The original documents are located in Box 2, folder "Aging - General (3)" of the Sarah C. Massengale Files at the Gerald R. Ford Presidential Library.

THE WHITE HOUSE

WASHINGTON

January 20, 1976

MEETING WITH MEMBERS OF THE AMERICAN ASSOCIATION
OF RETIRED PERSONS (AARP) AND THE NATIONAL
RETIRED TEACHERS ASSOCIATION (NRTA)
Wednesday, January 21, 1976
2:45 p.m. (10 minutes)
State Dining Room

From: Jim Cannon

I. PURPOSE

To greet the members of the Legislative Council of AARP and NRTA and to receive a book from the Presidents of the organizations.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background: The Legislative Council of AARP and NRTA will be meeting in Washington to determine their legislative objectives for 1976. AARP and NRTA are two groups, jointly operated, which represent about 9 million older persons. Both have very active, well thought of volunteer programs.

The Presidents of AARP and NRTA will present to you a book written by the founder of the two organizations which expresses the author's and the group's philosophy of the importance of self-determination and of service by older persons to the community.

After you and Mrs. Ford greet them, the group will be taken on a tour of the White House.

B. Participants: List attached at Tab A.

C. Press Plan: Full Press Opportunity. Meeting to be announced.

III. TALKING POINTS

To be provided by Paul Theis.

LEGISLATIVE COUNCIL

OFFICERS

*Miss Mary Mullen
President, NRTA
Laguna Beach, CA

*Mr. & Mrs. Douglas O. Woodruff
President, AARP
Salt Lake City, UT

Dr. & Mrs. J. Cloyd Miller
President-Elect, NRTA
Albuquerque, NM

Mr. & Mrs. A. H. Van Landingham
President-Elect, AARP
Morgantown, WV

Mr. & Mrs. George Schluderberg
Chairman
NRTA Board of Directors
Baltimore, MD

Mrs. Maud Haines
Chairman
AARP Board of Directors
Portland, ME

Mrs. Ruth Lana
Honorary President
Long Beach, CA

Miss Hariet Miller
Acting Executive Director
Washington, D.C.

MEMBERS

Mr. J. E. Aldridge, NRTA
Jackson, MS

Miss Oranda Bangsberg, AARP
Oshkosh, WS

Miss Kathleen V. Boyd, NRTA
Narragansett, RI

Mr. Henry Bertuleit, AARP
Fremont, CA

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Corpus Christi, TX

Mr. & Mrs. Edgar Scheid, AARP
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Mrs. Vera Weinlandt, AARP
Bloomfield, NJ

*Miss Mullen and Mr. Woodruff will present the book to you.

JOINT STATE LEGISLATIVE COMMITTEE CHAIRMEN

Mr. & Mrs. T. Preston Turner, NRTA
Richmond, VA

Mr. Isaac Fine, AARP
Falmouth, MA

Mr. Creel Richardson, NRTA
Ariton, AL

Mr. & Mrs. George Saunders, AARP
Sun City, AR

Mr. & Mrs. Francis W. Beedon, NRTA
Muskegon, MI

LEGISLATIVE STAFF

Mr. Cyril F. Brickfield, Counsel

Mr. Peter W. Hughes
Assistant Legislative Counsel

Mr. Harmon Burns, Jr.
Assistant Legislative Counsel

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Legislative Representative

Mr. Malachy M. McPadden
Legislative Representative

Mr. James M. Hacking
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file DRAFT

#1

STATE OF THE UNION MESSAGE
SECTION ON THE ELDERLY

[1976]

The elderly are a special concern to me. They have contributed to our society over the years and have earned a well-deserved retirement.

Because so many elderly persons are living on fixed incomes, the single most important problem affecting them today is inflation. As I said before, I pledge to continue all efforts to combat the inflationary trends and to restore economic stability. I believe that this, more than anything else, will help the elderly, as well as all other Americans.

I am also very concerned about the isolation of older people and its bad effects on them. To combat isolation and to keep the aged involved in the life of the community, we have established a national network organization. It consists of the Administration on Aging in the Department of Health, Education and Welfare, State Agencies on Aging, 489 Area Agencies on Aging, and 682 local agencies. Through this network, the development of community centers is stimulated where the elderly can come together to socialize and to have a hot meal. The community center provides a place and people that care and ~~all~~ are interested in those that come.

I am also concerned about the elderly when they are ill, ~~and I am~~ especially ~~concerned~~ when they have to move

out of their own homes. We are making every effort to help the elderly stay in their own homes and communities. We are trying to help the older person retain their independence and mobility with innovative demonstration projects in transportation. Through the networks, we provide supportive social services. For example, A homemaker comes to the home of an older person to help clean, make repairs and provide companionship. The Meals on Wheels program brings a hot meal to an elderly person right at home.

The importance of volunteers in these efforts cannot be overlooked. The nutrition program for older persons is now serving approximately 250,000 meals five days a week at about 4,900 sites. Approximately 62,000 volunteers are giving their time and effort to implement this program. In addition, 158 national voluntary organizations are participating in a program -- Project Independence -- sponsored by the National Council on Aging and designed to assist in the delivery of services which will enable older persons to continue to live in their own homes.

When an older person does become ill, the medicare and medicaid systems provide doctor, hospital and support services. ~~Last year~~ In FY 1975 $~~10.7 billion from~~ 12.6 billion in medicare benefits and $~~5.6 billion~~ 2.3 billion in ~~from~~ medicaid payments was spent to provide care ~~for the elderly.~~ for the elderly. We are making every effort to assure and upgrade the quality of services delivered through medicaid and medicare and at the same time to control the increases in cost.

As a general rule we prefer to see people living a normal life at home and in the community. Unfortunately, at times it is necessary to leave home and be cared for in an institution for long-term care. To assure the ~~safety~~ well being of these persons, we have developed life and safety standards for nursing homes. This is of the highest priority.

We also are carefully reviewing the questions of disability and long-term care. We are making an assessment of needs and an evaluation of current and proposed programs and will be making recommendations in this area.

I am very pleased that the National Institute on Aging which was recently organized under the National Institutes of Health has an active research program on aging. In FY 75 ~~$~~ $5.1 million ~~were spent on in-house research and studies and grants to private researchers~~ & $10.2 million on extramural research.

Finally, the financial situation of those over 65 is one of my major concerns. A financial backstop and income security is provided to the elderly poor through the Supplemental Security Income program. Great improvements have been made through SSI; a million more people are now receiving these income supplements than previously. It is a tremendously effective system. It is new and ~~it~~ was implemented rapidly. Administration of the program is being improved and streamlined to deliver services with minimal problems and minimal additional cost to the taxpayer.

Income security for retirees is of paramount importance. We are closely watching the social security system. Let me reassure you that it <u>is</u> a sound system and we will see that it <u>stays</u> sound. We are taking steps necessary to ensure the stability of the Social Security System and to ensure that our children will deserve ~~also~~ benefits from the system as we do.

#2

STATE OF THE UNION DRAFT STATEMENT - ELDERLY

We have arrived at a point where government is too big and imposes too many rules and regulations on American citizens and enterprises. As you know, I am attempting to reduce the size of the government and to return a greater degree of freedom and initiative to our citizens.

There are, however, certain functions of government which have evolved over time which are proper and necessary. One of these in which I believe is the responsibility to provide for older Americans -- people who have worked long and hard and have contributed to the well-being of our country.

We now assist the elderly in many ways. I believe that we should continue to do so. There will be disagreement about the level of funding for these programs, but I think we can all agree that the elderly have earned our support and assistance.

Because so many elderly persons are living on fixed incomes, the single most important problem affecting them today is inflation. As I have said before, I pledge to continue all efforts to combat the inflationary trends and to restore economic stability. I believe that this, more than anything else, will help the elderly, as well as all other Americans.

Older Americans are aided by a variety of programs including health services, transportation programs and social services. Let me describe just a few of these.

To combat isolation and to aide the aged in staying involved in the life of the community, we have established a national network organization. It consists of the Administration on Aging in the Department of Health, Education and Welfare, and state, area, ~~Agencies on Aging~~ and local agencies on aging. Through this network, the delivery of a variety of services for the elderly is coordinated. Such things as the development of community centers is stimulated where the elderly can come together to socialize and to have a hot meal. These community centers provide a place for working and socializing and people that care and are interested in those that come.

We are making every effort to help the elderly stay in their own homes and communities. We are trying to help the older person retain their independence and mobility, ~~with,~~ for example, with innovative demonstration projects in transportation. Also, through the networks, supportive social services to help the elderly keep their homes are provided. For example, a homemaker comes to the home of an older person to help clean, to make repairs and to provide companionship. And the Meals on Wheels program brings a hot meal to an elderly person right at home.

The importance of volunteers in these efforts cannot be overlooked. The nutrition program for older persons is now serving approximately 250,000 meals five days a week at about 4,900 sites. Approximately 62,000 volunteers are giving their

time and effort to implement this program. In addition, 158 national voluntary organizations are participating in a program -- Project Independence -- sponsored by the National Council on Aging and designed to assist in the delivery of services which will enable older persons to continue to live in their own homes.

When an older person does become ill, our health system through medicare and medicaid provides doctor, hospital and support services. In FY 1975 $12.6 billion in medicare benefits and $2.3 billion in medicaid benefits was spent to provide care for the elderly. We are making every effort to assure and upgrade the quality of services delivered through medicaid and medicare and at the same time to control the increases in cost.

Generally, I prefer to see people living a normal life at home and in the community. Unfortunately, at times it becomes necessary to leave home to be cared for in an institution for long-term care. To assure the well-being and safety of these persons, we have developed life and safety standards for nursing homes. I consider this to be of the highest priority.

We also are carefully reviewing the questions of disability and long-term care. We are making an assessment of needs and an evaluation of current and proposed programs and will be making recommendations in this area.

I am very pleased that the National Institute on Aging which was recently organized under the National Institutes of Health has an active research program on aging. In FY 75 $5.1 million was spent on in-house research and $10.2 million on extramural research.

Finally, the financial situation of those over 65 is one of my major concerns. A financial backstop and income security is provided to the elderly poor through the Supplemental Security Income program. Great improvements have been made through SSI; a million more people are now receiving these income supplements than previously. It is a tremendously effective system. It is new and was implemented rapidly. Administration of the program is being improved and streamlined to deliver services with minimal problems and minimal additional cost to the taxpayer.

Income security for the retired is of paramount importance. We are closely watching the social security system. Let me reassure you that it is a sound system and we will see that it stays sound. We are taking steps necessary to ensure the stability of the Social Security System and to ensure that our children will derive benefits from the system as we do.

[Feb 1976]

We are a nation that is aging. Today one of every seven Americans is over 60, as compared to only one in 15 at the turn of the century. By the year 2000, over 40 million persons will be in this category, 9 million more than today.

As a people, we are living longer and better than our ancestors. There are many accomplishments we can take pride in as we pause to reflect on our progress this Bicentennial year.

But we know that many who grow old in America today have inadequate income, health care, nutrition and lack the opportunities to remain involved in society. Our progress confronts us with a challenge to assure that older persons continue to share and contribute to the life and wealth of our society.

We have made progress in recent years in our efforts to meet this challenge. We have responded, for example, to recommendations made at the 1971 White House Conference on Aging to enact a Supplemental Security Income program, increase social security benefits more than the cost of living, liberalize the social security retirement test, increase benefits for delayed retirement, eliminate some of the inequities in payments to women, and protect 35 million workers investments in private pension plans.

A major accomplishment has been the strengthening of the Older Americans Act. Today nearly 500 Area Agencies on Aging are in operation in communities throughout the country coordinating comprehensive service systems for older persons.

Also, the Title VII Nutrition Program provides for about 300,000 hot meals for older persons at 5,000 sites all over the nation.

However we have no reason to be complacent. Conditions call for continued and intensified action for the aging.

I have supported the concept of the Older Americans Act since its inception in 1965 and signed the most recent amendments into law this past November. A key component of this Act was the national network on aging which provides a solid foundation on which action can be based. I am pleased that the Federal Government has helped to set up this network composed of State and Area Agencies on Aging and 700 nutrition agencies. The system, with the assistance of thousands of volunteers -- many of whom themselves are older persons -- can and must assure older persons an active role and place in community life.

Another concern of mine is that the voice of the aged, as consumers, be heard in the governmental decisionmaking process. The network offers opportunities for this through advisory council membership, public hearings, and input in the priority setting process at the local level.

Another concern of mine is that the voice of consumers, both young and old, be heard in the governmental decision-making process. The network offers opportunities for this:

-- Area agencies are responsible for establishing priorities for services for older persons at the local level where older consumers can communicate and influence the process;

-- Older consumers have the opportunity of testifying at public hearings on the annual plans of the State, Area and Nutrition Agencies on Aging.

-- At lease half the members of every State, Area and Nutrition Agency on Aging advisory council must be older consumers.

The ultimate objective of the national network on aging is to make contributions to developing at the community level a coordinated and comprehensive system for the delivery of services to older persons -- a system which will enable older persons to live in their own homes for as long as possible.

I join with all Americans in expressing the hope that this objective can be achieved. This will call for hard and creative work at all levels of the network -- Federal, State and Area. I call upon all Federal Departments and Agencies to cooperate in facilitating the coordination of all available Federal resources for services for older persons at the State and

community levels. I laud the efforts made by the Administration on Aging and the Federal Departments and Agencies who have signed agreements to work together to avoid waste and overcome administrative difficulties.

In addition to the progress made by these programs, income security is essential to the continued well-being and quality of life of those over sixty. Therefore, I am asking the Congress to grant a full cost of living increase in social security benefits in 1976. This will help those on fixed incomes to keep pace with the cost of living.

I am very concerned about the financial integrity of the Social Security trust fund. Unless we take action soon, the fund will be exhausted by 1983. To protect the social security system, on which so many citizens rely for income security, I am submitting legislation to the Congress to increase payroll taxes by three-tenths of a percent each for employees and employers. This increase will cost workers less than $1 a week and will help stabilize the trust funds so that current and future recipients can be assured of the benefits that they have earned.

Another crucial problem with the Social Security system is a flaw which overadjusts the benefits of <u>future</u> retirees to inflation. The current formula which determines future benefits for workers increases the weighting of earnings by the rate of inflation. Since wages normally grow with inflation, the

result is an overcompensation -- commonly referred to as a "coupled" system. Since there is a consensus that the inflation adjustment in the formula should be eliminated, thus "decoupling" the system, I am submitting legislation to the Congress to "decouple." This change will not affect the cost of living increases in benefits after retirement.

The normal health care needs of older Americans, with the special medical problems of aging -- degenerative and chronic disease -- require greater resources and commitment than the rest of the population. Many of those medical needs are not through the normal health care delivery system with the support Medicare and Medicaid. One major problem facing older Americans and their families is that of catastrophic illness. Few can afford to bear the costs of prolonged illness.

To alleviate the threat of this financial burden, I propose that Medicare beneficiaries be provided protection against catastrophic health costs by limiting the amounts an individual must pay annually to $500 for covered hospital care and $250 for covered physicians' services. While this will result in increased cost sharing by persons eligible for medicare steps will be taken to control the amount doctors and health institutions will be reimbursed.

I have pointed out, our progress has been substantial; but the challenge grows. Every resource of government must be brought to bear to continue to meet the changing needs of

older Americans, as well as, offer complete opportunity for those over 60 to participate fully in that process. Only in this way can we assure that our performance meets our promise.

We are a nation that is aging. Today one of every seven Americans is over 60, as compared to only one in 15 at the turn of the century. By the year 2000, over 40 million persons will be in this category, nine million more than today.

While it is true that as a people, we are living longer and better than our ancestors I know that many who grow old in America today have insufficient income, inadequate health care, poor nutrition and lack even the most basic opportunities to remain purposefully involved in society. We therefore must recognize the challenge of assuring that older persons continue to share in and contribute to life in our communities.

As President I intend to meet this challenge. I am pleased today to submit to the Congress two proposals that address income and health security. I feel that my proposals offer significant improvements in the quality of life of older Americans.

We must begin by asserting that the value of the Social Security system is beyond challenge. Maintaining the integrity of the system is a vital obligation each generation has to those who have worked hard and contributed to it all their lives. I strongly reaffirm my commitment to a stable and financially sound Social Security system. My 1977 budget and legislative program include several elements which I believe are essential.

First, to assist in protecting our retired and disabled citizens against the hardships of inflation, my budget request

to the Congress includes a full cost of living increase in Social Security benefits, effective July 1, 1976.

The Social Security trust fund is currently paying out more in benefits than its payroll tax receipts. To insure the financial integrity of the trust funds, I am proposing legislation to increase payroll taxes by three-tenths of one percent each for employees and employers. This increase will cost workers less than $1 a week more and will help stabilize the trust fund assets so that current and future recipients can be assured that they will receive the benefits that they have earned.

I am also taking steps to avoid serious future financing problems which will result if we do not act now to correct a flaw in the current system which overadjusts the benefits of future retirees to inflation. The current formula which determines future benefits for workers overcompensates for inflation. This change will not affect cost of living increases in benefits after retirement and will in no way alter the benefit levels of current recipients.

I believe that the prompt enactment of these proposals is necessary to revitalize our Social Security system and to keep it strong for future generations.

The normal health care needs of older Americans, with the special medical problems of aging -- degenerative and chronic disease -- require greater resources and commitment than the rest of the population. Many of those medical needs are met

through the normal health care delivery system with the support of Medicare and other Federal health programs.

I have identified three issues related to the operation of the Medicare program for which I am recommending solutions.

