aging. These ministries should work together across denominational lines developing a joint commitment to the spiritual and temporal needs of the elderly.

In fulfilling the temporal needs, an ecumenical spirit should prevail that would assign to that church body with the resources and the desire to act the responsibility for designing and providing facilities and programs for the elderly regardless of race or religion.

PLANNING

Goal: Government at all levels should establish a leadership-planning mechanism with sufficient power and funds to assure that the needs of older people are met either through adequate programs for the total population or through special programs for the elderly.

Planning at the Federal level. In order to achieve the clout essential to implement coordinated planning as well as advocacy, we recommend that there be established, within the Office of the President, an independent agency for the aging under the direction of a Presidential Assistant on Aging. We use the word "Aging" advisedly (rather than "Aged" or "Older Americans") because aging is of concern to the total population, not just to those having reached a certain chronological age.

The proposed White House agency should have the authority, funding, and staffing needed to formulate and administer policy, to coordinate and monitor programs of those Federal departments having a direct concern in matters relating to aging, and to significantly affect the budgeting process of the Federal government.

The agency should have whatever funds are needed to finance innovative aging programs of appropriate Federal departments or agencies—when deemed necessary by the Presidential Assistant on Aging—on a demonstration basis until their value has been proved and they can be delegated to existing agencies.

The independent agency would be served by an Advisory Council that is adequately representative of older people.

Federal departments or agencies especially concerned with programs for the aging should be required to establish a position of Assistant Secretary on Aging (or its equivalent) for the purpose of developing and maintaining operating programs on aging and for assuring appropriate emphasis on aging within the department or agency.

Through a Federal Council on Aging, directed by the Assistant to the President on Aging, the Assistant Secretaries for Aging would recommend interdepartmental policy and program innovations.

Planning at the State and local levels. The leadership-planning mechanism at State and local levels should—to the extent possible—parallel the mechanism at the Federal level. The White House-level office should have both the resources and prestige necessary to encourage the development of such parallel units.

Relationship of governmental levels. We believe that it is essential to establish a meaningful relationship between the planning activities in aging of all levels of government—just as it is essential to coordinate planning at any one level. Federal grants for State and local planning efforts should be accompanied by reasonable requirements for joint planning.

Primary objective of planning: The planning mechanism should have the authority and respect necessary to make existing programs and services responsive to the concerns of older persons and more effective in meeting their needs.

One of its major responsibilities is to identify areas where a separate program or earmarked funding of general programs is essential in order to assure that the needs of older people will be met—initiating and administering such programs if necessary until they can be safely delegated to existing agencies.

Participation of the aging in planning: The elderly must be sianificantly involved in planning, in cooperation with professiongl personnel who combine a knowledge of the needs of older people with expertise in program development and implementation. Middle-aged and younger people should also have a voice not only as future consumers but because their financial and moral support is necessary to the success of the plans.

FACILITIES, PROGRAMS, SERVICES

GOAL: A wide and adequate range of facilities and services appropriately designed to meet the needs of older people through consultation with older people must be developed and financed.

The emphasis in the management and operation of these services and facilities must be on the maximum feasible participation of older people.

Maintaining independent living. Our resources, public and private, must be directed toward maximizing the likelihood that older persons—even when enfeebled—can continue to live in housing arrangements of their own choice.

Given the option, the great majority of older persons would favor independent living to even the most benign type of custodial care.

This argues for a range of services—social, health, rehabilitation, recreational, nutritional, protective and counseling—that would enable the older person to live in his own home, or with his children or grandchildren or with a small group of other older persons, or reside in a residential facility.

Unfortunately, too many nursing homes are not living arrangements but custodial facilities to which an elderly person is committed until death.

Our public policy must be to keep the older person functioning at his or her maximum physical and mental capacity in the community—not separated from it in an institution. When it becomes necessary for medical reasons, the care then provided—whether for a few days or a longer period—must be in a facility capable of furnishing comprehensive medical and social services and geared to a rehabilitation philosophy—the concept of a geriatric hospital with an open admission policy.

We believe essential supportive services for the elderly should be organized, administered and delivered on a community-wide basis. This, we argue, is not only the most economical way to provide these services but has the particular advantage of keeping the resident of a housing project, for example, related to the community.

Sponsorship and operation of services and facilities should be primarily by non-profit private and governmental agencies. The great majority of the elderly cannot pay for the essential services and so must receive them free or be partially subsidized. Many of these services—recreational, protective, homemaker, nutritional and others—have significant preventive aspects and so like public health programs ought to be universally available.

As Guiding Principle No. 5 notes even an adequate level of income does not assure that a needed service will be available.

Only governmental or non-profit private agencies can assure the availability and accessibility of essential services most efficiently and economically.

Governmental agencies should have the major responsibility for the planning, financing and coordination of services and facilities for the aging. As indicated in Guiding Principle No. 6 voluntary non-profit agencies and organizations are an essential component in any well balanced program of services for the elderly, but the development of a universal system of services requires the resources of government.

These resources plus the rule making, standard-setting and inspectional powers needed argue for a governmental agency carrying the primary responsibility for the planning and coordination of facilities and services for the aging.

Role of older people in the management and operation of facilities and services. Programs for the elderly should be designed and operated with significant participation of older people in policy and management.

The fullest consideration should also be given to employing older people as staff. There are many older people with professional and technical competence for whom such employment can represent a second career. Moreover, the concern we profess for retirement roles and activities implies an obligation to design staff positions that can utilize older people.

Separate vs. integrated facilities, programs and services for the aging. As Guiding Principle No. 7 indicates, older people to the maximum extent possible desire to participate on equal terms in programs for the total population.

But older people have often special needs that demand programs uniquely designed for them. If these can be arranged by a recreation department or a housing agency, this would be preferred by many older people to setting up a facility, for example, to be utilized exclusively by older people.

The responsibility of government for consumer protection. Although there are a variety of governmental agencies charged with consumer protection—public utility commissions, the Federal Trade Commission, the Food and Drug Administration—these have largely become captives of the industries they are supposed to regulate.

To protect the consumer, legislation is needed to enable consumers to sue in the Federal courts on behalf of themselves and others similarly situated (class action litigation) for damages and court costs where manufacturers or merchants are found guility of defrauding the public.

Congress should also enact consumer product safety legislation, a consumer fraud prevention act, a fair warranty disclosure act and a consumer product test law.

To make consumer protection more effective, an independent Federal Consumers Council should be established.

Legal services for the elderly. Elderly persons need to have easily available legal services at no or low cost for the protection not only of their rights and property but also to assure them full access to their

legally entitled benefits—Social Security, housing assistance, health services and protection against arbitrary governmental action.

Elimination of age discrimination. Increasingly, age is becoming a key factor in denial of employment, eligibility for a home mortgage and denial of automobile insurance except at an exorbitant cost.

These practices call for a vigorous enforcement of the age discrimination in employment law accompanied by a removal of the upper age limit of 65 in current legislation to prevent growing practice of early "retirement." There is urgent need for a legislative requirement that insurance companies insure at a reasonable cost older drivers with valid drivers permits.

TRAINING

GOAL: To make sure essential services for the elderly are sufficiently and effectively provided and delivered, adequate manpower to render these services is essential.

Emphasis should be placed on the problems and needs of the elderly in training programs for service personnel. The curriculum for the education of service personnel—particularly physicians, nurses, social workers, rehabilitation personnel, recreation staff, and adult education teachers—should provide as an integral part of the educational process information on the special problems and needs of older people and, where appropriate, clinical experience.