In my State of the Union Address I proposed catastrophic health insurance for everyone covered by medicare. This proposal is based on my conviction that there is a need to protect the aged and the disabled from the extraordinary hospital and medical costs of prolonged illnesses. To alleviate the threat of this financial burden, I propose that Medicare beneficiaries be provided protection against catastrophic health costs by limiting the amounts an individual must pay annually to $500 for covered hospital care and $250 for covered physicians' services. The burden of catastrophic illness can be borne by very few older people. This proposal will eliminate this fear from the lives of the elderly and their families.

Added steps are needed to slow down the inflation of health costs and to enable the financing of this catastrophic protection. Therefore, I am recommending that the Congress limit increases in Medicare payment rates in 1977 and 1978 to 7% day for hospitals and 4% for physician services.

Additional cost-sharing provisions are needed in order to encourage economical use of services for short hospital stays and routine physician care. Therefore, I am recommending that patients pay 10% of hospital and nursing home charges after

the first day and that the existing deductible for medical services be increased from $60 to $77 annually.

Some of the savings from placing a limit on increases in medicare payment rates and some of the revenue from increased cost sharing will be used to finance the catastrophic program. I believe that the effect of short term costs increases will be greatly outweighed by the benefits of catastrophic protection.

In addition to submitting proposals relating to income and health services, I desire to underline my conviction that current conditions call for continued and intensified action for the aging on a broad front.

We have made progress in recent years. We have responded, for example, to recommendations made at the 1971 White House Conference on Aging to enact a Supplemental Security Income program, increase social security benefits more than the cost of living, liberalize the social security retirement test, increase benefits for delayed retirement, eliminate some of the inequities in payments to women, and protect 35 million workers investments in private pension plans.

In addition we have continued to strengthen the Older Americans Act. I have supported the concept of the Older Americans Act since its inception in 1965 and signed the most recent amendments into law this past November. Funds available

for programs administered by the Administration on Aging under this Act have increased from $44.7 million in FY 1972 to $270 million during the last fiscal year. A key component of the Older Americans Act is the national network on aging which provides a solid foundation on which action can be based. I am pleased that the Federal Government has helped to set up this network composed of 56 State and 489 Area Agencies on Aging and 700 nutrition agencies. These nutrition agencies provide 300,000 hot meals a day five days a week. The system, with the assistance of thousands of volunteers -- many of whom themselves are older persons -- can and must not only help meet the needs of older persons but also

Another concern of mine is that the voice of the aged, as consumers, be heard in the governmental decisionmaking process. The network on aging offers opportunities for this through membership on advisory councils, participation in regional public hearings, and involvement in the priority setting process for services at the local level.

The ultimate objective of the national network on aging is to make contributions to developing at the community level a coordinated and comprehensive system for the delivery of services to older persons.

I join with all Americans in expressing the hope that this objective can be achieved. This will call for hard and creative work at all levels of the network -- Federal, State and Area. I call upon all Federal Departments and Agencies to cooperate in facilitating the coordination of all available Federal resources for services for older persons at the State and community levels. I laud the efforts made by the Administration on Aging and the Federal Departments and Agencies who have signed agreements to work together to avoid

waste and overcome administrative difficulties. These agreements will help to make available to older persons a "fair share" of the resources requested in my 1977 budget in such areas as housing, transportation, social services, law enforcement, adult education and manpower -- resources which can play a major role in enabling older persons to live in their own homes for as long as possible.

Five percent, however, of our older men and women require the assistance provided by skilled nursing homes and other long term care facilities. An ombudsman process, related solely to the persons in these facilities, is being put into operation by the national network at the level of the Area Agencies on Aging. It is my hope that this program will not only help to resolve individual complaints but that it will also facilitate citizen involvement in the vigorous enforcement of Federal, State and local laws designed to improve health and safety standards as well as quality of care in these facilities. This nation can do no less for those who spend the last days of their lives in institutions.

We must never lose sight of our obligations to help deal with the needs of older persons. At the same time we must not overlook the fact that older persons constitute one of the nation's greatest resources because of the contributions they are capable of making to our society. We are seriously

short-changing our nation when we deny older persons the opportunity for continued productive involvement in our society.

This is why my budget for 1977 calls for increases in the ACTION programs designed to provide older persons with the opportunity for constructive service. Non-involvement on the part of older persons leads oftentimes to rapid mental and physical deterioration in their lives. It likewise, by depriving us of their services, leads to the weakening of the nation.

[End with either paragraph one or two]

Paragraph 1

And it is as a Nation that we meet these challenges of assuring a fair share of progress for those who have contributed so much to our history. Each generation of Americans is engaged in a tradition of growth and progress. Each generation's success can be measured by its ability to recognize, reward, and renew the contributions of its older citizens. I intend to do all that I can to see that this generation of Americans does measure up.

Paragraph 2

Today's older persons have made more significant contributions to the strengthening of our nation than any other generation

generation of older persons in our history. Many of them have lived through two world wars and the hostility in both Korea and Vietnam. They have provided the nation with a vision and strength that has resulted in unprecedented advancements in all of the areas of our life. Our moral strength can and will be judged in no small part by our recognition of this significance of their contribution. Our commitment to doing everything we can to respond to their needs, and our determination to draw on the strength which they represent as they continue to live among us. Above everything else we will be judged by our ability to ensure the fact that in the last years of their lives they are treated with dignity. These are the goals to which I am committed as I continue to work with the Congress in this all important area of our national life.

We are a nation that is aging. Today one of every seven Americans is over 60, as compared to only one in 15 at the turn of the century. By the year 2000, over 40 million persons will be in this category, nine million more than today.

While it is true that as a people, we are living longer and better than our ancestors I know that many who grow old in America today have insufficient income, inadequate health care, poor nutrition and lack even the most basic opportunities to remain purposefully involved in society. We therefore must recognize the challenge of assuring that older persons continue to share in and contribute to life in our communities.

As President I intend to meet this challenge. I am pleased today to submit to the Congress two proposals that address income and health security. I feel that my proposals offer significant improvements in the quality of life of older Americans.

We must begin by asserting that the value of the Social Security system is beyond challenge. Maintaining the integrity of the system is a vital obligation each generation has to those who have worked hard and contributed to it all their lives. I strongly reaffirm my commitment to a stable and financially sound Social Security system. My 1977 budget and legislative program include several elements which I believe are essential.

First, to assist in protecting our retired and disabled citizens against the hardships of inflation, my budget request

to the Congress includes a full cost of living increase in Social Security benefits, effective July 1, 1976.

The Social Security trust fund is currently paying out more in benefits than its payroll tax receipts. To insure the financial integrity of the trust funds, I am proposing legislation to increase payroll taxes by three-tenths of one percent each for employees and employers. This increase will cost workers less than $1 a week more and will help stabilize the trust fund assets so that current and future recipients can be assured that they will receive the benefits that they have earned.

I am also taking steps to avoid serious future financing problems which will result if we do not act now to correct a flaw in the current system which overadjusts the benefits of future retirees to inflation. The current formula which determines future benefits for workers over compensates for inflation. This change will ~~include a continuation of~~ not affect the cost of living increases in benefits after retirement and will in no way ~~effect~~ alter the ~~current~~ benefit levels of current Recipients.

I believe that the prompt enactment of these proposals is necessary to revitalize our Social Security system and to keep it strong for future generations.

The normal health care needs of older Americans, with the special medical problems of aging -- degenerative and chronic disease -- require greater resources and commitment than the rest of the population. Many of those medical needs are met

through the normal health care delivery system with the support of Medicare and other Federal health programs.

I have identified three issues related to the operation of the Medicare program for which I am recommending solutions.

In my State of the Union Address I proposed catastrophic health insurance for everyone covered by medicare. This proposal is based on my conviction that there is a need to protect the aged and the disabled from the extraordinary hospital and medical costs of prolonged illnesses. To alleviate the threat of this financial burden, I propose that Medicare beneficiaries be provided protection against catastrophic health costs by limiting the amounts an individual must pay annually to $500 for covered hospital care and $250 for covered physicians' services. The burden of catastrophic illness can be borne by very few older people. This proposal will eliminate this fear from the lives of the elderly and their families.

Added steps are needed to slow down the inflation of health costs and to enable the financing of this catastrophic protection. Therefore, I am recommending that the Congress limit increases in Medicare payment rates in 1977 and 1978 to 7% day for hospitals and 4% for physician services.

Additional cost-sharing provisions are needed in order to encourage economical use of services for short hospital stays and routine physician care. Therefore, I am recommending that patients pay 10% of hospital and nursing home charges after

(4)

* Some of the savings from placing a limit on increases in Medicare payment rates and some of the revenue from increased cost sharing will be used to finance the catastrophic program.

the first day and that the existing deductible for medical services be increased from $60 to $77 annually. I believe that the effect of short term cost increases will be greatly outweighed by the benefits of catastrophic protection.

In addition to submitting proposals relating to income and health services, I desire to underline my conviction that current conditions call for continued and intensified action for the aging, on a broad front.

We have made progress in recent years, ~~in our efforts to meet this challenge~~. We have responded, for example, to recommendations made at the 1971 White House Conference on Aging to enact a Supplemental Security Income program, increase social security benefits more than the cost of living, liberalize the social security retirement test, increase benefits for delayed retirement, eliminate some of the inequities in payments to women, and protect 35 million workers investments in private pension plans.

In addition we have continued to strengthen the Older Americans Act.

I have supported the concept of the Older Americans Act since its inception in 1965 and signed the most recent amendments into law this past November. ~~I am requesting an operative budget of $253 million for FY 1977 for the continuation of this act.~~ A key component of the Older Americans Act is the national network on aging which provides a solid foundation on which action can be based. I am pleased that the Federal Government has helped to set up this network composed of 56

Funds available for programs administered by the Administration on Aging under this Act have increased from $44.7 million in FY 1972 to $270 million during the last fiscal year.

State and 489 Area Agencies on Aging and 700 nutrition agencies. These nutrition agencies provide 300,000 hot meals a day five days a week. The system, with the assistance of thousands of volunteers -- many of whom themselves are older persons -- can and must not only help meet the needs of older persons but also assure them an active role and place in community life.

Another concern of mine is that the voice of the aged, as consumers, be heard in the governmental decisionmaking process. The network on aging offers opportunities for this through membership on advisory councils, participation in regional public hearings, and involvement in the priority setting process for services at the local level.

The ultimate objective of the national network on aging is to make contributions to developing at the community level a coordinated and comprehensive system for the delivery of services to older persons.

I join with all Americans in expressing the hope that this objective can be achieved. This will call for hard and creative work at all levels of the network -- Federal, State and Area. I call upon all Federal Departments and Agencies to cooperate in facilitating the coordination of all available Federal resources for services for older persons at the State and community levels. I laud the efforts made by the Administration on Aging and the Federal Departments and Agencies who have signed agreements to work together to avoid

waste and overcome administrative difficulties. These agreements will help to make available to older persons a "fair share" of the resources requested in my 1977 budget in such areas as housing, transportation, social services, law enforcement, adult education and manpower -- resources which can play a major role in enabling older persons to live in their own homes for as long as possible.

Five percent, however, of our older men and women require the assistance providee by skilled nursing homes and other long term care facilities. An ombudsman process, related solely to the persons in these facilities, is being put into operation by the national network at the level of the Area Agencies on Aging. It is my hope that this program will not only help to resolve individual complaints but that it will also lead to a continuing demand on the part of our citizens for a vigorous enforcement of Federal, State and local laws designed to improve health and safety standards as well as quality of care in these facilities. This nation can do no less for those who spend the last days of their lives in institutions.

We must never lose sight of our obligations to help deal with the needs of older persons. At the same time we must never overlook the fact that older persons constitute one of the nation's greatest assets because of the contributions they are capable of making to our society. We are seriously

short-changing our nation when we deny older persons the opportunity for continued involvement in ~~the life of our day~~.

This is why my budget for 1977 calls for increases in the ACTION programs designed to provide ~~[illegible]~~ with the opportunity for constructive service.

Non-involvement on the part of older persons leads oftentimes to rapid mental and physical deterioration in their lives. It likewise, by depriving us of their services, leads to the weakening of the nation.

And it is as a Nation that we meet these challenges of assuring a fair share of progress for those who have contributed so much to our history. Each generation of Americans is engaged in a tradition of growth and progress. Each generation's success can be measured by its ability to recognize, reward, and renew the contributions of its older citizens. I intend to do all that I can to see that this generation of Americans does measure up.

Today's older persons have made more significant contributions to the strengthening of our nation than any other generation of older persons in our history. Many of them have lived through two world wars and the hostilities in both Korea and Vietnam. They have provided the nation with a vision and strength that has resulted in unprecedented advancements in all of the areas of our life. Our moral strength can and will be judged in no small part by our recognition of ~~this~~ the significance of their contribution, our commitment to doing everything we can to respond to their needs, and our determination to draw on the strength which they represent as they continue to live among us. Above everything else we will be judged by our ability to ensure the fact that in the last years of their lives they are treated with dignity. These are the goals to which I am committed as I continue to work with the Congress in this all important area of our national life.

THE WHITE HOUSE

WASHINGTON

January 8, 1976

MEMORANDUM FOR: WILLIAM NICHOLSON

FROM: MIKE FARRELL

SUBJECT: National Retired Teachers Association/ American Association of Retired Persons

The Legislative Council of the above organizations will be meeting in Washington on January 21, 1976. Following a luncheon they will be coming to the White House for a special tour at 2:45 p.m. They have asked if the President and Mrs. Ford might meet them at some point during their tour.

The Legislative Council members represent both AARP/NRTA and come from all sections of the United States. The purpose of the meeting is to determine their legislative objectives for 1976. The two organizations have eight million members. By copy of this memorandum, I am asking Ted Marrs and Jim Cavanaugh to give you their recommendations directly. A list of attendees is attached.

Thank you.

cc: Ted Marrs
Jim Cavanaugh
Susan Porter

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Thank you.

cc: Ted Marrs
Jim Cavanaugh
Susan Porter

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Mr. Lloyd Singer

(call from Falk) Aging Nov.
12-19

O'callaghan - D. Gov
AG - Repub.

re ADA + Nov.

Declarations from:

2 days ago sworn motion from A.G.,
Robert List asking Ct. to
disqualify Atty & appt. admin hearing
officer to administer hrg

1 attached sworn affidavit
of Roger TROUNDAY, Dir Nev
Dept of human resources
believes Ct. is prejudiced,
impartial hrg officer to preside

based on that - DAA granted
motion - telegram to AG
accepting. Necessitate delay -
Mid Jan. AG to inform Gov.

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funding

FY76 state plan submitted - DAA intention
to disapprove. indicated cd
continue to operate under provisions of
FY75 state plan.
∴ until issue is resolved, continue
to operate under provisions of FY75.
State plan. continue to receive
quarterly allotments fr. Treasury.

(area agencies out of business on 12/31/75 at

~~$22,850~~

State initiative - would be out of compliance according to OAA.

(has become state's rights issue in Nev.)

Fleming will talk to O'Callaghan if he calls.

Fleming spoke with Trounday today - both agreed had no (sp?) choice but to go along w/ FY 75 plan & 2 area agencies until issue is resolved. (in spite of legisl. action)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

Office of Human Development
Administration on Aging

November 25, 1975

MEMORANDUM FOR: THE HONORABLE SARAH MASSENGALE

SUBJECT: Nevada Fiscal Year 1976 State Plan on Aging

Attached for your information, is a copy of the Federal Register Notice of Hearing on the FY 1976 Nevada State Plan on Aging, published on November 19.

As you will note, Commissioner Flemming will be the hearing officer. The letter to Governor O'Callaghan, which is included in the hearing notice, outlines the issue to be considered at the hearing, scheduled for December 19.

I'll keep you posted on developments on this. I appreciate all the help you've provided us on this issue, and if I can be of any assistance please don't hesitate to call me.

Sincerely,

Decker Anstrom
Assistant to the Commissioner

Attachment

Signed at Washington, D.C. on November 14, 1975.

E. J. PERSON,
Acting Executive Vice President, Commodity Credit Corporation.

[FR Doc.75-31190 Filed 11-18-75;8:45 am]

Farmers Home Administration

[Notice of Designation Number A 266]

MINNESOTA

Designation of Emergency Areas

The Secretary of Agriculture has determined that farming, ranching, or aquaculture operations in the following Minnesota Counties have been substantially affected as a result of the natural disasters described for each county:

Anoka—Excessive rainfall May 1 to July 5, 1975. A severe windstorm June 29, 1975. Drought July 10 to August 1, 1975.
Clearwater—Excessive rainfall, hail flooding June 1 to July 7, 1975.
Pine—Excessive rainfall, hail, high winds and flooding June 10 to July 15, 1975. Tornado June 2, 1975.
Washington—Excessive rainfall, hail, high winds and flooding April 25 to July 5, 1975. Tornadoes May 19, 1975 and June 1, 1975.

Therefore, the Secretary has designated these areas as eligible for Emergency loans, pursuant to the provisions of the Consolidated Farm and Rural Development Act, as amended by Public Law 91-32, and the provisions of 7 CFR 1832.3(b) including the recommendation of Governor Wendell R. Anderson that such designation be made.

Applications for Emergency loans must be received by this Department no later than December 22, 1975, for physical losses and July 26, 1976, for production losses, except that qualified borrowers who receive initial loans pursuant to this designation may be eligible for subsequent loans. The urgency of the need for loans in the designated areas makes it impracticable and contrary to the public interest to give advance notice of proposed rule making and invite public participation.