Consultation and in-service training in service agencies. Agency services for the general public, including older people, should provide consultation and in-service training directed toward assisting staff members to understand and serve the special needs of the elderly.

Development of leadership personnel. Schools of Education, Medicine, Nursing, Social Work and graduate departments in Psychology, Sociology and other disciplines related to human service should be stimulated and assisted financially to recruit promising students who are interested in becoming experts on the aging within their respective disciplines.

Such specialists are essential to sensitizing their basic disciplines to the problems and needs of older people.

A highly flexible approach to recruitment. Demands for staff in the service programs for older people should be met in a highly flexible manner and should seek young people planning a lifetime career, middle-aged persons seeking a career change and older persons for whom such employment would constitute their unique contribution to helping their fellow seniors. The young, the middle aged and the elderly could provide an unique identification with the needs of the people they serve.

RESEARCH AND DEMONSTRATION

GOAL: A comprehensive program of research into the causes of aging in humans and matters affecting the quality of life of older people should be developed including effective means for rapid and practical application of new knowledge by legislators, administrators and professionals.

Research priorities. The resources devoted to research on aging are meager. For every dollar paid for nursing home care less than ½ cent is invested in seeking to determine how to prevent chronic disabilities

and mental deterioration that force institutionalization of a great many elderly.

More intensive research into the causes of aging in humans by maximizing the ability of the elderly for self-care and independent living would bring incalculable benefits in human terms and would save billions of dollars in the process.

Research and evaluation versus facilities and services. There is dire need for increased expenditures both for research and evaluation and for facilities and services. One should not be at the expense of the other. It is not a question of "either/or" but efforts in both areas should complement each other so maximum results are achieved at minimum cost.

Federal coordination. Research in the area of aging in humans is not receiving sufficient financial support or making significant progress. It receives modest funding from a variety of sources but the total is inadequate.

A major need in aging research is a clearer delineation of what should be done and how best to do it.

A unified research effort in the area of aging under the leadership of the Federal government is the most feasible approach toward this objective and establishment of a National Institute on Gerontology is the most likely way to accomplish it.

Specialized versus multidisciplinary research. Specialized research projects are important and must be continued and expanded. But there is an increasing need for research or broader approaches that focus on areas and problems that will provide valuable information for determining social policy. Establishment of multi-disciplinary centers would help close the gap between specialized research knowledge and the use of that knowledge.

Basic and applied research. High priority must be given basic research efforts such as those directed toward an understanding of the biological aging process, geared to an attack on chronic diseases of middle and old age. But at the same time, there is a need for increased support for research that concentrates on improving the quality of life in later years. The goal should be a balanced growth in both the length and quality of life.

GOVERNMENT AND NONGOVERNMENT ORGANIZATIONS

GOAL: Government should implement its basic responsibility for assuring that the later years shall be secure, dignified and satisfying.

As Guiding Principle No. 4 indicates, "government has the duty and the responsibility to serve as an advocate for the beneficiaries of the programs it provides."

By policy, Government should administer its programs for the elderly in ways that will encourage and support the independence of the individual, supplement and strengthen family relationships, and utilize the resources of churches, private non-profit organizations and local government.

The public, including the elderly, have the right to look upon their government as truly of, by, and for the people—a "we" institution, not a "they" institution.

To perform an advocacy function effectively, government must provide strong leadership. To provide strong leadership in advocating and promoting programs for the elderly, there must be established at the Federal level an Office on the Aging within the Executive Office of the President—charged with oversight over all Federal activities related to aging and capable of raising the emphasis on aging in the Departments of Health, Education, and Welfare, Housing and Urban Development, Labor, Transportation, Agriculture, and the Office of Economic Opportunity (anti-poverty agency).

At the State level, equivalent independent bodies should be established with authority to oversee all activities related to aging. Such bodies should receive Federal support and be authorized to create regional offices and, where appropriate, city or county Commissions on Aging. The membership of such Commissions should include older people's organizations.

Where regional commissions or city or county commissions exist or are established, these commissions should possess authority to coordinate programs for the aging and be entitled to financing from the State Office on Aging.

Further to strengthen Congressional coordination and surveillance of programs for the elderly, a House Special Committee on the Aging similar to the Senate Committee on Aging should be established.

Provision of services and facilities as a matter of right. The right to a floor of income—above the poverty level—and the right to Social Security benefits which have been earned can no longer be argued. The right to health services for the elderly within the limits of Medicare has become fully accepted. The right to comprehensive health services for all citizens seems likely to become public policy at an early date.

A wide range of services for the elderly—recreational, homemaker, day care, nutritional and protective—are essential to the well-being of older people. Because these services are preventative or ameliorative—preventing the need for much more expensive institutional care—they should be viewed as analogous to public health services and offered on a universal basis with the sole eligibility requirement the need for the service.

Services for the elderly offered by private nonprofit organizations are an essential part of the range of services that should be available.

Non-profit agencies and organizations—membership organizations and direct service agencies—are essential components of a well balanced and adequate system of programs and services for seniors.

The mutual help activities of a senior citizens membership organization—programs provided by churches, unions, fraternal organizations and non-profit service agencies—are not only important supplements to basic governmental programs but provide for a degree of individualization and personal contact not always practical or possible under government programs.

Private organizations also are freer to innovate and experiment with programs than are government agencies.

Government should stimulate and encourage citizen organizations to undertake programs for the elderly and provide limited financing

for such programs. The voluntary organization, however, should not become so dependent on government funds that it is inhibited in acting as a constructive critic of governmental programs and as an advocate for seniors.

ITEM 2. THE ISSUES—WHERE WE STAND, A STATEMENT BY THE AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION*

Delegates to the White House Conference will break up into 14 sections to discuss the same number of general topics. AARP has adopted a position in relation to each topic. On this and following pages we list each topic (with subsections in some cases) and the Association's position.

INCOME

1. PRIVATE PENSIONS

A Pension Commission, as recommended by the President's Task Force on Aging, should be created to safeguard the funds of all pension systems in America and should include some form of guarantee of pension benefits in case of default. Early vesting and portability rights of employes should be a condition of all pension plans. The amount of individual pension plans should be a matter between employer and employee or his representative.

2. ASSURING BASIC INCOME

The Association rejects the concept of a basic floor of Social Security income at the poverty level. Income adequate for a moderate standard of living varies as defined by the Bureau of Labor Statistics. Assuring retirement income at this level is the primary issue to be resolved. Second is the method by which this is financed. AARP supports a mixture of contributory Social Security and general revenue.

HEALTH

1. INSURANCE: MEDICARE AND MEDICAID VS. NATIONAL HEALTH PLAN

We support the enactment of a national health plan which would guarantee the availability of comprehensive, quality health care to all Americans regardless of age or the ability to pay. Until the national health plan is enacted, we urge the Congress to assure that all persons become eligible for Medicare upon attaining age 65. We further support:

—Consolidation of Parts A and B of Medicare, elimination of premium payments under Part B, and removal of all deductibles and coinsurance features of both parts.

—The elimination of restrictions on the duration of coverage of hospital and extended care stays as well as the removal of the restriction of extended care benefits to post-hospital cases.

—The inclusion of prescription drug costs in Medicare.

*Reprinted from the October-November Issue of "Modern Maturity."

2. MANPOWER

Recognizing the urgent, critical need to increase the health manpower supply, we urge Federal assistance for training professional and paramedical personnel in geriatric medicine. We also urge that their training include a component on care of the aged, eventually producing geriatric-aide specialists.