Done at Washington, D.C., this 13th day of November, 1975.

FRANK W. NAYLOR, JR.,
Acting Administrator, Farmers Home Administration.

[FR Doc.75-31288 Filed 11-18-75;8:45 am]

DEPARTMENT OF COMMERCE

Maritime Administration

CHEMICAL WASTE INCINERATOR SHIP PROJECT

Draft Environmental Impact Statement; Notice of Availability

Notice is hereby given that copies of the U.S. Department of Commerce Draft Environmental Impact Statement on the Maritime Administration Chemical Waste Incinerator Ship Project will be filed with the Council on Environmental Quality and available to the public on December 1, 1975. Copies of the statement will be available for public inspection at the following locations:

Maritime Administration, Office of Public Affairs, Room 3895, Department of Commerce, Washington, D.C. 20230.
Maritime Administration, Eastern Regional Office, 26 Federal Plaza, New York, N.Y. 10007.
Maritime Administration, Central Regional Office, 701 Loyola Avenue, New Orleans, La. 70152.
Maritime Administration, Great Lakes Regional Office, 666 Euclid Avenue, Room 600, Cleveland, Ohio 44114.
Maritime Administration, Western Regional Office, 450 Golden Gate Avenue, San Francisco, California 94102.

Any questions concerning the statement should be directed to Dr. Sidney R. Galler, Deputy Assistant Secretary for Environmental Affairs, Department of Commerce, Washington, D.C. 20230, 202/967-4335. Persons desiring to file written comments should submit same to Dr. Galler prior to February 1, 1976.

The draft statement entitled, "Maritime Administration Chemical Waste Incinerator Ship Project", refers to proposed assistance to private industry to aid in the building of several chemical waste incinerator ships in the United States to be used for the disposal of toxic chemical wastes (approximately 450 pages).

By order of the Maritime Subsidy Board, Maritime Administration.

Dated: November 14, 1975.

ROBERT J. PATTON, Jr.,
Assistant Secretary.

[FR Doc.75-31290 Filed 11-18-75;8:45 am]

SECOND NATIONAL CONFERENCE ON DOMESTIC SHIPPING

Notice of Meeting

Notice is hereby given that the Department of Commerce, Maritime Administration, will hold the Second National Conference on Domestic Shipping in March 1976. The conference will focus on increasing productivity in the maritime industry.

The Conference will be held at The Fairmont-Roosevelt Hotel in New Orleans, Louisiana, on March 9, 10, and 11, 1976.

The purpose of the Conference is to explore techniques for improving productivity in domestic waterborne commerce through the exchange of ideas and information. Identification will be made of those key factors which are essential in the formulation and development of productivity measurements and goals. The agenda for the Conference is structured so that productivity challenges for the domestic waterborne shipping industry, and segments of that industry such as the inland waterways, Great Lakes, and domestic ocean interests, will be addressed.

Anyone wanting information on the Second National Conference on Domestic Shipping may write to Mr. William Bristor, Office of Domestic Shipping, Maritime Administration (MAR), 14th and E Streets NW., Washington, D.C. 20230. Phone—(202) 967-5110.

Dated: November 14, 1975.

ROBERT J. PATTON, Jr.,
Assistant Secretary.

[FR Doc.75-31291 Filed 11-18-75;8:45 am]

UNITED STATES INFORMATION AGENCY

U.S. ADVISORY COMMISSION ON INFORMATION

Meeting

Pursuant to the Federal Advisory Committee Act (Public Law 92-463), notice is hereby given of a meeting to be held on December 8, 1975. The session will commence at 9:15 a.m. in Room 660 at 1776 Pennsylvania Avenue, N.W., Washington, D.C. The subject of the meeting is "The USIS Program in Europe."

The session will be open to the general public. Persons wishing to attend the Commission's meeting should contact Mr. Louis T. Olom, Staff Director, U.S. Advisory Commission on Information, Room 1008, 1750 Pennsylvania Avenue, N.W., Washington, D.C. 20547, telephone 632-5210, so that adequate space will be assured. Written statements concerning the topic set forth in the agenda should also be submitted to Mr. Olom.

WALTER W. JONES,
Chief, Management Division.

[FR Doc.75-31176 Filed 11-18-75;8:45 am]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Administration on Aging

NEVADA; FISCAL YEAR 1976 STATE PLAN

Notice of Hearing

Notice is hereby given that in keeping with section 305(c) of Title III of the Older Americans Act of 1965, as amended, and 45 CFR 903.19 of the Federal Regulations (Sec. 305(c) Pub. L. 93-29, 87 Stat. 36-45 (42 U.S.C. 3021-3025); 38 FR 28045), and the request of the Governor thereunder, the Commissioner on Aging will hold a hearing to decide whether the Fiscal Year 1976 State Plan submitted by the State of Nevada under section 304 of the Act conforms to the Federal requirements which pertain to the State's request to be designated a single State planning and service area under Section 307(a) of the Act. Following is the notice of hearing from the Commissioner to the State of Nevada which states the time and place for the hearing, the issue which will be considered, and a reference to the rules of practice and procedure which will be followed.

NOVEMBER 17, 1975.

DEAR GOVERNOR O'CALLAGHAN: I have received your telegram of November 4 stating

your wish to have a hearing in response to my October 23 letter of intent to disapprove the State's request to be designated as a single State planning and service area and the Fiscal Year 1976 State Plan for Title III under the Older Americans Act of 1965, as amended.

I wish to notify you that I have scheduled the hearing for 9:00 a.m., December 19, 1975 to be held in Room 302, Federal Building, 705 North Plaza, Carson City, Nevada. I am enclosing the Rules of Practice and Procedure established for the proceedings which have been adapted from those published for hearings on conformity of State public assistance plans to Federal requirements set forth at 45 CFR Part 213.

I shall serve as the presiding officer for the hearing. I have designated Mr. Robert Hunter, Superintendent, West Nevada Agency, Bureau of Indian Affairs, Stewart, Nevada 89437, as the Administration on Aging Hearing Clerk. He shall perform those duties and responsibilities set forth in the enclosed Rules of Practice and Procedure.

The issue to be considered at the hearing is whether or not the evidence submitted by the State of Nevada in support of its request for designation as a single State planning and service area, as well as any other relevant evidence which may be adduced, support a conclusion under the criteria set forth at 45 CFR 903.57(f)(2) that there are circumstances relating to the State which justify approval of its request to be designated as a single State planning and service area.

As stated to you in my letter of October 23, based on the evidence submitted in the State Plan, the State did not appear to have met the test for designation as a single State planning and service area. The State's justification did not address the question of whether or not the State is too small to be divided effectively. It also failed to respond to the related criteria which concern whether the State has been constituted as one area for other purposes and whether State law proscribes the division of the State into areas for the administration of area plans by local agencies. Absent a presentation on these considerations, we assumed the answer to be negative in each instance. We noted that for purposes of implementing the National Health Planning and Resources Development Act of 1974, the State of Nevada has divided itself into areas which coincide with the boundaries currently established for the Title III Program.

In addition, relative to the criterion concerned with the effect of the size and distribution of the older population on the distribution of management and coordination resources, it was asserted in the evidence submitted in the State plan merely that the sparse population of the State should be taken into account; and that savings in the amount of $200,000 would accrue to the State to support social services for older persons by abolishing area agencies and thus their associated administrative costs. My letter of October 23 pointed out that, although the question of sparse population may be relevant, there was no documentation of the size and distribution of the older population, nor any showing of a pertinent relation between this factor and how resources might be distributed differently than they are at present. Moreover, we were unable to understand how the State arrived at the alleged savings of $200,000 in administrative costs. Section 303(e)(1) of the Act prescribes that funds awarded for planning and administration of area plans by area agencies may not exceed fifteen percent of a State's allotment for area planning and social services.

On the question of the State's capability to perform area agency functions for the entire State, the justification appeared to respond to a question other than that posed by the criterion: whether the State Agency is better equipped than the existing area agencies to carry out the Title III Program. The discussion on the criterion seemed to be irrelevant.

I very much regret any misunderstanding which may have resulted from my letter of October 23. The letter was not intended to notify you of any final disapproval action as it expressly recognized the requirements of the law relative to the opportunity of a State for a hearing. Until such time as the matter of the Title III State Plan for Nevada is resolved by the hearing, the operations of the Title III Program will continue to be governed by the currently approved State Plan for Fiscal Year 1975.

Please get in touch with me if you have any further questions.

Very sincerely and cordially yours,

ARTHUR S. FLEMMING,
Commissioner on Aging.

Any individual or group wishing to participate as a party shall file a petition with Mr. Robert Hunter, Superintendent, West Nevada Agency, Bureau of Indian Affairs, Stewart, Nevada 89437, telephone: 702–882–3411, within 15 days after the date of publication of this notice, and shall serve a copy on each party of record at that time. Such petition shall concisely state (1) the petitioner's interest in the proceeding; (2) who will appear for petitioner; (3) the issue on which petitioner wishes to participate; and (4) whether petitioner intends to present witnesses.

Individuals or groups may be recognized as parties, if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute. The Commissioner shall promptly determine whether each petitioner has the requisite interest in the proceedings and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the Commissioner may request all such petitioners to designate a single representative, or he may recognize one or more of such petitioners to represent all such petitioners. The Commissioner shall give each petitioner written notice of the decision on his petition, and if the petition is denied, he shall briefly state the grounds for denial.

Further information on the hearing may be obtained from the Office of the Commissioner, Administration on Aging, Room 4030, Donohoe Building, 400 Sixth Street, S.W., Washington, D.C. 20201, telephone: 202–245–2205.

Dated: November 14, 1975.

ARTHUR S. FLEMMING,
Commissioner on Aging.

[FR Doc.75-31175 Filed 11-18-75;8:45 am]

Food and Drug Administration

[Docket No. 75N-0213]

PRE-1962 NEW DRUG PRODUCTS NOT REVIEWED BY NAS–NRC

Invitation To Submit Data

In a notice published in the FEDERAL REGISTER of July 9, 1966 (31 FR 9426), all holders of new drug applications became effective prior to October 1962 were requested to submit Food and Drug Administration containing the best data available support of the effectiveness of products for the claimed indications information was needed to facilitate determination by the Food and Drug Administration, with the assistance the National Academy of Sciences tional Research Council (NAS) whether each claim in the labeling supported by substantial evidence fectiveness, as required by the Amendments of 1962. The holders some new drug applications that came effective prior to October 1962 did not submit information pursuant the July 9, 1966 notice and these therefore, were not reviewed by the NRC. Some of the firms that did submit the data requested are now reinvited to do so on or before ary 19, 1976.

In some cases, failure to submit requested information was due to sponsors' lack of further interest products. In other cases, the filing supplements to the new drug applications had been approved after October 1962, may have led the sponsors to clude that the effectiveness issue been resolved by those approvals. approvals, however, were not based a complete review of the entire question and did not constitute a determination that all claimed indications supported by substantial evidence effectiveness.

In general, the pre-1962 products were not submitted to Academy comprise three groups: 1. Those identical, related, or similar (as in 21 CFR 310.6) to products that reviewed by the Academy and to similar conclusions are applicable.

2. Those that are not identical or similar (as defined in 21 CFR to Academy-reviewed products, which sufficient information is available to the Food and Drug istration upon which to base a sion as to effectiveness.

3. Those products that are identical, related, or similar (as defined 21 CFR 310.6) to Academy-reviewed products and for which the Food Drug Administration now invites mission of data and information cerning effectiveness.

The holders of the following drug applications are now invited supplement their new drug applications with data and information concerning effectiveness. Persons marketing identical, related, or similar drug products that are not subjects of approved drug applications may also submit and information concerning the tiveness of such products.

Aging -
Older Amer Act
State Plans

11/14 problem in Nevada
w/ state plan for aged

talked w/ Armstrong + Fleming

Fleming disapproved date Oct
hearing set for Nov 14
cancelled - HEW counsel's ~~opinion~~ advice since
notice of hearing had not been published
in Fed Register.
hrg rescheduled for Dec 19
will be published 11/15 or 11/17 or so.

Gov Michael O'Callaghan very upset -
is playing both sides.
1 - will get plan approved in court
can't publish notice
2 - can't wait till Dec 19 for hrg.

Falk called back + assured Gov.
that Fleming will be there.

Falk asked that Mathews respond
to letter sent by Sen. Laxalt.

Sarah

THE WHITE HOUSE

WASHINGTON

November 19, 1975

Dear Governor O'Callaghan:

Thank you for your telegram of November 3, expressing your concern about HEW's letter to you on Nevada's 1976 State Plan on Aging.

I am pleased to tell you that Commissioner Flemming is planning to attend the scheduled hearing in Carson City on November 14, 1975. I am sure that this meeting will be a productive one.

If I can of any further help, please do not hesitate to contact me.

Sincerely,

Jim

James H. Falk
Associate Director
Domestic Council

The Honorable Mike O'Callaghan
Governor of Nevada
Carson City, Nevada 89701

Cancelled. Sen's Cong there
Nev was ready.
Fed was not. > failed to
give notice

(Dec 19th)

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PMS HONORABLE JAMES H FALK, ASSOCIATE DIRECTOR, DOMESTIC COUNCIL
, DLR
WHITE HOUSE 1600 PENNSYLVANIA AVE
WASHINGTON DC 20500
BOTH A LETTER (RECEIVED OCTOBER 28 1975) AND A TELEGRAM (RECEIVED NOVEMBER 3 1975) FROM ARTHUR S FLEMING, COMMISSIONER ON AGING, OHD DEPARTMENT OF HEW, RELATIVE TO NEVADA'S SUBMISSION OF ITS FISCAL YEAR 1976 STATE PLAN ON AGING IS OF A GRAVE MATTER TO ME.

COMMISSIONER FLEMING'S LETTER (DATED OCTOBER 23 1975) DISAPPROVES NEVADA'S PLAN, WITHOUT FIRST AFFORDING THE STATE REASONABLE NOTICE AND OPPORTUNITY FOR A HEARING UNDER SECTION 305 (C) PL93-29.

COMMISSIONER FLEMING'S TELEGRAM (DATED OCTOBER 31 1975) OFFERS NEVADA NOVEMBER 14 1975 AS A SCHEDULED HEARING DATE IN THE STATE CAPITOL IN CARSON CITY. BOTH COMMUNICATIONS ARE CONSIDERED AFTER THE FACT IN LIGHT OF A DECISION BY COMMISSIONER FLEMING "NOT APPROVING" NEVADA'S FISCAL YEAR 1976, STATE PLAN.

IN ORDER TO RESOLVE THIS MATTER EXPEDITIOUSLY, THE STATE OF NEVADA AGREES TO THE HEARING DATE SUGGESTED BY COMMISSIONER FLEMING. AT THE SAME TIME, I URGENTLY REQUEST THAT COMMISSIONER FLEMING APPEAR PERSONALLY IN CARSON CITY AS THE REPRESENTATIVE OF THE FEDERAL GOVERNMENT. HE MAY, OF COURSE, WISH TO BRING A NUMBER OF SUPPORTING STAFF MEMBERS BUT I BELIEVE HIS APPEARANCE IS ESSENTIAL IF THE QUESTION IS TO BE RESOLVED TO THE SATISFACTION OF ALL CONCERNED. QUITE FRANKLY, I AM SURPRISED THAT THE PLAN WAS NOT APPROVED. IT HAD

THE SUPPORT OF US SENATOR PAUL LAXALT, CONGRESSMAN JAMES SANTINI, THE ADVISORY COMMITTEE TO THE STATE DIVISION OF AGING SERVICES, THE NEVADA DEPARTMENT OF HUMAN RESOURCES AND NUMEROUS STATE LAWMAKERS. THANK YOU FOR YOUR ATTENTION TO THIS CRITICAL MATTER.

MIKE OCALLAGHAN GOVERNOR OF NEVADA

NNNN

December 2, 1975

NOTE TO SARAH MASSENGALE

Attached is a set of reports from the National Council on Aging which may be of use to you in preparing a list of possible initiatives for the a aged for the State of the Union. While some of these are pure flack, most may be of use and are certainly worth reviewing. When you've had a chance to take a look at these, let's sit down and make up a laundry list of possible initiatives, along with some indication of what costs might be attached to the initiatives and what policy implications of the initiatives are.

G.E.M.

Attachment

OFFICE OF THE VICE PRESIDENT

WASHINGTON

December 2, 1975

NOTE TO SARAH MASSENGALE

Attached is a set of reports from the National Council on Aging which may be of use to you in preparing a list of possible initiatives for the aged for the State of the Union. While some of these are pure flack, most may be of use and are certainly worth reviewing. When you've had a chance to take a look at these, let's sit down and make up a laundry list of possible initiatives, along with some indication of what costs might be attached to the initiatives and what policy implications of the initiatives are.

G.E.M.

Attachment

OFFICE OF THE VICE PRESIDENT

Correspondence Control Unit

Form Correspondence Response

From

The National Council on the Aging, Inc., 1828 L St., NW, Washington, DC

Subject

1975 Public Policy Statements of the National Council on the Aging

Form Number	Control Number
	14114

Special Instructions

John Veneman

FYI, NAN

OVP Form 003
March 1975

GPO 570-505

The National Council on the Aging, Inc.
25 Years of Service to the Elderly

1828 L STREET, N.W.
WASHINGTON, D.C. 20036
202/223-6250

November 17, 1975

Dear Colleague:

The National Council on the Aging is pleased to send you the 1975 Public Policy Statements from the NCOA Board of Directors which were issued at our 25th Annual Meeting held in Washington, D.C. in late September. As you may know, NCOA is a private nonprofit organization whose membership consists of individuals and organizations who serve the nation's older citizens. For 25 years, we have provided leadership in the field of aging to public and private agencies at the national, state and local levels.

NCOA believes that the voluntary sector has a vital role to play in the development and implementation of a public policy responsive to the needs and capacities of the nation's older citizens. As firsthand observers of the elderly's needs, those working in the field are able to evaluate the effectiveness of programs and services designed to serve the older population. NCOA is convinced that it can and must serve as a conduit of such information to policymakers at all levels of government.

Because the development of policy statements is an ongoing process, we are interested in your comment on them. In the coming months, NCOA will use the enclosed papers as a basis for additional policy statements. We hope you will keep these and forthcoming statements as a cumulative record of NCOA's position on issues affecting the lives of older Americans.

NCOA's 25 years of service have demonstrated the significance and validity of the private sector's involvement in the creation of an effective public policy in aging. Following the lead of the elderly themselves, and working with organizations and individuals concerned about the wellbeing of older persons, NCOA will continue to encourage a social policy responsive to the aged. We look forward to facing that challenge in cooperation with you in the years ahead.

Sincerely,

Albert J. Abrams

Albert J. Abrams
President

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September, 1975

CRIME AGAINST THE ELDERLY

The elderly, especially the urban elderly, are the most vulnerable victims of the recent dramatic increase in crime in America. Millions of the aged are virtual prisoners in their own homes, self-confined victims who fear even going out in the streets. The quality of life for thousands and thousands of elderly people is degraded not only by the existence of robberies, assaults, fraud and rape, but also by the threat of such crimes. In a recent NCOA study conducted by pollster Louis Harris, those over 65 rate crime or the fear of crime as their most serious personal problem.

Unfortunately, there is no reliable index of the volume of such offenses against the elderly. Numerous studies showing the high numbers of unreported and underreported crimes also indicate that the elderly are more likely to be silent victims. In addition, reported crime records only note the age of the criminal, not that of the victim.

NCOA believes that a number of steps must be taken

The National Council on the Aging, Inc.

1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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immediately, at both the national and local levels, to make America safe for its nearly 21 million older citizens.

1. A national Senior Citizens Crime Index should be developed to monitor the growth and delineate the development of offenses against older people.

2. The Law Enforcement Assistance Administration (LEAA) of the Justice Department should undertake studies to determine how localities may best cope with the problem of crime against older people and to use its resources to fund programs which protect the elderly.

3. Local police authorities should be encouraged to set up strike forces to prevent attacks on the elderly and to pinpoint the locations and modus operandi of the attacks.

4. Local police should undertake regular visits and liaison to facilities used by the elderly such as senior centers, housing projects, etc.

5. Self-help programs which train the elderly themselves in crime-prevention procedures should be developed.

6. Senior center leaders should be trained to train their members in crime prevention.

7. Community watch programs, involving community groups of all ages (teen patrols, radio-dispatch cab drivers, police hookups, high school student escorts, etc.) should be established to be alert to threatening or suspicious activities.

8. Patrol of streets (perhaps by retired policemen or police cadets) and areas older people use that have high incidences of criminal activities should be encouraged, and escort services to and from transportation services to housing projects, shopping malls, senior centers, clubs, clinics, etc., should be set up.

9. The police should train and assign the elderly stay-at-homes or home-bound to observe streets or sections of their neighborhoods, and to report suspicious behavior to police.

10. Regular police security checks of buildings and sites housing the elderly should be made (just as the fire department makes regular fire prevention inspections).

11. Housing for the elderly should have installed (on government subsidy or as tax-deductible expense) burglar-proof photoelectric beams on windows and doors, one-way glass, TV monitors in elevators and corridors, and central alarm buzzer systems linked to police dispatchers or patrol units.

12. Since crime against the elderly is reduced in specific housing as compared to intergenerational housing, more housing especially for the elderly should be encouraged and built.

13. Government checks should be mailed to banks for individual deposit; banks should provide free checking accounts for the elderly.

14. An offense against an older person should be made a Federal crime if committed in Federally funded facilities such as housing projects, centers, etc.

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- SOCIAL SERVICES ☐

September 1975

EMPLOYMENT

The nation is experiencing its highest unemployment rates since the Depression. Millions, regardless of occupation or age, are suffering. Middle-aged and older workers, with heavy family and financial responsibilities, tend to suffer special hardships when the economy takes a downward turn. Men and women over 40 constitute almost half of the present labor force and more than a fourth of all unemployed. As Bureau of Labor Statistics figures indicate, they undergo longer terms of unemployment than younger age groups. They tend to drop out of the labor force through discouragement in a futile job search. Advocates of a broader definition of unemployment believe that present figures--which categorize discouraged workers as not-in-the labor force--understate by a considerable extent the true unemployment rate. Middle-aged and older workers are often victims of age discrimination on the part of both employers and employment-manpower service agencies.

The National Council on the Aging, Inc.

1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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One goal of a national employment policy should be to assure continued participation for all age groups since it is a major factor in a full and satisfying life style. It should also be noted that periods of unemployment have serious repercussions in terms of unemployment insurance, welfare costs and social security benefits.

The basic premise of employment and manpower programs from the inception of the Wagner-Peyser Act of the 1930's to the categorical manpower development and training programs of the 1960's to the present Comprehensive Employment and Training Act (CETA) approach, has been that all Americans in need of assistance related to employment may fully participate in available programs. The desired outcome is free access for all individuals to the job market regardless of age and other possible limiting factors over which the individual worker has no control.

The Comprehensive Employment and Training Act (CETA)

There is no question that middle-aged and older workers are not receiving an equitable share of manpower services through the CETA and the United States Employment Service networks. These groups of workers lack priority in these systems - only 4 to 8 percent of the CETA participants are men and women over 45 and analysis of Employment Service data reveals that middle-aged and older workers are less likely to receive services than those under age 40.

NCOA's concern, therefore, with the current regulations pertaining to CETA is that they in no way guarantee improved status for middle-aged and older persons in need of employment assistance. CETA regulations must be established which assure that funds allocated to prime sponsors are equitably distributed to all participating age groups.

NCOA recommends that the Department of Labor include the following general guidelines and specific changes in revised regulations pertaining to Title I and II of the Comprehensive Employment and Training Act.

Prime sponsors and their agents in order to assure fair and equitable participation of middle-aged and older men and women of all racial and ethnic backgrounds in CETA programs must include within any state plan an analysis of the universe of need of individuals they intend to serve by age and sex categories. The following groupings are suggested: Under 22; 22-39; 40-54; 55-64; 65+.

An appropriate reporting system should be standardized whereby Prime Sponsors and any Subcontractor can report comparative services to age groups on a quarterly basis.

Prime Sponsors should see to it that middle-aged and older individuals, familiar with the manpower and employment needs of workers over 40, are included in fair proportions of all state and local manpower planning committees.

Any Prime Sponsor with responsibilities for implementing a Title II Public Employment Program must develop an Affirmative Action Plan to accommodate individuals within the protected group of the Age Discrimination in Employment Act. All state and local government and/or public employers are now covered and bound by federal age discrimination in employment legislation.

Middle-aged and older workers, by reason of their long neglect on the part of the Department of Labor, should be regarded as a new minority. Each Prime Sponsor, therefore, should be bound to submit within his state plan special training and technical assistance provisions to agents, or subcontractors on how to:

-- Assess the needs of middle-aged and older workers within a community.

-- Develop outreach capabilities to bring these older workers into CETA training and employment programs.

-- Develop special training methodologies and skill conversion techniques for middle-aged and older men and women.

-- Develop job placement strategies, in cooperation with other employment related agencies (e.g., the State Employment Security Agency) for those older individuals.

Appropriate Prime Sponsors should be informed and directed by the Manpower Administration that it is their responsibility to support all Senior Aide programs currently being funded by the Department of Labor through national contractors. <u>These are programs of demonstrated effectiveness</u>.

A separate title should be established under CETA that will address the manpower needs of the middle-aged and older worker, just as the Job Corps has been established for youth. It is important to note that although older workers were specifically mentioned along with Indians and youth in Title III, no money has ever been appropriated for this group.

Age Discrimination in Employment (ADEA)

The Age Discrimination in Employment Act (ADEA) has recently fostered significant legislative, administrative and judicial activity. The law's major objective is to eliminate discrimination against individuals between 40 and 65 years of age in matters of hiring, job retention, compensation or other terms, conditions and privileges of employment. ADEA promotes a policy of employment according to ability rather than age. Despite recent legislative improvement in the Age Discrimination in Employment Act, systematic implementation and enforcement is needed. In addition, because any worker, regardless of age, should be evaluated according to functional ability, NCOA recommends that the present upper age limitation for application of ADEA be removed.

To ensure uniform national standards protecting all citizens against discrimination in employment, NCOA further recommends the establishment of one national regulatory body with the authority and resources to enforce effectively one federal statute which prohibits employment discrimination on the basis of race, color, religion, sex, national origin, age and handicapped status.*

Mandatory Retirement

A recent survey conducted by Louis Harris and Associates for NCOA

* Basic recommendation from the Federal Civil Rights Enforcement Effort 1974, U.S. Commission on Civil Rights, July 1975.

found that a large majority of Americans feel that "nobody should be forced to retire because of age," and a smaller majority agree that "most older people can continue to perform as well on the job as they did when they were younger." Yet in mid-1974 there were over four million unemployed or retired persons age 65 and over who wanted to work but were not employed, compared to some 2.5 million who were working full-or part-time.

NCOA strongly urges that flexible rather than fixed retirement ages be adopted by employers and unions, allowing those who wish to retire early or at the "normal" retirement age of 65 to do so and allowing others to work as long as they are able, perhaps as determined by a physical examination or an objective scale such as that employed in the Industrial Health Counseling Service for the last four years in Portland, Maine. The fact that not all employers require mandatory retirement is evidence that flexible retirement is administratively feasible.

United States Employment Service

To increase services to middle-aged and older workers, NCOA recommends that the Manpower Administration mandate that the Older Worker Specialist be a full-time position at the state and local office level and institute a system for financial incentives to local offices that do an outstanding job of placing older workers. In addition, we recommend that the Manpower Administration set up on a pilot basis an employment service based on the 40-plus methodology to test techniques and procedures for adequate service to middle-aged and older workers.

Senior Community Service Project (SCSP)

The Senior Community Service Project has clearly demonstrated that older workers can adequately carry out diverse work assignments, involve people in

meaningful relationships, motivate them to initiate action on their own behalf, mobilize community resources and generally serve as a bridge between the consumer of services and the agency providing the services. It has also demonstrated that the program participants measure up in all ways to standards for younger workers - and often exceeded these standards. SCSP is a manpower model for the older disadvantaged worker. It has successfully carried out its primary mission of providing meaningful public service employment for older workers.

NCOA believes that the funds available for this program and similar ones are totally inadequate and that steps should be taken by the national Manpower Administration, local prime sponsors and national contractors to establish these projects at the local level on a permanent basis.

Functional Capacity

NCOA believes that middle-aged and older persons should be assured of opportunities for continuing employment. The extension of employment opportunities for this group and the removal of barriers to their employment remain primary goals. There is a need for the expanded use of techniques which have been developed for relating the functional abilities of workers to the functional requirements of jobs. In general, functional capacity and not chronological age must become the primary employment standard.

Pre-retirement Planning

Planning ahead for retirement can significantly reduce the mistakes and frustrations that accompany a trial-and-error approach after retirement. Problems may still arise, but the individual will be better prepared to cope with them. The three critical elements are opportunity and incentive to plan, and concrete, relevant data on which to base the planning.

NCOA recommends that the Federal government recognize the need for planning and assume a partnership with educational institutions and private industry by funding research and training programs, sponsoring demonstration projects and providing incentives for employers to pay the tuition for appropriate courses as well as setting an example as a model employer.

Second Careers

A change in mid-life from one job pursuit to a different field is no longer considered unusual in our rapidly changing society. For some workers, because of technological displacement or involuntary early retirement, the need for a second career is a necessity. To fill the need, career oriented educational and training programs should be developed which are aimed not at the beginning worker but at those who must transfer from one career track to another.

Women and Minorities

Unemployment and poverty among middle-aged and older single women and members of minority groups are particularly severe problems. NCOA urges that special attention be paid to the employment problems of these groups in Employment Service job development and in training programs.

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September, 1975

ENERGY AND THE ELDERLY

A limited supply of electricity, natural gas, fuel and motor oil at inflated prices is potentially damaging to older people themselves, as well as to the institutions and programs which serve them. As the price of energy continues to rise, increasing numbers of older people living on fixed incomes will be forced to decide between heat or food. Cost-of-living increases in Social Security and Supplemental Security Income benefits are quickly eroded by inflation in this area alone. Already inadequate public and private transportation becomes either too expensive or non-existent. The loss of volunteer drivers due to the lack, or high cost, of gasoline can cripple many programs geared to serve older Americans, including homemaker-home health aide projects, escort services, meal deliveries and senior centers. Reduced heat in the home aggravates arthritis and many other chronic conditions that affect the elderly. The benefits of programs, including those authorized under the Older Americans Act, are reduced because

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

25 Years of Service to the Elderly

appropriations do not include increased costs for lighting, heating, cooking and transportation.

To avoid and/or alleviate these present or potential problems, NCOA recommends the following:

1. The development and implementation of a national energy policy should assure that all citizens are equitably treated and particularly that the elderly and other vulnerable groups are not adversely affected.

2. The use of any gasoline allocation formula should include extra supplies to agencies who operate elderly transportation services and unrestricted access for volunteer agency drivers.

3. Any fuel allocation and/or rationing, if developed, should take into consideration the special needs of the elderly.

4. Government program regulations which restrict reimbursement of drivers should be changed periodically to reflect the higher price of gasoline.

5. The appropriations for service programs dependent on energy resources should be increased to account for inflation's impact on the cost of energy.

6. The Federal government should institute a program of low-cost loans for housing insulation.

7. Comprehensive consumer information on energy conservation and rights should be developed for the elderly and effectively distributed to them.

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September, 1975

HEALTH OF THE ELDERLY

Good health is a basic ingredient of a satisfactory life for all people. For older Americans this goal is more difficult to attain and maintain than for the remainder of the population. Growing older is almost always accompanied by an increasing need for health care services (people aged 65 and over, while approximately 10 percent of the population, account for 30 percent of health care costs).

While recognizing that good health should be a public policy goal for all Americans, the National Council on the Aging is particularly concerned that there be a public commitment to assuring that the necessary steps are taken so that older Americans can live healthfully and can choose and purchase appropriate health care services.

NCOA believes that the final responsibility for comprehensive health services, both physical and mental, for older Americans lies in the public sector at the Federal level. The objective of such health services should be the provision of

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1828 L St., N.W., Suite 504
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expanded and specialized health programs and facilities and rehabilitative and preventive care, including mental health services, for older persons. The provision of these facilities and services must be complemented by the establishment and enforcement of national standards to guarantee quality physical and mental health care and decent living conditions. Therefore, NCOA supports the early establishment of a national health security program which incorporates the following principles:

1. Comprehensive physical, mental, environmental and social health care benefits for all Americans;

2. The integration of Medicare into a national health security program for Americans throughout the life span;

3. The elimination of all co-insurance, deductibles and premiums;

4. Administration and fiscal management of the new health security program by a public agency without an intermediary between the providers and the public agency;

5. Financing of the health program through general revenues and payroll taxes.

6. Consumer participation of the aged in the development and implementation of this program including involvement in quality controls (in such areas as accessibility, acceptability and accountability) and in cost controls.

7. Coverage for the full range of long-term care services, including home-based, community-based and institutional-based services, with appropriate quality and cost controls specifically designed for the aged.

8. Monies allocated to research and output measurement to include appropriate attempts to develop criteria for evaluation of health care delivery to the aged related to functional capacity, ranging from minimal self-care

to full independence; and

9. The exclusion of means tests from any aspect of the program.

Pending the establishment of a national health security program and recognizing that health care costs are now increasing 50 percent faster than the economy as a whole; that per capita health care costs in 1973 were 3 1/2 times greater for people aged 65 and over than for younger age groups; that Medicare, which covered 49 percent of the total costs for medical expenses in 1969 covered only 38.1 percent of these expenses in 1974; and that skyrocketing costs of health programs do not reflect advances in health services for older people, NCOA recommends:

10. The present Medicare and Medicaid programs should be improved and expanded immediately to meet more adequately the health needs of older persons in relation to such matters as length of stay in acute hospitals; extended care and nursing home facilities; psychiatric hospitals; coverage for home care; diagnostic and preventive services; and out-of-hospital drugs and medicines; the elimination of the premium paid for Medicare Part B and the co-insurance features related to hospital care.

11. Greater coverage should be provided for dental care, eye and hearing care and aids as well as for other prosthetic devices which contribute to social and health functioning, and which facilitate mobility.

12. A nation-wide program of comprehensive long-term care for older persons suffering from chronic disease and disabilities must be developed. Such a program should include specialized health programs and facilities for rehabilitation and resocialization as well as alternatives to institutional care, such as health maintenance organizations, neighborhood clinics, day or night hospital care, and home care services.

13. Present standards of care should be better enforced and, when promulgated, vigorous state implementation of national standards for nursing homes and personal care homes should be encouraged. This should assure not only the safety and appropriate levels of health care for older persons, but also the inclusion of social care perspectives which help to preserve the human rights and dignity of the older residents.