NUTRITION

NATIONAL NUTRITION: GOVERNMENT VS. PRIVATE CONCERN

We urge the present Administration to effectively implement its commitment to alleviate the problem of inadequate nutrition of the elderly, through permanent nutrition programs for needy older persons and an intensive quality control and consumer information program for all Americans.

HOUSING

1. IDENTIFICATION OF HOUSING FOR THE ELDERLY

Policy on housing should make specific provision for the elderly. A fixed proportion of all funds allocated for housing should provide for housing for the elderly, both in separate units and in overall housing programs, and should be identified as such.

2. REAL ESTATE TAX ABATEMENT

We believe in enhancing the possibility of maintaining independent living. We, therefore, urge that State and Federal governments provide financial incentives to make local property tax relief for elderly homeowners possible.

3. LIVING ARRANGEMENTS

The elderly have the right of freedom of choice in housing. Therefore, housing programs should endeavor to provide various types of living arrangements and services to support that freedom of choice.

TRANSPORTATION

1. COST OF TRANSPORTATION

Although income assistance is certainly a good thing, we should take the position that, unless services are available, money will not take the individual very far, and support the idea of government-funded transportation service facilities.

2. ACCESSIBILITY OF TRANSPORTATION

We feel that, with stimulating and imaginative leadership, society's attitude toward the elderly can be changed and that, with the Federal Government showing the way in interstate commerce, through financial help, demonstration projects, etc., the states and communities can offer individualized, flexible transportation to older citizens.

3. PHYSICAL BARRIERS IN TRANSPORTATION

We recommend that the Federal Government provide leadership and set national policies, but that the diverse needs of older persons for safe and convenient transportation be met by local and State governments.

EMPLOYMENT AND RETIREMENT

1. AGE DISCRIMINATION

We are opposed to mandatory retirement for reasons of age alone; therefore, we urge strongly that a study be undertaken immediately to establish the effectiveness of the Age Discrimination in Employment Act as it now stands. If findings show that the law does not properly protect those now covered, steps should be taken to insure its enforcement. When that action has been taken, or if initial studies show that the law does what it was set up to do, the Act should be extended to all older workers with no age limitation.

2. PLACEMENT AND TRAINING PROGRAMS

With our unique and proven interest in the useful employment of the elderly, we recommend that specific placement, training and job assistance programs be designed and implemented to allow older workers who so desire to be gainfully employed.

3. FORCED RETIREMENT

We urge that no situation such as health, plant shutdowns, etc., be used as a guise for discriminating against older workers. When workers are forced to retire before retirement age, the Federal Government should have a program to help them.

4. PRERETIREMENT EDUCATION

We, who through publications and nationwide seminars have long been in the vanguard in preretirement education, urge Federal leadership in preretirement training in the private sector.

EDUCATION

START NEW OR IMPROVE THE OLD PROGRAMS?

Although a certain amount of research is always necessary, recalling the success of the Foster Grandparent Program, we feel that existing programs that have been successful should be continued and extended to realize their full potential.

ROLES AND ACTIVITIES

1. RESPONSIBILITIES FOR ROLE DEVELOPMENT

The development of satisfactory roles for older persons is the combined responsibility of the older persons themselves, their families, voluntary organizations and government agencies. Opportunities and resources to engage in such roles must be fostered to the extent of the capacity of the individuals and families involved, but they must be aided and underwritten by the two basic sources—voluntary associations and government units. Older persons should not be left solely to their own initiative and resources to develop and pursue appropriate and meaningful retirement roles. In our social system based on a mix of government and voluntary effort, all four sources—individual, familial, voluntary organization and government—have a responsibility. Each must contribute within its appropriate means to the effort of fostering or engaging in those activities and functions which provide the most satisfactory role for the aged.

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2. ROLE ACTIVITY PRIORITIES

All sectors of the aging can be provided with programs to meet their role problems or for creating new role opportunities. In periods of severely limited resources, the reductions in programs when necessary must be equitably applied to all older persons. The greater likelihood is that our country can aid both those in greater need and in lesser need if it but has the commitment and will. It should not be necessary to pose alternatives which provide for the aged most in need at the expense of the other sectors of older persons.

SPIRITUAL WELL-BEING

GOVERNMENT COOPERATION

Given the pluralistic nature of American society, we recommend that the Federal Government provide informational and technical assistance where required and cooperate closely with churches in community-oriented programs; however, this should in no way impinge on our tradition of separation of church and state.

PLANNING

PLANNING MECHANISMS

The planning mechanisms that have been developed in communities, states and nationwide must continue, but must become much more effective in their response to the concerns and needs of older persons. We take this position because we recognize that for the immediate future the basic form of organization will be of a general-purpose, functional type responsible for specific functions for the total population. However, alongside these functional units the continuing efforts of special organizations for the aging are needed to induce the functional organizations to pay greater attention to their responsibilities for the aged. Just as in the community, special committees or units on planning for the aged, under the umbrella of a total community planning function, can be effective if properly structured and empowered, so for the States and Nation, special units and agencies are necessary. This applies to both government and voluntary efforts. Strong, visible special units for and of the aging, under the umbrella of existing central and functional planning bodies, are necessary to stimulate the existing planning mechanisms to do a better job of planning for the aged.

FACILITIES, PROGRAMS AND SERVICES

1. CENTRAL POSITION OF THE ELDERLY

Maximum opportunity should be accorded old people to participate in policy formation of service programs for the elderly. All older people who want to participate in these efforts should have this course of action available to them. Older persons should be encouraged to participate, particularly in policy formation. To the maximum feasible extent, both employment opportunities and volunteer openings should be made available to older persons in the operation and management of services to the elderly. Policy formation and staffing of programs for old people cannot and should not be the exclusive domain of old

people themselves. The action promotion of a greater role for old people in these efforts does not contravene the use and employment of other age groups. The avenues must remain open for all interested persons, regardless of age, to participate in the program and policy determination, and the management and operation of facilities and services for old persons.

2. OWN HOME RESIDENCE

Older people should not be forced into congregate facilities that demean their personality and decrease their opportunities for independent living, unless their disability and isolation become such that further independent living is hazardous to themselves or others. Home care, house maintenance and housing aide services, properly organized and controlled, should be expanded. Housing authorities providing large-scale housing for the old should be charged with the responsibility of increased financing, if not operating sponsorship, for these types of services. Maximum efforts should be asserted and programs devised to maintain older people in their own homes to the extent that it is feasible to do so. Institutional care in nursing home facilities should be restricted to those elderly who require continuous nursing procedures. Better organized programs of supervision to enforce proper standards on nursing homes should be developed. Even with the best operated nursing homes for the elderly, the movement of old people to these facilities should be primarily of a "last resort" character.

RESEARCH AND DEMONSTRATION

1. FACILITIES AND SERVICES VS. RESEARCH AND DEMONSTRATION

We wholeheartedly support that some proportion of public (and private) funds be allocated toward research and demonstration. We urge that, since private industry allocates 3–5 percent of its funds to research and demonstration, and most HEW programs earmark approximately 7 percent for this activity, an average of these percentages, 5 percent, is a realistic allocation for the aged.

In advance of such an increase in funds, we urge that current and future research and demonstration be monitored to avoid gaps or overlap in activity and insure that specific issues are being investigated.

In sum, we believe that the basis for current and future facilities and services is responsible research and demonstration and its judicious application.