14. The encouragement of specialties in geriatric medicine and other health professions should be a matter of national policy, with funds made available for recruiting and training these specialists required to staff a comprehensive health service for older persons.

15. A national policy and program on the physical fitness of older Americans should be developed and coordinated.

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September, 1975

THE DEVELOPMENT OF SOCIAL UTILITIES FOR LONG-TERM CARE

The growth of the nursing home industry in recent years has been phenomenal; and, for the most part, caused by the introduction of Federal funds through Medicare and especially the Medicaid program. In fact, public funds now account for approximately $2 out of every $3 in nursing home revenues. In 1973, Medicare contributed $200 million and Medicaid $2.1 billion to the industry. In addition, there are almost 50 other Federal programs which assist nursing homes. These public funds support an industry in which 77 percent of the nursing homes are operated for profit, 15 percent are philanthropic, and only 8 percent are government owned.

Despite this rapid growth and public support, a recent study by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging concludes that there is no coherent policy on the long-term care of older Americans. As a result, in too many cases, public funds are used to perpetuate deficient care for thousands of older people, thus causing them

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
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to live in unconscionable conditions. That Senate report concludes that the majority of nursing homes in the country do not meet minimum standards of acceptibility.

It is critical that the Federal government redirect public funds to encourage the development of quality long-term care institutions. Therefore, NCOA believes that there should be a systematic diversion of Federal funds now being spent on proprietary nursing homes (estimated between $3.5 and $7.5 billion) into public or private nonprofit social utilities for long-term care. By social utilities we mean facilities or services not exclusively oriented to the care of in-patients, but also planned to provide services beyond their walls. In other words, those facilities would become an integral component of the service delivery network to the elderly throughout the community.

The possible services are many and diverse - day care, congregate dining, disease detection, intellectual and social programs, group and individual counseling and psychotherapy, outreach care, social services and health education. Thus, while offering a quiet sanctuary for those who require it, these facilities for long-term care could also become lively places with ties to the larger community. Instead of the dread of inhumane treatment or the fear of being left in a home only to die, an older person entering such a facility would expect and receive the kind of care which offers rehabilitation and a renewed sense of hope and self-esteem

The elderly need and deserve long-term care facilities geared to meeting the full range of their medical and social needs, places where they can go and be assured of quality treatment. In the best tradition of American society, public support for the social utilities described here would reinforce competition in the nursing home industry and encourage proprietary homes to develop similar constructive programs.

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September, 1975

NUTRITION FOR THE ELDERLY

Proper nutrition is a prerequisite of good health, but it is often hard for older people to maintain an adequate diet. Poor nutrition is frequently found among older adults because they live alone; they are often frail; and many more are poverty stricken. Inflation has increased food costs alone by 20 percent in the last year. Thus, the elderly poor are forced to "pay more to eat less." To ensure an appropriate public commitment to providing adequate nutrition benefits for older Americans, NCOA believes:

1. Title VII of the Older Americans Act should be fully funded to provide the necessary support for the Nutrition Program for the Elderly which, despite its success, now reaches only a minority of those who need such support.
2. The food stamp program should have an expanded outreach as well as an improved administration in order to be of greatest value to older persons.
3. Information about the influence of nutrition on the

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aging process should be incorporated into all health education programs. Such programs should be given in the public schools, be an integral part of the health education functions of the proposed national health security program, and be a significant part of senior center programs and of other services through which large numbers of older persons can be reached.

4. Standards for nutritional quality for food services for older people should be established at the Federal level and be included in the licensing and inspection procedures in every state and community.

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THE RURAL ELDERLY

Until very recently there has been a large migration of the American people from rural to urban areas. Thus, people residing in rural areas faced a dramatic reduction in income, a lack of essential services and, of course, a reduced population. Rural America became less visible in terms of priority in Federal and state programs. What was once the backbone of the country became a skeleton, standing alone and forgotten. Interestingly, the same could be said of the older adult throughout America. For an older adult living in rural America, the problems of poverty, isolation, poor health, inadequate housing, and lack of visibility were compounded.

However, recent migration trends seem to be changing. The population is now leaving urban areas for rural ones, although services are not so quick to follow. The National Council on the Aging calls for a national effort through the voluntary public and private sectors to utilize the capabilities of rural older adults to restore them to productiveness and to expand

The National Council on the Aging, Inc.

1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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and develop services to enable rural older adults to enjoy a life of dignity, health, and safety. To this end, we make the following recommendations:

In non-metropolitan society, pensions or annuities are almost non-esistent. Therefore, older adults rely on social security benefits or income maintenance programs for their only source of income. To relieve the burden of these often inadequate income levels for older adults in rural areas:

1. An accelerated effort to develop rural manpower programs should be made to enable older adults to remain self-sufficient.

2. An income maintenance program tailored and directed to meet the needs of the rural older adult should be established. Such programs should take into account the traditional multi-generational family model which is still common in rural America since this structure often prevents older family memebers from receiving full income benefits although they must contribute to the family's income in order to avoid impoverishing them.

3. An effort by Federal, state and local governments must be made to protect the independence of rural older adults by reducing property taxes, especially those of persons on limited incomes.

Noting that in 1973 the U.S. Department of Health, Education and Welfare spent only $7 million out of $175 million on health services delivery in rural areas although statistics show that approximately 140 rural counties in the nation do not have a physician and very limited auxiliary health services, NCOA recommends the following:

4. The Federal government should collaborate with medical schools in planning for special stipends for medical students who make a commitment to serve in rural areas (as well as other delivery areas) following their training as well as field placements during their training.

5. More support should be given to developing other professionals such as doctor's assistants, nursing and medical aides to provide supportive medical servcies to older adults in rural areas.

6. Mobile health service units, mini-medical clinics, visiting nurses services and emergency transportation services should be developed to alleviate this serious problem.

7. More emphasis should be given to medical service development, linkage of auxiliary services and provisions to enable the utilization of these services.

Public transportation is virtually non-existent in most rural areas and medical and social facilities are too distant from residential areas to be reached by taxi or by walking. These conditions immobilize older adults and keep them from making social contacts and reaching professional services. NCOA recommends:

8. The National Mass Transportation Act of 1974 should be re-examined and new allocations made to offer more than token assistance to rural areas.

9. Efforts should be made toward ensuring the full development and utilization of volunteer transportation services, minibus services and school buses during "off hours" to fill this transportation gap.

10. State Public Commissions should remove those regulations which might restrict the implementation of transportation programs, and state Agencies on Aging should be prepared to follow up such action with

recommendations of transportation programs which would benefit the elderly.

Sixty percent of the substandard housing reported in the nation's counties is in rural areas; one-fourth of those dwellings are occupied by the older adult. NCOA recommends the following:

11. A major national housing focus must be directed at rural America with particular emphasis given to the housing needs of older adults. An effort to broaden the programs of, and the appropriations for, the Farmers Home Administration specifically to meet the housing needs of rural America would be an important step in this regard.

12. Legislation should be enacted to make available funds for low-interest rate loans for major home repairs. The development of community services to provide minor home repairs could enable many older adults to maintain their independence by remaining in their own homes. Many others, by using their skills in carpentry, masonry and plumbing could earn extra income.

13. Planners and administrators should make greater efforts to provide social services, which are so often denied the rural elderly because of their limited mobility, with public housing projects for the elderly.

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HOUSING FOR THE ELDERLY

With the moratorium on subsidized housing, instituted in the last several years, the need for suitable housing for older persons has reached critical proportions. Waiting lists for existing low and moderate income housing for the elderly are extensive and growing. Hundreds of thousands of America's older people are forced to live in environments which are substandard, too expensive, too difficult to maintain, too inefficient for their age and capacities.

Older people everywhere find it difficult to understand why a demonstrated need for a program which has been singularly successful - financially and socially - should be suspended and unfulfilled.

Because of time, because of special needs with age, older Americans require a special priority today. They have the right to make independent choices of their living arrangements regardless of their current income situation. These choices can include single family homes, independent apartments,

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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congregate facilities and rehabilitative centers. In all instances, such housing should have easy access to senior center activities, health services, therapy programs, nutrition programs, cultural activities - all designed and implemented to maintain independent living even when disability occurs.

NCOA has the following specific recommendations:

1. To achieve independent choice of living arrangements, all the programs of low and moderate income housing authorized by the Congress should be used fully and immediately. Of vital importance in this regard is the full implementation of the Section 202 Program. Congress has authorized and appropriated substantial funds for a new beginning of this very successful program of housing for the elderly. The Administration should accept this action and institute an effective program of direct financing both in the construction period and for the permanent loan for qualified nonprofit applicants.

2. Such loans should have available to them a special set-aside of Section 8 subsidy to ensure that low incomes will not bar older people from suitable housing. This is a priority, major action required today.

3. There should also be enactment and execution of full appropriations under the Section 8 Program and Section 236. These programs individually, and especially in combination, could generate the volume of specially-designed housing older Americans need and require.

4. In addition, a substantial program of special grants to senior citizens who own their own homes should be underway on a sizeable basis. This will permit older persons of modest incomes to improve and rehabilitate their own homes and to go on living independently in neighborhoods of their own choice.

5. In any housing program, more than sheer shelter is required. Urgently

needed senior centers, adequate nutrition programs, physical and occupational therapy, health programs, cultural enrichment programs, etc., should be financed by grants, rather than out of the rents of residents.

6. Administration of the subsidy programs must be realistic if the program is to be effective. This means reassessing fair market rents, construction costs, methods of financing and speed of administrative processing.

7. New construction should be emphasized. Too many older persons live in homes which are too old and too inefficient for them. They require having arrangements suitable to their age and physical conditions at rentals and prices they can afford.

8. A major national focus must be directed at rural America with particular emphasis given to the housing needs of older adults. An effort to broaden the programs of, and the appropriations for, the Farmers Home Administration specifically to meet the housing needs of rural America would be an important step in this regard.

9. There is a great need for a new investment in research on the physical and social aspects of housing for the elderly. New generations of older Americans with different values and different abilities will soon constitute our retirement populations. We need to evaluate the past, conduct research on the frontiers of our knowledge and develop criteria for the near future.

10. There should be legislative enactment creating the Office of Assistant Secretary of the Department of Housing and Urban Development for Housing for the Elderly. The field is so large and so important that overall policy and planning should be centered by law in an Assistant Secretary with trained staff to ensure effective knowledge, coordination and administration.

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RESEARCH ON AGING

During the past decade there has been a substantial degree of Federal government support for research and development of social, behavioral and biomedical research on aging. This has come through as many as 30 government agencies and departments, each of which has found that it needs to support research on problems of aging and evaluation of its programs for the elderly.

There is naturally some question whether this variety of research projects and programs is well planned and coordinated so as to cover essential problems without overlapping in some places or causing serious gaps in other areas.

The situation is now ripe for a major effort to get more coherence and better planning into the Federal government's support of research on aging.

The new National Institute on Aging is almost ready to function and its National Advisory Committee has been at work for several months. Also, the Department of Health, Educatio

The National Council on the Aging, Inc.
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and Welfare has a Federal Council on Aging consisting of non-governmental personnel which advises on programs in HEW. We urge these two groups to get together, and perhaps to jointly create a Task Force on Research and Development in Social Gerontology, with the mission of producing a Five Year Plan for government support of research and development in this area.

Some of the most needed research can be foreseen. NCOA recommends:

1. Studies of methods of providing long-term care of elderly persons in feeble physical condition should be undertaken. This involves studies of standards and methods of financing nursing homes; as well as studies of facilities that can serve home-bound or physically impaired people through home-maker services and home-delivered meals - thus avoiding the cost and difficulty of moving into a nursing home.

2. Research should be started on ways of protecting the incomes of elderly people from erosion by monetary inflation.

3. Senior centers should be carefully studied. These agencies are increasing in numbers, and probably are the most useful single service facility for the elderly. A variety of model programs should be studied, evaluated and then those that work well should be spread over the land.

4. Television and radio programs, as well as the printed media, should be monitored and evaluated for their values to elderly viewers. Possibly some experimental programs should be created and tried out.

5. Research should be done on the adequacy of existing retirement roles and programs for development of new retirement roles.

6. Factors that affect policies governing retirement age should be studied.

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RETIREMENT INCOME

In the last few years, there has been a sharp reduction in poverty for persons 65 and older, from one out of four older Americans in 1969 to one in six by 1973. Nevertheless, the elderly are still the most economically disadvantaged age group, since the proportion of aged living in poverty (16.3 percent) is higher than for any other age group. The majority of aged persons in poverty are women living alone.

Many more older Americans, although not considered to be in poverty, do not have incomes sufficient to meet a modest standard of living. Almost half of all aged couples have incomes below the Bureau of Labor Statistics intermediate budget for a retired couple ($6,041 in 1974) which was recommended as a standard by the 1971 White House Conference on Aging.

Thus, the nation has still not achieved the long-sought goal of an adequate retirement income for all even though income maintenance for the aged has been improved in three major areas: Social Security benefits have been substantially raised;

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Washington, D.C. 20036
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the old age assistance welfare program has been federalized by enactment of the Supplemental Security Income program administered by the Social Security Administration; and, private pensions have been made more secure by the pension reform law.

At the same time that these improvements have been made, however, inflation has offset their impact on retirement income. Social Security increases have lagged behind price increases, particularly in the areas where the elderly have their greatest expenditures--housing, food, medical care and transportation. In the SSI program, recipients in at least 21 states will not even receive the benefits of a recent eight percent cost-of-living increase which they are entitled to along with other Social Security and SSI recipients.

Reduced Social Security taxes because of the recession and a long-term change in the population mix, have generated questions about the financing of the Social Security program. The National Council on the Aging has addressed itself to the financing aspects as well as to the adequacy of benefits in a statement adopted earlier this year. The goal with regard to financing is to bring income and outgo of the Social Security trust funds into balance within the next few years and maintain them in balance over the long-range future. There is no need to achieve a close balance in the present recessionary period or to maintain such a balance in the future over every year or short period of years.

The suggested measures to achieve this goal are:

1. The amount of earnings subject to Social Security taxes and counted in determining Social Security benefits should be increased substantially, as of 1977, from the present $14,100, and from then on adjusted, on an automatic basis, to increases in average wage levels. An increase to $24,000 in 1977 could be expected to bring the Social Security system as

a whole (cash benefits and Medicare) into financial balance for the next several decades without an increase in the tax rates.

2. Beginning in about 1985 and increasing over the following three or four decades until covering about one-third of costs, a contribution from general tax revenues should supplement employer and employee tax contributions to the Social Security cash-benefits program. The general revenue contribution should begin within the next decade and be phased in gradually.

In order to achieve more adequate Social Security benefits (and supplemental work income) the National Council on the Aging recommends:

3. An increase in the amount of earnings covered (see above no. 1) which would lead to higher future benefits and therefore greater economic security for workers in the middle and upper income brackets.

4. Gearing benefits to total wages in covered employment instead of to changes in the cost-of-living. Thus, as standards of living and levels of living increased for the working population, the retired would have a share in the increases.

5. Abolishing the premiums paid by beneficiaries for Part B Medicare.

6. Increasing the amount a Social Security beneficiary may earn in a year without reduction in benefits from $2,520 to $3,000.

The objective of the Supplemental Security Income program for the elderly is to provide an adequate standard of living for those who do not have income, or enough income, from Social Security, pensions or savings. It provides a federal "income floor" for those without other adequate income resources. Experience with the program has shown, however, that although there are some 2.3 million aged persons receiving benefits, there are still many aged persons not receiving benefits to which they are entitled, and that implementation of the

program is reducing already limited benefits.

To achieve the goal of bringing all eligible aged persons into the program and to provide a more adequate income from SSI benefits, NCOA recommends that the Social Security Administration take the following, necessary administrative steps:

7. Field visits to those potential beneficiaries who are homebound and unable to come to local SSA offices.

8. Development and implementation of a permanent outreach and information program to inform potential recipients of their rightful benefits.

9. States should be mandated to pass along all cost-of-living increases in the federal portion of the SSI payment by requiring states to at least maintain supplementation payments at June, 1975 levels.

10. SSI recipients should be guaranteed that SSI benefits will not be reduced when Social Security benefits rise.

11. All applications for SSI benefits should be processed with the utmost promptness, preferably within thirty days. The present $100 advance should be increased to cover the full amount of the standard monthly payment for two months, and the present provision for advance payments on the basis if presumptive disability should be broadened to include presumptive blindness.

12. Legislation should be enacted authorizing the Secretary of HEW to provide a permanent mechanism for on-going emergency assistance, as often as needed, effective within twenty-four hours of a recipient's application for such aid.

13. The use of an Ombudsman at the state or regional level to respond to claims that individuals have been denied benefits to which they are entitled should be studied and seriously considered for use in the program.

The Employee Retirement Income Security Act of 1974 provided some new protections and guarantees for the some 30 million employees covered by private pension plans.

Enforcement of the new pension reform law has just begun and it is too early to assess its impact. Studies will be needed (and some are provided in the law) to determine its impact in such areas as the employment opportunities of middle-aged and older workers, the improvement of survivor provisions and the expansion of private plan coverage. The provision establishing individual retirement accounts for those not covered by other pension plans is already quite popular, but there is little information if the additional requirements provided by the law have had any effect on establishment of additional group plans. It is important that additional plans be established to extend coverage for less than half of the work force in private industry is now covered by retirement plans.

NCOA recommends two goals with regard to private pensions:

14. Existing pension plans should continue to be liberalized with regard to such features as early vesting, portability between employers and the provision of survivor benefits.

15. The establishment of new pension plans should be encouraged so that coverage would be extended to a larger proportion of the workforce.

Specific legislative and other recommendations await further study and experience under the new pension reform law.

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EXTENSION OF THE GENERAL REVENUE SHARING PROGRAM
(STATE AND LOCAL FISCAL ASSISTANCE ACT OF 1972)

Since the inception of the General Revenue Sharing Program in 1972, the National Council on the Aging has provided technical assistance to public and private local, state and national agencies serving the elderly and poor on how they should go about obtaining their "fair share" of the allocated funds. We were pleased that social services to the poor and aged was one of the priority areas in which local governments were required to spend their funds. Yet a recent study by the General Accounting Office revealed that less than half of one percent of the total monies authorized for expenditure by the local governments surveyed were directed specifically to programs to benefit the aged. To compound the problem, cutbacks in and even complete elimination of categorical programs benefiting the poor and aged have been justified on the existence of general and special revenue sharing funds to take their place.

It is clear that, without additional safeguards in the

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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legislation being drafted to extend the program, the needs of the poor, particularly the elderly poor, will not be a significant objective of revenue sharing programs. Therefore, NCOA urges the Congress and the President to support in any legislation extending the State and Local Fiscal Assistance Act of 1972 the following provisions:

1. A restriction on the use of general revenue sharing funds by both state and local governments to the eight priority areas in the current legislation.

2. A requirement that states and local governments spend no less of these funds on social services for the poor and aged than the percentage of aged and poor in that particular political jurisdiction as determined by Bureau of the Census data.

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SENIOR CENTERS

Findings from the National Institute of Senior Centers' Multipurpose Senior Center Research Project affirm the role of the Senior Center as a community focal point for older person services and activities. Nutrition, health and social services plus educational, recreational and community service opportunities are made accessible and available for older persons through Multipurpose Senior Centers in thousands of communities throughout the country. There are, however, great gaps in the development of Multipurpose Senior Centers. In rural areas, for instance, where services are particularly sparse and accessibility a major problem, there are great numbers of older persons who could benefit from Center services; yet, these are the communities which do not have sufficient local resources for such programs. NCOA thinks the following steps are necessary:

1. The Congress should appropriate funds to provide Title V of the Older Americans Act with the means to do

The National Council on the Aging, Inc.

1828 L St., N.W., Suite 504
Washington, D.C. 20036
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JACK OSSOFSKY, Executive Director

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the task it was authorized to accomplish. At the minimum, each planning and service area should have a Multipurpose Senior Center from which service delivery could be coordinated - in a sense the action arm of the Area Agency on Aging.

2. A Part C for Title V of OAA, which would provide assistance to existing programs which qualify or have the potential to become Multipurpose Senior Centers by authorizing grants to sustain all or part of the costs of staff, should be developed. The current focus of Title V is too limited. It reflects a major restriction on service delivery throughout the Older Americans Act - no support for ongoing programs. Emphasis is on new projects, with nothing to maintain services and activities which have been proven to be life-sustaining to millions of America's aged.

3. Community Development funds should be authorized for nonprofit Senior Centers in addition to those which are publicly sponsored. We also urge the Department of Housing and Urban Development to encourage support of Senior Centers in the Community Development program. The extension and ultimate funding of Title V remains the primary route of Federal support for Senior Centers. Reports from around the country indicate that centers are not receiving monies under the Housing and Community Development Act of 1974. Although Centers were specifically designated by the Congress as eligible recipients of such funds, little support has emerged.

4. The Administration on Aging should encourage Area Agencies on Aging to develop service contracts with Senior Centers whenever possible, thus recognizing and extending the comprehensive service delivery system which Multipurpose Senior Centers represent.

5. The Administration on Aging should provide support for the development of standards for Senior Centers. This would be an important step forward

in the provision of services for older people because it would assure more consistency in quality and a means to maintain programs meaningful to the community and to older persons. The Senior Center field as a whole should assist in the development of these standards and be involved subsequently in their adoption as a means of promoting the best for those who deserve the best - the older people of America.

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SOCIAL SERVICES AND THE ELDERLY

A social service system exists to help individuals and families to make optimal use of the resources which exist to sustain and enhance social functioning in our very complex society and its physical environment. Social services are needed by all people at some time in their lives to maintain or to attain their roles as socially or economically productive members of society, and to effectively cope with their environment.

The elderly particularly, because of their vulnerability and the impact of their problems on family and society, as well as their relatively little knowledge about the social interventions which are needed, represent a primary target for social services. The provision of social services in their preventive, supportive and restorative functions can provide for the individual and collective needs of older persons.

Social services can include a wide variety of individual and group or community services, such as nutrition, health,

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JACK OSSOFSKY, Executive Director

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educational or recreation and involve not only delivery systems but policy formation, training, education, and research. Transportation as well is an important ingredient of services and a link to resources in the community.

Where responsibility rests for providing needed social services for the aged has not been clearly defined. Neither has accountability been clarified nor the mechanisms for this developed. Perhaps most importantly, the resources which are provided are insufficient.

Social services have developed in three separate systems, one private profitmaking, and the others private-voluntary and public. None of these systems functions adequately for the aged and the separation of the three systems has been dysfunctional to meet all needs of the total elderly person. The identification of this group as a special category to receive government resources has weakened not only the principle of right to service but the integration of all services, private (profit-making and voluntary) and public, into one cooperative system which functions effectively.

The National Council on the Aging is aware of the wide disparity which exists at present between the needs of the elderly and the social services which are provided to meet the greatly varied needs and wishes of this diverse population. No national policy now exists regarding meeting the needs of all Americans; this should be a primary goal. There should be a public commitment to the elderly so that necessary steps may be taken to ensure that the gap be closed between service needs and services for Older Americans.

The new Social Service Amendments of 1975 (Title XX) basically represent special revenue sharing as applied to public service programs. Unfortunately, Title XX does not provide for the provision of essential services and omits the specific language permitting group eligibility or standards for adult care; it does not define strongly what constitutes an eligible service. What is most

important, moreover, is that no attempt has been made to coordinate this social service program with other programs - private and public - which provide services to the elderly.

NCOA has continually worked for improvements to insure that the current delivery and future expansion of critical social services to older Americans be facilitated. Delivery and expansion of services, however, is not enough. NCOA is concerned with regulation and means to insure the quality of the services.

The assumption is that there will be little change this year in provision of social services, and the present pattern will continue until review and planning can affect new modes of implementation. Since Title XX provides for public review and comment, mechanisms for utilization of these to maximize allocations for the elderly are essential. In this way changes may take place in direct response to service needs of the elderly.

The National Council on the Aging makes the following policy recommendations accordingly:

1. Title XX should make explicit that services be designated for the elderly specifically, so that low-income elderly are not in competition with other groups for services;

2. Group eligibility in the provision of services to adults should be allowed under Title XX.

3. Standards which ensure quality adult care must be established under Title XX. Funding to ensure enforcement of these standards through inspection and education must also be forthcoming.

4. Attempts should be made to coordinate the Title XX programs with other service programs - private or public - which serve older people.

5. Provision of services under any law is useless unless knowledge and access to the services is made readily available to the group which needs

them. Thus, a system which will provide information and make referral for the elderly to link them to services should be developed.

6. Transportation is a means to bring services and older people together. Mass transportation and/or diverse mobility systems which are responsive to the unique needs of older people should be developed.

7. Levels of appropriation for services should meet the massive needs of the elderly. Insufficient funding represents tokenism and results in inadequate services and blocks access to services.

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TRAINING AND EDUCATION

Training

With what is bound to be a major expansion of services and programs for the elderly during the next few years, there is a growing need for continuing education of people in the field. NCOA believes the following steps are necessary:

1. Continuing education and supplementary training programs for people who wish to serve as staff members of area agencies, as staff members of senior centers, and as staff of long-term care institutions should be supported.

2. The present flow of young people through doctoral programs in gerontology and related disciplines should be maintained. The provision of a limited number of fellowships for doctoral candidates in the spring of 1975 is commendable and should be continued.

3. Training grants for university programs in the social and biological aspects of aging should be maintained with

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funds that will guarantee the supply of research and university teaching personnel at a somewhat increased level.

4. The continuing needs for training persons at the doctoral and the semi-professional levels should be coordinated with the aid of the National Institute on Aging and the Federal Council on Aging. The time has come to set up an ongoing program for at least five years, with funding authorized by the Congress. Appropriations for training have been $8 million in the most recent years, and support should be continued at this level, or increased over the next five years.

Education

Programs of general cultural and socio-civic education provided for people in their 50s, 60s, and 70s are now beginning to catch the attention and interest of mature people much more than they have in the past. This is partly due to the ingenuity and effort of educators, working especially in community colleges and in extension divisions of the state universities. It is also partly due to the increasing level of formal education of elderly people. Within ten years, the majority of people aged 65 will be high school graduates. And those who have the most formal education are the ones who want more continuing education.

To encourage and meet this growing interest, NCOA recommends:

1. Educational programs should be effectively free of tuition charges for all people over age 60, which means that colleges and public schools should have access to Federal or state funds to support such programs.

2. Legislation has paved the way for support of continuing education programs, but very little money has yet been appropriated and made available. Federal funds should be appropriated specifically for these programs.

3. Curricula regarding the aging process should be developed and introduced at all educational levels.

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September, 1975

TRANSPORTATION AND THE ELDERLY

Transportation provides a link to needed services for the elderly, who are more reliant on transportation than any other segment of the population. Yet the elderly are least likely to be served by the present transportation system. Most transportation money goes to networks serving the private automobile, and the elderly are generally non-drivers. Where transportation is available - and almost none is available in rural areas - the elderly either can't afford it or design, routing or scheduling make use of facilities difficult. Thus, barriers are created to service and employment for the elderly, particularly the elderly poor. NCOA, therefore, recommends:

1. The Federal government must take the leadership in increasing the mobility of older people through subsidies and promotion of free or low-cost coordinated, accessible transportation systems with special attention to their unique needs. Ultimately, the responsibility in this

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

ALBERT J. ABRAMS, President
JACK OSSOFSKY, Executive Director

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area must rest with state, regional and local transit authorities.

2. The provision of transportation is an essential part of any social service, welfare or health program serving older people. Any of these which receives subsidy from local, state or Federal government should include transportation as the vital linkage between the older person and the service.

3. Funds should be provided by all levels of government to test out new alternative ways to provide low-cost transportation to meet the needs of older persons in both urban and rural areas.

4. Older people themselves should be actively involved in the planning, policy making and development of transportation programs designed to serve them.

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September, 1975

OLDER AMERICANS AND THE ARTS

For 25 years the National Council on the Aging has sought to facilitate the full utilization by the aged of services and programs that could make their lives more meaningful and personally gratifying.

NCOA continues to seek new alliances that can improve the quality of life for older people particularly as that quality relates to the loneliness, isolation and lack of new social roles that exist in the world of the aged. Leaders and policy-makers in the burgeoning field of cultural services must be increasingly made aware of how the arts network, both public and private, can serve and be served by older Americans. Agencies and practitioners in the field of aging must become active advocates for older persons in the field of the arts.

NCOA believes that while the aged's involvement in cultural services and programs may not be a matter of life and death for older persons, it can be a matter of happiness or unhappiness, usefulness or uselessness. The overall goal in

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this area is to ensure that older persons have an equal opportunity, with other population groups, to participate in and have access to cultural programs and services.

In addition, NCOA recognizes the need to preserve the folklore and forgotten arts of America, including the ethnic heritages of our diverse population, for the enjoyment of all citizens. It is the older adult who has the knowledge and skills not only to produce such crafts and artwork, but also the capability to teach others the techniques of these accomplishments.

With these goals in mind, NCOA makes the following recommendations:

1. The arts constituency should be broadened to include the elderly.
2. The quality of arts programs now available to older people should be upgraded.
3. New employment opportunities for artists young and old in the field of aging should be provided.
4. Art forms which otherwise might be lost forever must be preserved.
5. Support for the arts should be broadened through better use of the energy and ability of older persons whether as volunteers or as paid professionals.
6. Arts resources at local, state and national levels in both the public and private sectors that are currently overlooked or underused in the field of aging should be mobilized.
7. Local initiatives to preserve the folklore and forgotten arts of America can be encouraged by developing co-ops and/or channels to the retail market where they can reach the consumer. Any public effort to develop such channels should ensure that the proceeds of sales benefit the older artisan.
8. Older artisans should be given opportunities to share their knowledge

with others and be provided opportunities to improve their skills. Both Federal and state governments need to be sensitive to these needs and provide avenues by which this unique talent can be shared and enhanced.

To date, cultural services for, with and by the aged is a concept without priority status in either the arts or aging fields. We recognize that promoting a new concept which is not considered as important as survival support services is difficult at best and is more so in two fields that are currently underfunded. The arts are primarily concerned with survival of cultural institutions and the individual artist. Likewise, practitioners in aging emphasize survival and support of aging service agencies and the aged themselves. Nevertheless, NCOA remains convinced that there is something positive for both the arts and the aging fields in the marriage we have proposed.

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September, 1975

THE PRESIDENT'S RESPONSE TO
THE ANNUAL REPORT OF
THE FEDERAL COUNCIL ON THE AGING

The National Council on the Aging urges the President to reconsider his rejection of the major recommendations made by the Federal Council on the Aging in its first annual report.

The Federal Council on the Aging was established by the 1973 Amendments to the Older Americans Act to advise and assist the President on the special needs of the elderly. Members of the Council were confirmed by the Senate on June 5, 1974, and, on March 31, 1975, as required by law, they submitted their first annual report to the President. On July 2, President Ford transmitted that report with his comments to the Congress.

NCOA believes that, because the FCOA is composed of leading experts from the field of aging, the recommendations and advice in that report deserve more consideration than the President's negative comments gave them. It is especially unfortunate that the first official dialogue between the

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
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202/223-6250

ALBERT J. ABRAMS, President
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President and the FCOA should be so negative. We hope that this is not the beginning of a pattern of animosity which would destroy a potentially valuable relationship for all concerned - particularly for the nation's 21 million older people.

The President criticized the report for being "limited to a particular area of interest and advocacy." NCOA believes this criticism is inappropriate and unjustified. The Congress established the FCOA to perform a limited and particular function which it also considered essential; that is, the Council was to provide advice, assistance and advocacy on the special needs of older Americans. The FCOA's first report definitely fulfills this mandate.

NCOA has consistently supported the major policy recommendations contained in the FCOA report: The development of high standards of safety and care in nursing homes and the rejection of Administration proposals to cut back Federal programs essential to the welfare of the elderly.

We congratulate the FCOA on its initial efforts and look forward to the findings and recommendations of its ongoing studies. NCOA remains hopeful that, in the future, the President will be more receptive to the recommendations of the Federal Council on the Aging.

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September, 1975

THE MEDIA AND THE ELDERLY

Because the Media reflect society's perception of older persons and also make these perceptions self-fulfilling, the National Council on the Aging believes that the Media must make a major nationwide effort to develop greater public understanding of the diverse character and characteristics of older persons. NCOA, through the National Media Resource Center on the Aging, has developed recommendations for a new focus within the Media on a more positive and accurate portrayal of older men and women.

1. The Media should enable more older persons to play a fuller role in the community by exposing and reducing ageism and discrimination by increasing public understanding of the older population's value.
2. The general public should be educated to a better understanding of the processes and potentials of aging. Everyone ages and therefore has a stake in assuring that society provides the elderly with opportunities

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and options making it possible for them to live a full and contributing life.

3. The Media should stimulate consciousness-raising among the elderly themselves to enhance their own sense of worth and power.

4. The social issues and programs which affect the elderly should be dealt with more fully so that lack of information or misinformation does not prevent them from participating in activities and assistance programs which are available.

5. Staff should be developed with special knowledge in the area of aging, perhaps to monitor neighborhoods with a high concentration of elderly residents and report accurately on developments within them.

6. More cultural programs which are for, by and with the elderly should be initiated by the broadcast media.

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September, 1975

THE SPIRITUAL WELL-BEING OF THE ELDERLY

Spiritual well-being is the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness.

The spiritual is not one dimension among many in life; rather it permeates and gives meaning to all life. We call attention to this fact of life: To ignore or to attempt to separate the need to fulfill the spiritual well-being of man from attempts to satisfy his physical, material and social needs is to fail to understand both the meaning of God and the meaning of man.

We recognize that human wholeness is never fully attained. Throughout life it is a possibility in process of becoming; thus, it is no less important to the older man and woman than it is to the adolescent. In the Judeo-Christian tradition, life derives its significance through its relationship with God. While we acknowledge and respect the rights of others to have other frames of reference, we reaffirm our belief that

The National Council on the Aging, Inc.
1828 L St., N.W., Suite 504
Washington, D.C. 20036
202/223-6250

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JACK OSSOFSKY, Executive Director

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it is this relationship with God that awakens and nourishes the process of growth through wholeness in itself, crowns moments of life with meaning and extols the spiritual fulfillment and unity of a person.[1]

Spiritual wholeness is the right of all people. So that older persons can achieve and maintain a state of spiritual well-being and fulfillment, the National Council on the Aging recommends the following:

1. The spiritual leadership of the nation should address itself to a greater commitment of psychic and financial resources toward serving the elderly. While meeting the needs of the elderly and working for programs that contribute to the well-being of the elderly, religious bodies should attempt to ensure that older persons share in the planning and implementation of all programs related to them, and that these programs are directed not only to the independent aged in the community, but also to the elderly living in public or private institutions.