2. ORGANIZATION: FRAGMENTED VS. CENTRALIZED

In light of the existing fragmented and underfinanced approach to aging research, coupled with a rapidly increasing older population, we support an Institute of Gerontology and a coordinated, systematic approach to research on aging.

TRAINING

LEVEL OF INSTRUCTION

We feel that priority should be placed on advanced education of teachers and researchers, with equal emphasis on direct-service education of professionals and semiprofessionals.

GOVERNMENT AND NONGOVERNMENT ORGANIZATION

1. GOVERNMENT ADVOCACY FOR THE ELDERLY

The interests of older people are best served by special organizations of, by and for the aging rather than undifferentiated, all-population agencies organized along functional lines. A reasonable resolution of the basic needs of the aged requires specialized government and voluntary organizations, each playing its proper role of advocacy and action, with all eflorts concentrated on problem-solving rather than organizational devices.

2. A CENTRAL AGENCY FOR THE AGING

A strong, visible and authoritative Administration on Aging is a necessary ingredient of Federal organization. Without a central Federal agency of this type, or recognized status, the beginning developments in better meeting the needs of the elderly will deteriorate. The proper organizational locus of this agency is within the Department of Health, Education and Welfare. The position of this unit within the department must make it adequately independent and self-determining if it is to work effectively. The primary assignments of the Administration on Aging should be promotional and operational. It is needed to administer aging programs, promote the interests of the aging, and centralize research and fact gathering. Our Association also proposes that an additional mechanism is necessary for the policy development, program planning and coordination aspects. We do not subscribe to the position that the proper place for this function is the President's executive staff. To place these functions within this organizational format is to subject these activities directly to the political influences of changing administrations. The Office of Management and Budget has increasingly been given this role for all Government functions. We propose that a unit be developed in this office, staffed with gerontologists, with responsibility for policy, planning, coordination and management oversight of all activities on aging performed by the Federal Government. Insofar as government organization within States follows comparable patterns, we recommend a counterpart type of organization at State levels.

3. GOVERNMENT-VOLUNTARY AGENCY RELATIONS

Our Association believes it is important for government institutions to listen and react positively to the viewpoint and the concerns of the voluntary associations of and for the aging.

Government grants should be made available to voluntary organizations for specific uses. A balanced approach to the distribution of responsibility and the financing of programs must be our national goal. Government support by means of grants-in-aid to voluntary operations should be encouraged and expanded to the extent that the voluntary activities can make positive contributions of effort and results. The American system of providing services to the elderly by means of cooperating government and nongovernment associations is supported by our Association. Emphasis should be placed on financial support by government for those voluntary programs which initiate and continue programs that creatively expand services to old people.

APPENDIX 4

U.S. SENATE SPECIAL COMMITTEE ON AGING ADVISORY COUNCIL ON THE ADMINISTRATION ON AGING

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Mr. William C. Fitch, Executive Director, National Council on the Aging, Washington, D.C.

Mrs. James H. Harger, former Director, N.J. Division on Aging and former President, National Association of State Units on Aging, Annandale, N.J.

William C. Hudelson, Director, Division of Services & Programs for Aging, Prince Georges County Department of Community Development, Md.

J. R. Jones, Director, Office on Aging, Little Rock, Arkansas.

Dr. Jerome Kaplan, President, Gerontological Society, Washington, D.C.

Mr. Garson Meyer, Chairman of President's Task Force on Aging (1970) and former President, National Council on the Aging, Miami Beach, Fla.

Dr. Woodrow W. Morris, Institute of Gerontology, University of Iowa, Iowa City, Iowa.

Mr. Bernard E. Nash, Executive Director, American Association of Retired Persons/National Retired Teachers Association, Washington, D.C.

Mrs. Kay Pell, Director, Idaho Department of Special Services, Boise, Idaho.

Mrs. Margaret Schweinhaut, Chairman, Maryland Commission on Aging, Baltimore, Md.

Dr. Harold Sheppard, Staff Social Scientist, W. E. Upjohn Institute for Employment Research, Washington, D.C.

Clarence M. Tarr, Vice-President, National Association of Retired Federal Employees, Washington, D.C.

Bernard S. Van Rensselaer, Director, Senior Citizens Division, Republican National Committee, Washington, D.C.

Frank Zelenka, Associate Director, American Association of Homes for the Aged, Washington, D.C.

APPENDIX 5

U.S. SENATE SPECIAL COMMITTEE ON AGING ADVISORY COUNCIL ON THE OLDER INDIAN

Mrs. Dorothy G. Baker, (Shoshone-Bannock) former member of Health and Welfare Committee, Fort Hall, Idaho.

Mrs. Irene C. Cuch, (Ute) Standing Rock Tribal Council Member, Fort Duchesne, Utah.

Mr. Vine DeLoria (Sioux), President, Institute of the Development of Indian Law, Executive Director, Southwest Intergroup Council, Bellingham, Wash.

Mr. Frank D. Ducheneaux, Sr., Charter Member of the Tribal Council of the Cheyenne River Sioux Tribe, Eagle Butte, S. Dak.

Mr. Steven V. Hotch, Vice Grand President, Alaska Native Brotherhood, Grand Camp Kluhwan, Alaska.

Mrs. Anna Gover (Commanche), former Foster Grandparent, Lawton, Okla.

Mr. Ted James, Pyramid Lake Tribal Council, Nixon, Nevada.

Mr. Samuel C. Kolb, Vice Chairman, Mission Indian Tribal Council, Window Rock, Ariz.

Mr. Rodger H. Sandoval, Project Director, Local Community Development Program Office of Navajo Economic Opportunity, Fort Defiance, Ariz.

Mr. Ronald Moore, Deputy Director Affiliated Tribes of Arizona, Phoenix, Ariz.

Mr. Earl Old Person, President, National Congress of American Indians, Browning, Mont.

Mr. Frell M. Owl, (Cherokee), former Chairman of Planning Board for Eastern Band of Cherokee Indians, and member of White House Conference on Aging Planing Committee, Cherokee, N.C.

Mr. Eugene Parker, Member, Indian Committee on Aging, Neah Bay, Wash.

Mrs. Agnes Savilla, (Mohave) Member, Governor's Task Force on Aging and Tribal Housing Authority Committee, and Chairman, HEW Tribal Committee, Parker, Ariz.

Mrs. Milton Schiffman, Regional Representative, National Council on Aging, San Francisco, Calif.

Mr. Perry Swisher, Director of Special Educational Services, Idaho State University, Pocatello, Idaho.

Mr. David M. Vallo, Community Organization Specialist, Intertribal Council of California, Sacramento, Calif.

Mr. Joe Exendine, Acting Director, Office of Program Planning and Evaluation, Indian Health Service, Rockville, Md.

Mrs. Betty Mae Jumper, Former Tribal Council Chairman, Public Health Representative, NCIO Council Member, Hollywood, Fla.

APPENDIX 6

U.S. SENATE SPECIAL COMMITTEE ON AGING ADVISORY COUNCIL ON AGING AND AGED BLACKS

Bishop (A.M.E.) John D. Bright, (Philadelphia), President, National Committee of Black Churchmen.

Robert Butler, M.D., (Washington, D.C.), Chairman of the D.C. Advisory Committee on Aging and Chairman of the Committee on Aging for the Group for the Advancement of Psychiatry.

Kenneth W. Clement, M.D., (Cleveland, Ohio), Member of the Board of Trustees of Howard University and former President of the National Medical Association.

Donald L. Davis, (Washington, D.C.), Director of Senior Community Service Project National Council on the Aging.

Jean L. Harris, M.D. (Washington, D.C.), Executive Director, National Medical Association Foundation.