2. The religious community should take it upon itself to become the prime impetus toward developing special understanding and competency in satisfying the spiritual needs of the aging among its members and among those who deliver services to the aging in private and public agencies.

3. Religious bodies should take the initiative in developing a greater sensitivity toward, and appreciation of, the cultural and ethnic diversity of our nation in order to better serve the elderly. They should work closely with the diverse minority communities to ensure that cultural or language barriers to communication are broken down without destroying the common ethnic or racial identities which bind those communities and which give greater meaning and identity to so many older people.

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[1]The introduction was adapted from a statement on Spiritual Well-Being developed by the National Interfaith Coalition on Aging at its Fourth Annual Meeting, April 29-30, 1975, in Washington, D.C.

4. Religious organizations should be aware of agencies and services other than their own which can provide a complete ministry to older persons. Other organizations designed for the benefit of older persons should develop, as part of their services, channels to persons and agencies who can help in spiritual problems.

5. Religious bodies have traditionally and properly developed their own philosophies. In this context, they should work together with the elderly and coordinate their efforts with other groups to develop and declare an affirmation of rights for the elderly as well as to become actively concerned with spiritual, personal and social needs. Such efforts would work to ensure the basic values of all while guaranteeing the basic right of freedom of religion.

6. Religious bodies and the government should affirm the right to, and reverance for, life. In that framework, we believe an individual has the right to choose to die a natural and dignified death. When there is no reasonable expectation of recovery from physical or mental disability, an individual should be allowed to die and not be kept alive by artificial or heroic means. Medication should be mercifully administered during times of terminal suffering, even if it hastens the moment of death. Such a decision by an individual does not ask that life be directly taken, but that dying be not unreasonably prolonged. This decision should be made by an individual for himself or herself. To ensure that such a request for a natural death is understood and not abused by others, individuals are urged to compose living wills. These wills would communicate the conscious desire to be allowed to die even though the individual be unconscious or otherwise incapacitated near the moment of death.

7. Institutions caring for the aged should provide the opportunity for

chaplaincy services. In all cases, however, the aged resident should be the sole arbiter of the religious denomination and degree of any assistance provided.

8. The government should cooperate with religious bodies and private agencies to help meet the needs of the elderly, but, in doing so, should observe the principle of separation of church and state.

We hope that these recommendations will stimulate a rededication of national efforts toward enriching the lives of older people. In particular, we seek a society and spiritual atmosphere in which the elderly can grow to accept the past, to be aware and alive in the present, and to live in hope of fulfillment.

December 2, 1975

NOTE TO SARAH MASSENGALE

Attached is a set of reports from the National Council on Aging which may be of use to you in preparing a list of possible initiatives for the a aged for the State of the Union. WHile some of these are pure flack, most may be of use and are certainly worth reviewing. When you've had a chance to take a look at these, let's sit down and make up a laundry list of possible initiatives, along with some indication of what costs might be attached to the initiatives and what policy implications of the initiatives are.

G.E.M.

Attachment

OFFICE OF THE VICE PRESIDENT

WASHINGTON

November 20, 1975

MEMORANDUM FOR ART QUERN

FROM: GRADY MEANS

SUBJECT: Initiatives for the Aged

I've been a little concerned that, in the midst of proposing limitations on OASI benefits, consolidation of OAA programs with other service programs, and other similar suggestions, that someone is going to ask what positive initiatives we have advanced to help the aged. Along this line, I asked John Martin (former head of AOA) to lay out some ideas on initiatives to support the aged. His suggestions (attached) can be summarized as follows:

-- Federalization and consolidation of welfare;

-- better coordination of retirement systems with welfare;

-- decouple SSA benefits;

-- Age Discrimination and Employment Act of 1967 -- increase funding and extend coverage to workers over 65;

-- raise the earnings level in the retirement test or eliminate the test altogether;

-- allow the use of General Revenue Sharing funds to match Title XX funds;

-- support the comprehensive Medicare Reform Act of 1975 to upgrade Medicare;

-- Federalize Medicaid;

-- support the Barber Conable Medicare/Long Term Care Act or at least visibly elevate the level of the discussion;

-- implement Federal controls of health care costs and State regulation and physician and hospital fees;

-- reaffirm support for the SSI program and raise the benefit levels to the standard set by the CSA Income Poverty Guidelines.

Many of these proposals are contained in whole or in part in our initiatives. Some of the others may be relatively inexpensive to institute and be worth including for visibility as well as substantive purposes. I think we should discuss these and other possible options.

Attachment

cc: Sara Massengale

NATIONAL RETIRED TEACHERS ASSOCIATION
AMERICAN ASSOCIATION OF RETIRED PERSONS

November 13, 1975

Mr. Grady E. Means
Office of the Counselor
to the Vice President
268 Old Executive Office Bldg.
Washington, D.C. 20500

Dear Mr. Means:

In the course of our recent discussion you encouraged our Associations to submit to you a statement of the major issues or initiatives affecting our older population which we feel the President should embrace in his State-of-the-Union message. What follows is an attempt to outline a few such initiatives which seem to us to be of preeminent importance in the lives of older Americans and which we believe would warrant legislative and executive action. Each one can be developed in greater depth, if you desire.

BUDGET CONTROLLABILITY

Our Associations appreciate the Administration's concern over the rate of growth in federal spending. We, too, are concerned. However, we do not believe that short-term federal expenditure reductions in vital programs are an acceptable remedy for the problem of budget controllability or for an inflation, which is generated by too much public and private spending in an economy producing at or near capacity. We do not feel that the federal government's limited budget controllability over the short term is a significant constraint on its ability to exercise countercyclical fiscal policy. The federal government has the power to raise or lower taxes to restrain or stimulate the economy. We think short-term fiscal policy shifts should be made on the revenue side of the budget rather than on the expenditure side.

As means for bringing the rate of budget growth under greater control over the long term, our Associations suggest federalization and reform of our inefficient, duplicative, and wasteful patchwork of cash and in-kind welfare programs and legislation

Mary Mullen
President, NRTA

Douglas O. Woodruff
President, AARP

Bernard E. Nash
Executive Director

National Headquarters: 1909 K Street, N.W., Washington, D. C. 20049 (202) 872-4700

to coordinate the primary retirement systems with each other and with a reformed welfare structure. Moreover, by adopting the Social Security Advisory Council's proposal to decouple the indexing of social security benefits from the indexing of future retiree earnings records, the system's earnings replacement ratio should be stabilized and future cost brought under control.

AGE DISCRIMINATION

The opportunity to work and to earn a living is a critical need of most Americans. Age discrimination is one major barrier to the employment of older persons. While the Age Discrimination in Employment Act of 1967 prohibits discrimination against persons between the ages of 40 and 65 in matters of hiring, compensation and other terms, conditions and privileges of employment, age discrimination remains a widespread practice. Such discrimination can be subtle and difficult to prove. Often the victim himself comes to believe that the discrimination is somehow justified and fails to protest. Yet, age discrimination is based purely on myth. A 1971 survey conducted by the New York Commissioner of Human Rights has demonstrated that older workers perform as well as and in some cases noticeably better than workers of younger age groups.

Our Associations believe that the enforcement of the Age Discrimination in Employment Act of 1967 should be stepped up and that increased funding and increased staff should be provided to the Age Discrimination and Equal Pay Branch of the Labor Department's Employment Standards Administration. The budget request for fiscal year 1976 of $2.2 million is far below the authorization level of $5 million. Furthermore, we urge the Domestic Council to recommend to the President that he request that the Age Discrimination in Employment Act be amended to cover workers age 65 and older, as well as those between the ages of 40 and 65. There can be no logical reason for arbitrarily ending the protection of the law as soon as a worker has reached his 65th birthday. Legislation eliminating the upper age limit of the Age Discrimination in Employment Act of 1967 has been introduced in both the House and the Senate, but no action has been taken during the 94th Congress. Executive approval would greatly improve its chance of passage.

SOCIAL SECURITY RETIREMENT TEST

Still another barrier or disincentive to work which is placed in the way of older persons is the "retirement test" or "earnings

limitation" which is placed on the recipient of Social Security. Under present law, an individual may not earn more than $2,520 a year without losing Social Security benefits--$1 for every $2 earned above $2,520 until all benefits are lost. Our Associations urge immediate liberalization of the retirement test to $4,000 with a view to ultimate abolition of the test. We feel that the retirement test, as it is now constituted, poses a virtually insurmountable barrier to continued employment by low-income workers--the very group which would benefit most from continuing to work past age 65.

We are advised that 600,000 workers between age 65 and 71 will have all of their Social Security benefits withheld in 1975 and 800,000 will have some of their benefits withheld. It has been estimated that 600,000 are receiving full benefits but are intentionally holding their earnings down because of the penalty. We thus have a total of two million workers affected by the retirement test. The GAO has estimated that complete elimination of the test for all persons over 65 would cost approximately $2 billion, taking into account increased payroll and income taxes. Action short of complete elimination would obviously cost less.*

So long as the retirement test is still in effect, we feel that the Social Security benefits of an individual who continues to work past age 65 and who continues to pay into the Social Security system should be readjusted on an actuarial basis at the time of retirement to reflect his increased contributions and decreased life expectancy at the time of retirement.

REVENUE SHARING

Congress now has under consideration the extension and revision of the revenue sharing act (State and Local Fiscal Assistance Act of 1972). We are aware that the President has presented his recommendations to Congress for the extension of this Act basically in its present form. Our Associations feel most strongly that general revenue sharing should be renewed, but we have a serious question rising out of the fact that although one specified priority category in Public Law 92-512 is "the poor and aged," far less than one percent of these moneys appear to have

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* The Social Security Advisory Council has considered this question recently. Their conclusions are set forth in Appendix A. They propose a reduction in the withholding rate for earnings above the annual exempt amount of $1 for every $3 up to twice the exempt amount and thereafter $1 for every $2. Cost for 1976 would be $600 million.

been devoted to benefits for this needs category. Instead, local communities appear to have preferred to spend these additional funds on fire equipment, police protection, and similar needs rather than to increase the availability of social services to the elderly. We are aware of the obstacles to earmarking these funds in a general revenue sharing act. As an alternative, therefore, we urge the President to recommend the removal of the prohibition against use of revenue sharing funds for matching contributions in federally funded programs, particularly as to social services grants under Title XX of the Social Security Act. This should be coupled with a requirement for state and local maintenance of effort in present funding levels.

This approach would have two favorable results. First, rather than violate the sacred principle of general revenue sharing by arbitrary earmarking provisions, this proposal would increase the incentives for local communities to fund social services programs without making such allocation a requirement. Second, through the incentive mechanism, chances are improved that social services programs would be expanded in order to receive the optimum match under Title XX and, at the same time, extended to meet the required maintenance of effort by the local governments.

HEALTH PRIORITIES

Improve Medicare--In face of the fact that Congress lacks the consensus to enact a national health plan, we urge the President's support to give priority attention to improving the Medicare program. Our nation's older citizens, who as a class face the highest incidence of illness and disability and are least able to pay for adequate health protection, cannot and should not be asked to wait any longer for Congressional action to resolve the inability of present programs to provide quality health care. We call attention to one measure before the Congress that seriously deals with each of the points which we suggest needs to be addressed in improving the program performance of Medicare. The legislation is S. 1456, the Comprehensive Medicare Reform Act of 1975. The product of more than two years of study, this measure, which incorporates the key recommendations of the 1971 White House Conference on Aging, offers a comprehensive approach to meeting the health needs of the aged.

Federalize Medicaid--A second high priority in our view is the necessity to federalize Medicaid. It is apparent that the only

way to overcome the shortcomings of the Medicaid program is to follow the experience which we have gained in the income-maintenance area and have the federal government assume the primary responsibility for standardizing the Medicaid program. The present Medicaid program meets neither the principle of equity nor the principle of allocation efficiency. There are great variations in coverage of different families and individuals who are equally poor. There is also coverage in some states for persons who are not poor, and no coverage in other states for those who are. We have 52 different programs with 52 different benefit packages.

Long-Term Care--The recent disclosures of abuses in nursing home facilities has stimulated both executive and Congressional review of our nation's long-term care sector. We see a specific need for an elevation of the discussion from one focused on incremental reform to one which places an emphasis on the optimum use of our health resources by developing a health-social services delivery system.

We solicit the President's support in the elevation of the priority given to long-term care. Legislation has been introduced in the Congress by Congressman Conable of New York to establish a comprehensive national policy on long-term care as part of the Medicare structure. Senator Beall of Maryland will be introducing the Conable measure within the Senate with certain technical amendments to perfect the delivery mechanism. Given the inability of present public policy to stimulate sufficient quality resources to meeting the special needs of the chronically ill, there is growing support for a federal stimulus to organize available community resources at the local level and under local control for the provision of such care. Presidential acceptance of the program-design suggested in the Medicare/Long-Term Care Act would be consistent with the Administration's efforts to encourage alternatives to costly institutional nursing care and to stimulate retention of individuals within their communities through the mobilization of local resources.

Restrain Health Care Inflation--Although our Associations are not in favor of blanket economic controls, since such controls produce great disruption and misallocation of resources in essentially competitive markets, we are prepared to accept the imposition of selective controls as a first step toward restraining inflation in the health sector. The economic stabilization program was reasonably effective in suppressing the rate of inflation in health care costs. In the absence of such controls, we have witnessed a wholly unacceptable rate of price increases

which result in an increase in both the Medicare program costs and the out-of-pocket expenditures of the Medicare recipient.

Our Associations would favor vigorous action by the President, first, to return to controls with respect to the health industry and, second, to propose more fundamental reforms which, when implemented, would make the controls unnecessary. We believe that long-term control of the problem of rising health care costs will require the imposition of prospective budgeting for institutional providers, stronger internal controls on the part of hospital management, regional health resource planning, containment of physician charges beyond negotiated assignment, implementation of the professional standards review organization network to assure proper utilization of health care services, and controls on third-party insurance reimbursement policies.

SUPPLEMENTAL SECURITY INCOME PRIORITIES

We must emphasize that the Supplemental Security Income program has worked to the betterment of most eligibles. While inflation has eaten away many of the real gains which the program payment levels had aimed to secure and while the processing of claims has fallen short of expectations, comparatively speaking, the Supplemental Security Income program is a major improvement over the earlier federal-state matching grant-in-aid programs for income maintenance for the aged, blind and disabled. We emphasize this point because we fear that assorted criticism of the program may create an unhealthy climate of regression rather than progression. We would encourage the President to reaffirm his support of the program. The major thrust of such reaffirmation could be through calling for a raising of the benefit levels under the SSI program to the standard set by the Community Services Administration Income Poverty Guidelines.* The significance of this change would be to provide the minimum income support which the aged, blind and disabled deserve. The original consideration of the Title XVI program was steeped in the politics of the Family Assistance plan. While we recognize the numerous economic tradeoffs, which occur at the margin in discussing an income maintenance program for those who are capable of gainful employment, the shamefully low assistance levels presently advanced in the SSI program neither provide the dignity, which should be shown to the aged, blind and disabled for whom alternative

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* See Appendix B.

sources of escape from poverty are unavailable, nor sustain an independent living within the mainstream of community involvement, which is the essential thrust of related social programs administered by the Department of Health, Education and Welfare.

Sincerely,

John B. Martin

JBM:sgd

APPENDIX A

Section 3. Liberalize Provisions of the Retirement Test

Despite basic agreement with the concept of the retirement test, the Council recognizes that negative consequences arise from its application. Under the present $1-for-$2 withholding rate for earnings above the exempt amount, the additional earnings a beneficiary receives over the exempt amount may result in little additional net income to the worker when allowance is made for the additional effects of Federal income, OASDHI, State, and local taxes, in addition to work-related expenses. Thus, the retirement test discourages work by healthy and able individuals aged 65–71. At the moment there is much concern over unemployment, but recent and current low birth rates will soon cause a decline in the rate of increase in the labor force. The Council is, therefore, concerned with provisions of the law which may act to discourage participation in the labor force.

In addition, the burden of the retirement test probably falls most heavily on low-income individuals who do not have access to private insurance, pension plans, savings, or other sources of nonwork income to supplement their social security retirement benefits. Such individuals are most likely to be dependent on additional income from gainful employment to supplement social security benefits after "retirement."

The Council believes that the most appropriate means for mitigating the disincentive effects of the retirement test and the heavy burden it imposes on low-income workers aged 65–71 is to reduce the withholding rate on earnings which are just above the exempt amount. The Council proposes to establish three levels of earnings that would be subject to different reductions in benefits.

The first level would include earnings up to the annual exempt amount as defined in the present law ($2,520 in 1975). As under the present law, no benefits would be withheld from earnings within the first level.

The second level would include earnings between the annual exempt amount under the present law and twice this annual exempt amount ($2,520 to $5,040 in 1975). Earnings within this level would be subject to a withholding rate of $1 in benefits for each $3 earned, instead of the present withholding rate of $1 for every $2 earned.

The third level would include all earnings in excess of twice the annual exempt amount under the present law (i.e., $5,040 in 1975). The withholding rate at this level would be, as under present law, $1 in benefits for each $2 of earnings.

The provision of the law which automatically adjusts the exempt amount assures that the second level of earnings, to which the $1-for-$3 withholding rate is applied, will increase in the future as general levels of earnings rise.