Hubert L. Hemsley, M.D. (Compton, California), President-Elect, Charles Drew Medical Society.

Robert Hill, Ph.D., (Washington, D.C.), Associate Director of Research Department, National Urban League.

Jacquelyne J. Jackson, Ph.D. (Durham, North Carolina), Assistant Professor of Medical Sociology, Duke University Medical Center.

Maurice Jackson, Ph.D. (Riverside, California), Associate Professor of Sociology, University of California.

Hobart C. Jackson, (Philadelphia), President, National Caucus on the Black Aged and Administrator, Steven Smith Geriatric Center.

Robert Kastenbaum, Ph.D. (Birmingham, Michigan), Professor of Psychology, Wayne State University.

Donald P. Kent, Ph.D. (State College, Pennsylvania), Professor of Sociology and Head of the Department of Sociology, Pennsylvania State University; and former Director U.S. Office on Aging, Department of Health, Education, and Welfare.

Benjamin E. Mays, Ph.D., (Atlanta, Georgia), President Emeritus of Morehouse College, Atlanta, Georgia and President, Atlanta Board of Education.

Lawrence Oxley, (Washington, D.C.), Director of Special Projects, National Council of Senior Citizens.

Frank Pohlhaus, (Washington, D.C.), Counsel for the Washington, D.C. Bureau, National Association for the Advancement of Colored People.

Louise M. Singleton, (New York City), representing National Welfare Rights Organization.

Mrs. Carolyn N. Watts, (Boise, Idaho), Member and former Board Member of the National Association for the Advancement of Colored People Chapter in Boise, Idaho.

APPENDIX 7

U.S. SENATE SPECIAL COMMITTEE ON AGING ADVISORY COUNCIL ON ELDERLY MEXICAN-AMERICANS

Mr. Armando R. Atencio, Assistant Department Manager, Department of Health and Hospitals, State of Colorado, Denver.

Mr. Cipriano John Baca, Sr. (Advisory Council Cochairman) Member of the Economic Opportunity Board for Albuquerque-Bernalillo County, Albuquerque, N. Mex.

Mr. Leonel J. Castillo, Former Director of Community Relations, Diocese of Galveston-Houston, Tex.

Mr. Dennis V. Fargas, Senior Associate, Center for Program Implementation, National League of Cities, U.S. Conference of Mayors, Washington, D.C.

Dr. Clotilde P. Garcia, Committee for Education and Aging, American GI Forum, Corpus Christi, Tex.

Mrs. Corine M. Garcia, Senior Opportunities and Services for Bent, Crowley, and Otero Counties, Rocky Ford, Colo.

Mr. Robert E. Gonzales, Member, Board of Supervisors, City and County of San Francisco, Calif.

Mr. Homer T. Martinez, Regional Representative, National Council on the Aging, Dallas, Tex.

Mr. Theodore F. Martinez, Assistant to the President, University of New Mexico, Albuquerque, N. Mex.

Mrs. Graciela G. Olivarez, Executive Director, Food for All, Inc., Phoenix, Ariz.

Mr. Eduardo Pena, Jr., Director of Compliance; Equal Employment Opportunity Commission, Silver Spring, Md.

Mrs. Anna M. Plasencia, Member, Governor's Comprehensive Health Planning Commission, Nampa, Idaho.

Dr. Jorge Prieto, Health Center at Caprini Hospital, Chicago, Ill.

Mr. Cruz Reynoso, Director, California Rural Legal Assistance, San Francisco, Calif.

Mr. Vincente T. Ximenes, Vice President, Field Operations, National Urban Coalition, Former Commissioner, Equal Employment Opportunity Commission, Washington, D.C.

Mrs. Julia S. Zozaya, Resource and Information Officer, Arizona Office of Economic Opportunity, Phoenix, Ariz.

Mr. Alexander S. Zermeno (Advisory Council Chairman) Assistant Director, Southwest Council of La Raza, Phoenix, Ariz.

APPENDIX 8

U.S. SENATE SPECIAL COMMITTEE ON AGING REPORTS, COMMITTEE PRINTS, AND HEARINGS, DECEMBER 1970–DECEMBER 1971

The publications listed below may be obtained by writing to the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402, enclosing a check or money order for the total cost of publications ordered.

REPORTS

Developments in Aging—1970, Report No. 92–46, March 1971. ($1.50)
Income Tax Overpayments by the Elderly, Report No. 91–1464, December 1970. (20¢)
Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, December 1970. (50¢)
Economics of Aging: Toward A Full Share in Abundance, Report No. 91–1548, December 31, 1970. ($1.00)
Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92–433, November, 1971. (75¢)
The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92–450, November 1971. (35¢)
A Pre-White House Conference on Aging Summary of Developments and Data, Report No. 92–505, November 1971. (70¢)

COMMITTEE PRINTS

The Nation's Stake in the Employment of Middle-Aged and Older Persons, (Working Paper) July 1971. (35¢)
The Administration on Aging—or a Successor?, (Committee Print Report) October 1971. (30¢)
Alternatives to Nursing Home Care: A Proposal, October 1971. (20¢)
Advisory Council on the Elderly American Indian, (Working Paper) November 1971.*
Elderly Cubans in Exile, (Working Paper) November 1971.*
Making Services for the Elderly Work: Some Lessons From the British Experience, (Committee Print Report) November 1971.*

HEARINGS

Evaluation of Administration on Aging and Conduct of White House Conference on Aging:
Part 1. Washington, D.C., March 25, 1971 (50¢)
Part 2. Washington, D.C., March 29, 1971 (25¢)
Part 3. Washington, D.C., March 30, 1971 (30¢)
Part 4. Washington, D.C., March 31, 1971 (30¢)
Part 5. Washington, D.C., April 27, 1971 (30¢)
Part 6. Orlando, Fla., May 10, 1971 (30¢)

* Price not determined at time of this printing.

Part 7. Des Moines, Iowa, May 13, 1971 (35¢)
Part 8. Boise, Idaho, May 28, 1971 (30¢)
Part 9. Casper, Wyo., August 13, 1971*

Trends in Long-Term Care:
Part 10. Washington, D.C., December 14, 1970 (Salmonella) (30¢)
Part 11. Washington, D.C., December 17, 1970 (50¢)
Part 12. Chicago, Ill., April 2, 1971 ($1.00)
Part 13. Chicago, Ill., April 3, 1971 (65¢)
Part 14. Washington, D.C., June 15, 1971 (25¢)
Part 15. Chicago, Ill., September 14, 1971*
Part 16. Washington, D.C., September 29, 1971*
Part 17. Washington, D.C., October 14, 1971*
Part 18. Washington, D.C., October 28, 1971*
Part 19. Minneapolis, Minn., November 29, 1971*

Legal Problems Affecting Older Americans: Boston, Mass., April 30, 1971 (25¢)

Cutbacks in Medicare and Medicaid Coverage:
Part 1. Los Angeles, Calif., May 10, 1971 [1] (60¢)
Part 2. Woonsocket, R.I., June 14, 1971*
Part 3. Providence, R.I., September 20, 1971*

Unemployment Among Older Workers:
Part 1. South Bend, Ind., June 4, 1971.*
Part 2. Roanoke, Ala., August 10, 1971.*
Part 3. Miami, Fla., August 11, 1971.*
Part 4. Pocatello, Idaho, August 27, 1971.*

Adequacy of Federal Response to Housing Needs of Older Americans:
Part 1. Washington, D.C., August 2, 1971.*
Part 2. Washington, D.C., August 3, 1971.*
Part 3. Washington, D.C., August 4, 1971.*
Part 4. Washington, D.C., October 28, 1971.*
Part 5. Washington, D.C., October 29, 1971.*

A Barrier-Free Environment for the Elderly and the Handicapped:
Part 1. Washington, D.C., October 18, 1971.*
Part 2. Washington, D.C., October 19, 1971.*
Part 3. Washington, D.C., October 20, 1971.*

Flammable Fabrics and Other Fire Hazards to Older Americans: Washington, D.C., October 12, 1971.*

*Price not determined at time of this printing.
[1] Working Paper incorporated as an appendix to the hearing.

APPENDIX 9

THE AREAWIDE MODEL PROJECT PROGRAM[1]

SUMMARY

INTRODUCTION

In today's rapidly changing physical and social environment, the needs of the elderly are multiple in number, complex in their composition, and constantly undergoing change. They cross the health, socioeconomic, emotional, and psychological spectrum of life.

These problems can be summarized as: (1) the increased difficulty in maintaining independent living in the later years of life; and (2) the limited opportunity for active and meaningful participation in community life during the retirement years.

The resources of the areawide model project program will be utilized in the form of special demonstration projects to develop, test, and design innovative solutions to the problems associated with independent living and active engagement in community life for the aged.

LEGISLATIVE PROVISIONS OF THE PROGRAM

The areawide model project program was authorized by the 1969 Amendments to Title III of the Older Americans Act. Under this program, awards may be made only to designated State agencies on aging through grants or contracts. State agencies receiving awards may operate the program directly or through contractual arrangements.

There is no limitation under the act as to the length of time that a State agency may receive Federal funds under the program for an individual project. Federal funds received under the program may be used to pay not more than 75 percent of the cost of a project for any project year.

OVERVIEW OF THE PROGRAM

The areawide model project program will seek to develop and test innovative approaches to change those conditions that prevent or limit opportunities for older persons to live independently and participate meaningfully in community life. Each areawide model project must propose realistic plans for meeting the stated objectives of high priority in a community. Initially, a State agency must undertake those activities necessary to identify or clarify a pressing need of the elderly citizens of the project area having potential for solution within the scope of this program. Second, a plan of action must be developed which outlines a feasible scheme for combating in a comprehensive manner the need that has been identified. Such plan must then be submitted to the Administration on Aging for approval. And, finally,

[1] U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Administration on Aging, Publication No. (SRS) 72-20232.

if approved, the project will undertake those steps necessary to implement the plan in an efficient and effective manner throughout the project area.

The success of the program will depend in large part on the readiness of States and communities to deal affirmatively with change regarding service delivery to the aged, and the extent of the commitment that can be obtained from agencies and programs to jointly tackle a high priority problem confronting older people.

Project Operations

The successful implementation of an areawide model project will depend on a variety of factors. First, the community must have the capacity to identify the major problems faced by the elderly in their attempt to lead independent lives and remain actively engaged in community life. Second, and of primary importance, the agencies and programs of the community must be willing to join forces and cooperatively resolve that particular problem or condition identified. Of equal importance is the plan itself. It must be practical and offer substantial potential for solution or alleviation of a major problem throughout the project area.

The areawide model project program seeks to make a substantial impact in a specific program area rather than across the spectrum of problem areas. First, the resources of the program are not of adequate scope to make substantive impact in all problem areas. Second, it is anticipated that each areawide model project will become a model program and training site for other communities to replicate for solutions or approaches to similar problems faced by their elderly citizens. Thus, only through concentration on a particular problem area having high potential for solution can the expectation of a true model program be achieved.

By way of example, a State agency might identify (1) limited alternatives to institutional care in the community as critical problems to be resolved by the areawide model project; (2) prevention or delay of physical and mental health dysfunction; (3) creative roles in retirement; (4) linking older persons with available area services; (5) continuing adult education—socialization; (6) consumer information, education, and protection; and other broad problem areas.

The selection of such narrow problem areas as (food) nutrition, transportation, employment, housing, social services, or recreation, when viewed as separate efforts will be unacceptable for purposes of the areawide model project program. Since a major goal of the program is to find comprehensive solutions to major problems, all of the separate problems noted above may be related to the solution of a specific problem faced by older people living in a specific area.

A major goal of the areawide model project program is to demonstrate alternative ways in which existing resources can be utilized to a maximum extent for meeting the needs of the elderly. In every case, the identification of needs and development of plans of action must be carried out on a cooperative basis by all appropriate agencies and programs within the community. In addition, the plan developed must provide for cooperative and joint efforts in the delivery of services and activities under the plan—including joint funding. The resources of the areawide model project program will be available only to assist in the

implementation of those plans containing highly innovative potentially successful activities, and extensive financial participation and cooperative program activities by other agencies and programs of the project area.

When a State receives an areawide model project award, the State agency on aging will be expected to employ a qualified staff person to work full time in providing leadership, technical assistance, and support to the project. The primary mission of this individual is to provide on-going linkage between the regional office, SRS, and the project, and to facilitate the participation of other State agencies and programs in the areawide model project.

Operation of an Areawide Model Project

In order to receive an award, the designated State agency must propose the development and conduct of the project in a high-priority geographic area of the State in keeping with provisions of the regulations as approved. Such regulatory provisions include:

1. The designation of a suitable local agency of general purpose government, a local private nonprofit agency, or other local agency or entity receiving the approval of the Administration on Aging to conduct the project (if such project is not to be conducted directly by the State agency);

2. Provide for the formation of an area task force comprised of older persons and representatives of the major public and private agencies of the area having programs affecting the elderly and for quartering of such task force in the local agency designated for the project (if any). Such task force shall assist in the development and implementation of the project, which shall include the following functions;

(*a*) Identification or updating of data on a specific problem of the elderly of the project area.

(*b*) Planning on behalf of the elderly on an on-going basis.

(*c*) Development of a plan of action containing innovative program designs or alternative solutions, with special emphasis on cooperative and combined agency activity and joint funding arrangements for meeting the objectives of the areawide model project program and the highest priority needs of the elderly identified.

(*d*) Implementation of the plan developed on behalf of all older persons of the area having need for such services or activities specified in the plan.

3. The hiring of a qualified staff person employed full time at the project level by the State agency or by the designated local agency, if any, to coordinate the activities of the area task force and to direct the implementation of the plan of action developed (if approved by the Administration on Aging), and the employment of such additional staff members as may be necessary to operate the project.

The designated State agency on aging will, in every case, be the grantee of awards for an areawide model project. As such, the State agency will retain overall responsibility for the project. However, the act provides for a State to operate an areawide model project through contractual arrangements. Where such contractual arrangements are

entered into, the local agency designated will be responsible for the conduct of the project at the local level. Such local agency will provide day-to-day leadership for the project, overall administrative and management control, program evaluation, and staff support to the area task force formed to assist in the development and implementation of the project. It is anticipated that the plan developed by the project will consist of a number of individual, but related, program components. The individual components of such plan (for example: a transportation service, in-home services, volunteer activities, and counseling service, et cetera, required to alleviate a particular problem in a comprehensive manner) will be expected to be carried out by existing or newly established service delivery mechanisms of the community, not by the designated State or local agency.

Considerable flexibility is provided for individual projects. Priority will be given to those proposals which offer the great potential for achieving the program's objectives. Priority will be determined by such factors as: (1) the capacity of the designated community agency (if any); (2) the capacity of individuals represented on the project task force to commit staff and financial resources to the project; and (3) the extent of the overall commitment by the area for cooperative and collaborative activities and joint funding arrangements.

Important to the successful completion of the project is the caliber of staff chosen to head the project. Considerable attention should be devoted to the qualifications and experience of the individual chosen for this responsibility.

National Implementation of the Areawide Model Project Program

Initially, the Administration on Aging will implement the areawide model project program as a national demonstration program. Since one of the major goals for the program is to have the locations at which projects are conducted become model demonstration and training sites for other communities and program leaders, potential applicants and proposals will be screened and final awards made with great care. The staff of the Social and Rehabilitation Service Regional Office will play a major role in all phases of the implementation of this program.

Criteria to be used by Regional Office staff in selecting potential State agencies will include:

1. The leadership, staff, and organizational capacity to achieve cooperative and financial assistance from other major State agencies for the areawide model project as evidenced by progress in statewide planning activities.
2. The contribution of State moneys for earning Federal funds under this program.
3. The capacity and willingness to cooperate with a regional task force formed for this program, such task force having responsibility to provide ongoing technical and program assistance to the project at the local level.

Criteria to be used in determining potential project sites within States selected include the following:

1. An appropriate geographic area

The project area should be—

(*a*) Compact, cohesive, and of manageable size.

(*b*) A single geographic area.

(*c*) Of adequate size to include a significant target population of older persons, including a high percentage of low income and minority group older persons.

2. Demonstrated commitment on behalf of the elderly

The past performance of the proposed project area on behalf of the elderly should include—

(*a*) Financial support for local projects on aging.

(*b*) Participation in national programs designed to improve the lives of the elderly, such as adult social services under the Social Security Act; public and middle-income housing, medicaid, etc.

(*c*) Planning on behalf of the elderly in the proposed project area, either through an established overall planning organization, or planning specifically for the elderly, including model city or 1971 White House Conference on Aging activities in which the needs of the elderly have been identified.

(*d*) Public and private agency and citizen involvement on behalf of older persons on an ongoing basis in the form of a council, commission, or office on aging, or other similar organizations.

3. Receptivity of the area to participate in the areawide model project

(*a*) Commitments should be available from the agencies and programs of the area to earmark funds, staff, facilities, or other resources to support the project.

(*b*) The agency designated to conduct the project (if any) should have the capability to assure that the project will receive high visibility, support, and effective leadership.

(*c*) The individual chosen for project director should be highly qualified through experience and training, to assume effective overall leadership for the project.

(*d*) The representatives appointed to the area task force should consist of individuals with the authority to plan and make financial and staff commitments to the project on behalf of the agency they represent.

Through application of the above criteria, potential State agencies and local sites will be narrowed to those having the greatest potential for achieving the objectives of the areawide model project program with a high degree of success.

SUMMARY

Implemented as a national demonstration program, areawide model projects will seek to develop and implement innovative program designs for meeting identified high priority needs of the elderly. Special consideration will be given to those projects proposing cooperative activities between the agencies and programs of the area to meet the objectives of the project, including joint funding. Locations at which areawide model projects are conducted will be utilized as model demonstration and training sites for other State and community leaders seeking innovative solutions to the problems of the elderly.

AREAWIDE MODEL PROJECT AWARDS—FISCAL YEAR 1971

Maine: The designated project area includes the counties of Androscoggin, Franklin, and Oxford, located in central west Maine, and combining rural and urban areas. The area also includes a model city. The project will focus on improving accessibility of services for the elderly. The project is notable for advanced statewide planning effort and commitment of State and community support. The project will be operated directly by the State agency. The amount of the award for the first project year is $234,543.

Mississippi: The project area includes the coastal counties of Hancock, Harrison, and Jackson. This area was hard hit by Hurricane Camille 2 years ago and affected many elderly persons who lost their homes and are not yet successfully relocated. Poor housing conditions and lack of alternatives to institutional care have resulted in the project's focus on developing alternative living arrangements for these elderly persons affected. The State agency has contracted with the Southern Mississippi Economic Development District for the conduct of the project. The amount of the award for the first project year is $261,863.

Nebraska: The designated project area includes the city of Lincoln and Lancaster County. The project will seek to develop alternatives to unnecessary institutionalization of older people which has been a major problem, statewise, for some time. The project will be operated out of the office of the mayor of Lincoln, with whom the State agency has contracted for conducting the project. The amount of the award for the first project year is $220,000.

Oregon: The project area encompasses the city of Portland and Multnomah County. The project will seek to develop alternatives to institutionalization of the elderly through improved health services designed to delay or prevent physical and mental deterioration. In addition to the Administration on Aging areawide grant, the Model City Agency in Portland is making a major commitment of funds and the existing and effective city-county council on aging is providing support of staff and resources. The State agency has, also, contracted with the council for the conduct of the project. The amount of the award for the first project year is $250,000.

Puerto Rico: The selected area includes Rio Piedras, the San Juan (Urban Renewal District's I and II and adjacent areas). The project will focus on the problem of isolation of senior citizens. The older residents of the area have extremely low per capita incomes and are in need of services, particularly those related to health. Commonwealth support and wide community participation has been promised. The project will be operated directly by the State agency. The amount of the award for the first project year is $220,000.

South Carolina: The project area includes the six counties of South Carolina's Appalachian area—Anderson, Occonee, Pickens, Greenville, Spartanburg, and Cherokee. The project plans to focus on improving the level of physical and mental health of older people, through the development of linkages with existing health and related services and the development of new services. The project will be operated directly by the State agency. The amount of the award for the first project year is $234,705.

Texas: The project includes the city of Houston which also includes a large Model Neighborhood area. The project has identified the isolation of the elderly as the major problem. It plans to attack this problem through the development of services to prevent institutionalization, services to elderly in crises situations, and services to elderly in nursing homes. The area includes a significant number of older Mexican Americans. The city demonstration agency and other area agencies have provided large commitments of funds. The State agency will operate the project directly. The amount of the award for the first project year is $250,000.

Utah: The project area encompasses Salt Lake County, which includes a model city in the city of Salt Lake. The project will seek to develop preventative methods for unnecessary institutionalization of older persons because of the lack of alternative living arrangements. The project will also work to develop in-home supportive services. The State agency has contracted for the conduct of the project with the Salt Lake County Council on Aging which has been an effective instrument in the past for addressing elderly needs. The amount of the award for the first project year is $250,000.

Virginia: The project area encompasses the Southeastern Virginia Planning District #20 including the cities of Norfolk, Chesapeake, and Portsmouth. Norfolk is also a model city. The State agency will operate the program directly; however, it has contracted with the local Health, Welfare, and Recreation, Planning Council to conduct the activities related to the first 120-day planning period. The project will seek to aid isolated and withdrawn older people and provide new, or make more accessible, existing services and programs. A heavy concentration of black elderly reside in the district. The amount of the award for the first project year is $260,817.

TITLE 45—PUBLIC WELFARE

CHAPTER IX—ADMINISTRATION ON AGING SOCIAL AND REHABILITATION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FEDERAL REGULATIONS

SUBPART B—AREAWIDE MODEL PROJECTS ON AGING

§ 903.70 General.

Through grants to or contracts with State agencies as designated under § 903.10, the Commissioner is authorized to pay not more than 75 per centum of the cost of the development and operation of statewide, regional, metropolitan area, county, city, or other areawide model projects for carrying out the purpose of Title III of the Act to be conducted by State agencies either directly or through contractual arrangements. Sections 903.71–903.82 deal with grants and § 903.83 with contracts.

§ 903.71 Program Objective.

The objective of the Areawide Model Project on Aging program is to determine in geographic areas of high priority the needs of the elderly citizens, to satisfy these needs on a priority basis, and to change those conditions which either directly or indirectly pose significant

barriers to those older persons who desire to live independently in the community and to participate in a full and meaningful way in community life.

§ 903.72 Conditions for approval of awards.

(a) Each application under this subpart submitted by a State agency shall include only on Areawide Model Project.

(b) Consideration will be given under this subpart only to those applications submitted by State agencies which:

(1) Establish that the area chosen for the conduct of the project contains large numbers of older persons, including a high percentage of individuals of low income;

(2) Provide for the designation of a suitable local agency of general purpose government, a local private nonprofit agency, or other local agency or entity approved by the Administration on Aging to conduct the project if the project is not to be conducted directly by the State agency, and set forth the contractual arrangement between the State agency and the local agency with respect to the conduct of the project. Such local agency must have the capacity to achieve the objective of the project throughout the area;

(3) Provide for the formation of a task force comprised of older persons and representatives of the major public and private agencies of the area having programs affecting the elderly; and for quartering of such task force in or by the local agency designated for the project. if any. Such task force shall assist in the development and implementation of the project which shall include the following functions:

(i) Identification of or updating data on the specific needs of the elderly of the area, and listing such needs in order of priority;

(ii) Planning on behalf of the elderly on an ongoing basis;

(iii) Development of a plan of action containing innovative program designs or alternative solutions, with special emphasis on cooperative and combined agency activity and joint funding arrangements, for meeting the objectives of the Areawide Model Project program and the highest priority needs of the elderly identified; and

(iv) Implementation of the plan developed on behalf of all older persons of the area having need for such services or activities specified in the plan.

(4) Propose to utilize to a maximum extent the existing public and private resources of the area to meet the needs and problems of the elderly which have been identified;

(5) Contain commitments from public and private agencies for joint and cooperative activities by such agencies to a maximum extent possible in the planning and implementation of the plan including joint funding;

(6) Contain recognition for the project from the major political jurisdiction of the area;

(7) Provide for the use of State financial resources, wherever available, for meeting part of the cost of the product;

(8) Provide for the interrelationship of the project proposed with other related comprehensive planning or service delivery efforts of the area (if any);

(9) Provide for the employment by the State agency of a qualified staff person who will work full time, in providing leadership, technical assistance, and support to the Area-wide Model Projects in the State;

(10) Provide that there will be a qualified staff person employed full time at the project level by the State agency or by the designated local agency, if any, to coordinate the activities of the task force and to direct the implementation of the plan developed under subparagraph (3)(iii) of this paragraph, and the employment of such additional staff member as may be necessary to operate the project; and

(11) Set forth a budget containing proposed estimated expenditures for a budget period covering 12 months of project operations

§ 903.73 Categories of older persons

The plan proposed under § 903.72 must have as its goal that services or activities of the project be available and accessible to all older persons of the project area having need for such services or activities. Provision must be made for special efforts to reach low income older persons having need for such services.

§ 903.74 Eligible applicants and review of applications.

(a) Any State agency designated under § 903.10 may file an application for an Areawide Model Project on Aging with the Commissioner. Such application shall be submitted in writing and in accordance with guidelines issued by the Commissioner. The application shall be executed by an individual authorized to act for the applicant agency and to assume the obligations imposed by the terms and conditions of any award, including the regulations of this subpart.

(b) Applicants may be requested to submit additional information while a project application is being considered by the Administration on Aging. All applications which meet the legal requirements for an award will be considered for funding. The Commissioner will determine the action to be taken with respect to each application and notify the applicant accordingly in writing.

§ 903.75 Awards.

Within the limits of funds available for such purpose, the Commissioner will award a grant to those applicants whose proposed projects will, in his judgement, best promote the purposes of Title III of the Act and the objectives set forth in this subpart. All grant awards shall be in writing, shall set forth the amount of funds granted, and shall constitute for such amounts the encumbrance of Federal funds available for such purpose on the date of the award. The initial award shall also specify the project period for which support is contemplated if the activity is satisfactorily carried out and Federal funds are available. For continuation support within the project period, grantees must make separate application in accordance with the guidelines established.

§ 903.76 Project revisions.

Projects shall be conducted in accordance with the provisions of the application as it is approved. A project grantee shall request in writing that a project be revised whenever it is proposed that the approved plan of operation or method of financing will be materially changed.

The request for revision shall be submitted for approval in the same manner as the original application. Project revisions may be initiated by the Commissioner, if, on the basis of reports, it appears that the project is ineffective, or if changes are made in Federal appropriations, laws, regulations, or policies governing Areawide Model Projects.

§ 903.77 Program evaluation.

The plan developed under an Areawide Model Project must propose a feasible plan, including participation in a national evaluation of the Areawide Model Project program, to evaluate the extent to which the objectives set forth under this subpart are being met, and the impact of the program on the lives of the elderly in the project area.

§ 903.78 Payments.

The Commissioner shall from time to time make payments to a grantee of all or a portion of any grant award either in advance or by way of reimbursement for expenses to be incurred or incurred in the project period, to the extent he determines such payments necessary to promote prompt initiation and advancement of the approved project. All such payments shall be recorded by the grantee in accounting records separate from all other fund accounts, including funds derived from other grant awards. Amounts paid shall be available for expenditure by the grantee in accordance with the regulations of this subpart throughout the project period subject to such limitations as the Commissioner may prescribe.

§ 903.79 Termination.

A grant may be terminated in whole or part at any time at the discretion of the Commissioner. Noncancelable obligations properly incurred prior to the receipt of the notice of termination will be honored. The grantee shall be promptly notified of such termination in writing and given the reasons therefor.

§ 903.80 Reports.

The grantee shall make such reports to the Commissioner including reports of findings and results of evaluation, in such form and containing such information as may reasonably be necessary to enable him to perform his functions under this subpart and shall keep such records and afford such access thereto as the Commissioner may find necessary to assure the correctness and verification of such reports.

§ 903.81 Expenditures.

Grants under this subpart will be available to pay not to exceed 75 per centum of the costs of the project necessary to carry out the objectives set forth under this subpart and in keeping with policies set forth in Bureau of the Budget Circular A–87, or its revision.

§ 903.82 Audits.

All fiscal transactions by a grantee relating to grants under section 305 of the Act are subject to audit by the Department to determine whether expenditures have been made in accordance with the Act and this subpart.

§ 903.83 Contracts.

(a) Eligibility. Subject to applicable provisions in this subpart, the Commissioner is authorized to make contracts with State agencies designated under § 903.10 to carry out the purposes of Title III and section 305 of the Act.

(b) Provisions. Any contract under this subpart shall be entered into in accordance with, and shall conform to all applicable laws, regulations and Department policy.

(c) Payments. Payments under any contract under this subpart may be made in advance or by way of reimbursement and in such installments and on such conditions as the Commissioner may determine.

(Sec. 101 et seq., 79 Stat. 218–226, 81 Stat, 106–108, 92 Stat. 1101, 83 Stat. 108–115; 42 U.S.C. 3001 et seq.)

Effective date. These amendments shall become effective on the date of publication in the Federal Register (6–29–71).

Dated: June 14, 1971.

JOHN D. TWINAME,
Administrator, Social and Rehabilitation Service.

Approved: June 25, 1971.

ELLIOT L. RICHARDSON,
Secretary.

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