The main effect of this liberalization would be a significant reduction in the benefits withheld from individuals who earn between one and two times the annual exempt amount. For example, under present law, a worker who earned $5,040 in 1975 would have $1,260 of social security benefits withheld. Under the Council's proposal, this individual would have only $840 withheld, corresponding to a ⅓ reduction in the burden of the retirement test. The table below illustrates the effect in 1975 of the proposed reduction in withholding rates for earnings in the second level. The percentage reduction in the amount withheld is greatest at the lower level of earnings, where the needs of social security benefit recipients may be presumed to be greater.

Annual earnings	Withholding under present law	Withholding under proposed liberalization	Percentage reduction in amount withheld
$2,520	0	0	
$5,040	$1,260	$840	33.3
$7,560	2,520	2,100	16.7
$10,080	3,780	3,360	11.1

It is estimated by actuaries of the Social Security Administration that this liberalization of the withholding rate would increase the cost of the program by an average of 0.04 percent of taxable payroll over the next 75 years (about $0.6 billion for months in 1976, the first full calendar year).

APPENDIX B*

CSA poverty guidelines for all States except Alaska and Hawaii

Family size	Nonfarm family	Farm family
1	$2,590	$2,200
2	3,410	2,900
3	4,230	3,600
4	5,050	4,300
5	5,870	5,000
6	6,690	5,700

For family units with more than 6 members add $820 for each additional member in a nonfarm family and $700 for each additional member in a farm family.

CSA income poverty guidelines for Alaska

Family size	Nonfarm family	Farm family
1	$3,250	$2,750
2	4,270	3,620
3	5,290	4,490
4	6,310	5,360
5	7,330	6,230
6	8,350	7,100

For family units with more than 6 members add $1,020 for each additional member in a nonfarm family and $870 for each additional member in a farm family.

CSA income poverty guidelines for Hawaii

Family size	Nonfarm family	Farm family
1	$2,990	$2,540
2	3,930	3,340
3	4,870	4,140
4	5,810	4,940
5	6,750	5,740
6	7,690	6,540

For family units with more than 6 members add $940 for each additional member in a nonfarm family and $800 for each additional member in a farm family.

* Chapter X, Part 1060, Title 45, Code of Federal Regulations, Attachment A.

The Council of State Governments

November 13, 1975

Mr. James H. Falk
Associate Director
Domestic Council
The White House
Washington, D. C. 20500

Dear Jim:

You will recall that I promised to send you a letter concerning the National Symposium on Aging that will be held in Washington on Thursday and Friday, February 26-27, 1976. These sessions will be the culmination of a cooperative HEW-CSG project designed to prepare and disseminate the best possible suggested state legislation in the field of services and assistance to senior citizens. A major portion of the attendance will come from state and local elected officials and administrators of programs for the aging.

The National Symposium will come at a point in the project when we have identified priority issues for States through regional forums. We will have drafted suggested state statutes and will be considering policy issues highlighted in the forums. The purpose of the Symposium will be to explore the broader implications of these issues for the quality of life of older Americans. Naturally, the thrust of federal goals and priorities in this area is of great import, and our activities would be greatly enhanced by White House participation. We would be honored if the President or his representative would address the Symposium on the morning of February 26 at the Mayflower Hotel in Washington.

Dr. Arthur Fleming, Commissioner of the Administration on Aging, joins me in urging that The White House and Domestic Council play an appropriate role in the Symposium. Dr. Fleming has over the years worked with us on a number of projects which sought to improve intergovernmental relations. Both of us believe that this is another worthy effort in that direction.

Cordially,

Brevard Crihfield
Executive Director

BC:id

P. O. BOX 11910, IRON WORKS PIKE, LEXINGTON, KENTUCKY 40511 - TELEPHONE (606) 252-2291

94th Congress
1st Session

COMMITTEE PRINT

CONGREGATE HOUSING FOR OLDER ADULTS

Assisted Residential Living Combining Shelter and Services

A WORKING PAPER

PREPARED FOR USE BY THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NOVEMBER 1975

Printed for the use of the Special Committee on Aging

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Prepared by Marie McGuire Thompson, Commissioner, U.S. Public Housing Administration, 1961–67

PREFACE

President John F. Kennedy, in his "Message on Aid to Elderly Citizens" in February 1963, focused at one point on "a substantial minority" of older people who, "while still relatively independent, require modest assistance in one or more major aspects of daily living."

To help them—and to defer their potential need for nursing home or hospital care—President Kennedy proposed group residential facilities "with housekeeping assistance, central food service, and minor nursing from time to time."

Soon after the Kennedy message, several Federal agencies worked cooperatively to establish pilot projects in Georgia, Nebraska, and Ohio. These projects are still very much in existence, and there is much to be learned from each of them.

But the logical next step—a national effort to help assure semi-independent living to older persons with impairments of one kind or another—has been taken only partially.

Congress, in 1970 [1] and again in 1974, enacted legislation authorizing "congregate" units and facilities in federally assisted public housing. One reason for the concern about the elderly in public housing was their fairly large numbers: about 40 percent of the heads of households in such projects are 62 and over. Another is the fact that many residents have lived in such units for many years and have a high ratio of chronic illnesses or disabilities.

For reasons made clear on the following pages, public housing congregate authority has not been widely used. And yet, as the author says so emphatically:

> As could be anticipated, an increasing number of public housing agencies are faced with the fact that either they must evict the more frail or impaired who cannot sustain the shopping, cooking, or heavy housekeeping chores designed for the hale and hearty, or they must develop—on a crash and, perhaps, ill-founded basis—some semblance of the services these aging occupants need to maintain at least semi-independence in a residential setting.

This warning is worthy of immediate examination and, indeed, it recently received attention at a hearing by the Subcommittee on Housing for the Elderly.[2] That hearing, however, was not limited to congregate shelter in public housing, just as this working paper is not. Rather, the public housing situation serves as an early indicator of the extent to which the need for assisted group living will grow unless that need is more fully understood and acted upon.

[1] Legislation introduced by Senator Williams was incorporated as a section of Public Law 91–609, the Housing Act of 1970.

[2] "Federal Response to Housing Needs of Older Americans: Service Needs of the Elderly in Public Housing," by the Subcommittee on Housing of the Elderly, Senate Special Committee on Aging, Oct. 7, 1975. Washington, D.C., Senator Harrison A. Williams, Jr., presiding.

As the author of this working paper puts it:

> Although particular attention is paid to public housing in this report, the principles underlying the program enacted in 1970 and reaffirmed in 1974 are equally applicable to the development of congregate housing under other public programs or in the private market. Tenant characteristics and basic operations will be similar even though the financing and sponsorship may differ.

Additional perspective on the potential need for congregate housing was provided at the recent hearing by a witness[3] *who estimated that better than 3 million older persons in the United States today can be considered to need assisted housing. Of these, 2.4 million are candidates for residential congregate housing with services. If the services are not provided, said the witness, the entire 3 million may be forced to resort to nursing homes—80 percent of them unnecessarily.*

At a time when there is much talk about so-called alternatives to institutionalization, it would seem that congregate housing should rank high.

At a time when the Federal share of nursing home expenditures is almost $4 billion yearly, the need for less costly alternatives becomes even more obviously urgent.

The Subcommittee on Housing for the Elderly and the entire Senate Special Committee on Aging are in the debt of Marie McGuire Thompson for writing this working paper and for sharing it so generously with members of this committee and the entire Congress. Dr. Thompson has, over a period of decades, insisted that human considerations are at least as essential in housing as are financing considerations and physical design. Moreover, she has backed up her thinking with action. As executive director of the San Antonio Public Housing Authority from 1949–61, she paid special attention to the shelter needs of the elderly. A demonstration project, Victoria Plaza, won national attention and still serves as a model public housing project for gerontologists and architects. She then served as Commissioner of the U.S. Public Housing Administration from 1961 to 1967 and later served the Department of Housing and Urban Development as a specialist on housing for the elderly and handicapped. Since 1973, she has been housing specialist for the International Center for Social Gerontology.

Her working paper is timely and thought-provoking; and her recommendations are worthy of extensive consideration by Congresional units with an interest in housing or aging, or both. In the interest of providing information and ideas needed for full public discussion of the wide range of housing needs of older Americans, the Subcommittee and Committee are happy to offer Dr. Thompson's working paper for review and thought.

FRANK CHURCH, *Chairman,*
Special Committee on Aging.

HARRISON A. WILLIAMS, Jr., *Chairman,*
Subcommittee on Housing for the Elderly.

[3] Wilma Donahue, Ph. D., director of the International Center for Social Gerontology, Washington, D.C. Dr. Donahue also gave this definition of congregate housing: "A residential environment which includes services, such as meals, housekeeping, health, personal hygiene, and transportation, which are required to assist impaired, but not ill, elderly tenants to maintain or return to a semi-independent life style and avoid institutionalization as they grow older."

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APPENDIXES

CONGREGATE HOUSING FOR OLDER ADULTS

By Marie McGuire Thompson*

Commissioner, U.S. Public Housing Administration, 1961–67

INTRODUCTION

The congregate public housing program provides local housing authorities with an opportunity and a challenge to expand the choices now available to low income older persons to select a living environment best suited to their personal and social needs, functional capacities, and financial resources. Enacted in 1970 as part of the Housing and Urban Development Act, the program encourages the development of residential settings to accommodate older people, as well as handicapped and displaced persons, who need some services to sustain independent living but not enough to warrant institutional supervision and care. Statutory authority for the program was retained in the 1974 Housing and Community Development Act (title II, section 201(a)(7)). It is assumed that programs will be funded and activated if they fulfill the goals of the legislation and the related HUD regulations.

Local and county housing authorities have already established a successful record in providing residential environments for older people who can and prefer to live independently. Since 1956, in over 3,000 localities throughout the United States and its territories, they have helped develop some 600,000 specially designed dwellings to assure low-income elderly persons safe, comfortable shelter at rents they can afford. These accommodations also provide tenants with an active environment filled with a wide range of social, recreational, and leisure pursuits to offset loneliness and improve the quality of their retirement years. Even today the number of applicants on waiting lists for these units far exceeds the number of dwellings available.

However, many tenants now in public housing have "aged" in their present quarters as have those in private housing in the community. As could be anticipated, an increasing number of public housing agencies are faced with the fact that either they must evict the more frail or impaired who cannot sustain the shopping, cooking, or heavy housekeeping chores designed for the hale and hearty, or they must develop—on a crash and, perhaps, ill-founded basis—some semblance of the services these aging occupants need to maintain at least semi-independence in a residential setting.

There can be little doubt that the demand and need for residential living with basic services will increase dramatically within the next decade, and probably more markedly after that. The number of "middle-old" and "old-old" aged Americans is

*For additional biographical details, see preface. Dr. Thompson received editorial assistance in preparing this report from Mr. D. J. Curren.

growing faster than that of almost any other age group. Given such a trend, there will be greater and greater need for assisted residential living arrangements with services similar to those rendered in a family setting for an older relative.

Congregate housing is one achievable answer to this imminent rise in demand and need. Under the congregate public housing program, local housing authorities can provide residential environments for their tenants who are substantially intact and well elderly, but whose functional capacities are somewhat limited due to diminished physical or mental energy, impaired mobility, or special social or economic conditions. This type of housing resource planning is an alternative to institutional living when that level or extent of supervision and care are not required. Other similarly impaired elderly, already in institutions, might return to semi-independent living if they could relocate in a setting which includes access to services designed to strengthen their capacity for self-support in a living arrangement more attuned to their desire to continue to participate in community life. For other low-income older persons who are becoming frail through advancing age or diminished capacities, congregate public housing could serve as a "next step" program, providing a range of services to sustain their maximum potential for self-management and thus reduce any unnecessary dependence on inappropriate, costly institutional care.

The distinguishing characteristic of congregate public housing, and one critical to its success in serving the special needs of this portion of the low-income older population, is the range and quality of services available to sustain independent living among tenants whose functional capacities vary at different stages of the aging process. In the planning, design, and operation of this type of public housing, housing authorities will need to reach out and establish linkages with other local resources, since the provision of coordinated multiple services will require careful planning in order to adapt them to tenant requirements. Together with local service agencies, housing authorities will need to explore ways to coordinate Federal, State, and local support now available to help provide housing and services at costs that tenants can afford. They will also need to study ways in which local and national programs (such as those funded under the Older Americans Act or title XX of the Social Security Act) can help provide reasonable assurance of continuity of services in the future. Finally, housing authorities will need to develop and foster a new kind of management and staff who are trained in general property management and tenant-landlord relations but also are skilled in relating housing and service support to each tenant's need and capacity to live successfully in a congregate residential environment.

This report is designed to assist public housing officials and others working with them to consider the major factors affecting the design and scope of congregate housing for the elderly. These factors include the particular population and area of need to be served; special features involved in the planning and design of congregate housing; issues which may arise in relation to management and staff responsibilities, such as the meals service and group activities; and sources of support to cover the full costs of providing housing and services to residents on low, fixed incomes.

Although particular attention is paid to public housing in this report, the principles underlying the program enacted in 1970 and reaffirmed in 1974 are equally applicable to the development of congregate housing under other public programs or in the private market. Tenant characteristics and basic operations will be similar even though the financing and sponsorship may differ.

58-430—75——2

PART 1

BACKGROUND

There is no single meaning or definition of the term "congregate housing" upon which all agree. The term is used loosely in this country to describe any type of collective or group living arrangement, supervised or not, ranging from large scale, campus-type developments to small cooperative housing projects or boarding homes sometimes organized by older people themselves.

Nor does "congregate" fully describe the nature and purpose of this type of housing. It is, however, the term used in the 1970 and 1974 Housing and Urban Development Acts to describe housing with food and other services for the elderly under provisions of the low rent public housing program.

One definition of congregate housing is:

> . . . a residential environment which includes services, such as meals, housekeeping, health, personal hygiene, and transportation, which are required to assist impaired, but not ill, elderly tenants to maintain or return to a semi-independent life style and avoid institutionalization as they grow older.*

Congregate public housing can be best understood as another residential environment for the elderly which is adapted in design and operation to the realities of the aging continuum. It can be expected to serve those of a more advanced age, those with decreased energy and mobility levels, and those who retain the capacity and desire for as much self-management as possible. In short, such a setting offers aids to continued community living, thus delaying or avoiding premature reliance on institutional care. Congregate public housing is neither a care home nor a medical facility; it is residential in character. The services provided to tenants should be related to and be consistent with this residential atmosphere. They should offer neither continuous supervision nor skilled nursing care. Instead, services should aid tenants in managing the range of activities of daily independent living such as housekeeping assistance as needed, personal aid in special circumstances, and the preparation of nutritious, balanced meals.

The purpose and value of congregate housing for the elderly have been recognized and discussed for more than two decades by government officials, professionals in the field of aging, and older people themselves. But until now little has been done to encourage its development throughout the country, to resolve financing and operating

*Developed by Dr. Wilma T. Donahue, director, International Center for Social Gerontology, Washington, D.C.

difficulties, or to explore its potential benefits as a residential alternative for large numbers of the frail aged who need housing with basic services in addition to leisure and recreational activities.

EARLY SUPPORT FOR THE CONGREGATE HOUSING CONCEPT

In 1950, the first National Conference on Aging stated that it "felt a definite handicap that complete data are not available on the apportionment of older people by types of living arrangements, such as independent living quarters, homes (shared) with married children or relations, boarding homes, or congregate living quarters."

In 1961, the White House Conference on Aging recommended that "a Federal definition of terms relating to various types of institutions and care be formulated so that there can be a common understanding of terms generally used for allocation of funds and financing to meet the continuum of independent-to-dependent living arrangements." The range of types of needed housing was outlined by delegates and firm recommendations were made to proceed with the development of various levels of housing and services.

President John F. Kennedy, in the following excerpt from his message on Aid to Elderly Citizens (issued February 21, 1963, cf. H. Doc. 72), recommended group residential facilities as a complement to Federal provisions for independent living (which had been enacted in the period from 1956 to 1959) and a nursing home program (enacted in 1961):

> GROUP RESIDENTIAL FACILITIES
>
> For the great majority of the Nation's older people, the years of retirement should be years of activity and self-reliance. A substantial minority, however, while still relatively independent, require modest assistance in one or more major aspects of their daily living. Many have become frail physically and may need help in preparing meals, caring for living quarters, and sometimes limited nursing.
>
> This group does not require care in restorative nursing homes or in terminal custodial facilities. They can generally walk without assistance, eat in a dining room, and come and go in the community with considerable independence. They want to have privacy, but also community life and activity within the limits of their capacity. They do not wish to be shunted to an institution, but often they have used up their resources, and family and friends are not available for support. *What they do need most is a facility with housekeeping assistance, central food service, and minor nursing from time to time. The provision of such facilities would defer for many years the much more expensive type of nursing home or hospital care which would otherwise be required.* [Emphasis added.]
>
> To meet the special needs of this group, facilities have been constructed in many communities, and many more should

be constructed. Such buildings can be small, with facilities for group dining, recreation, and health services; and they should be integrated with the various community resources which can sustain and encourage independent living as long as possible. I am requesting (a) that the Housing and Home Finance Administrator give greater emphasis to the construction of group residences suitable for older families and individuals who need this partial personal care, and (b) that the Secretary of Health, Education, and Welfare, using the funds under the proposed Senior Citizens Act and other resources already available to his Department, work with communities to assure that health and social services are provided efficiently for the residents of such facilities in accordance with comprehensive local plans.

EARLY EXPERIMENTS IN CONGREGATE PUBLIC HOUSING

Following this Presidential directive, the Housing and Home Finance Agency, the Public Housing Administration, and the Department of Health, Education, and Welfare cooperated in formulating joint policies on housing and services. A formal agreement was signed between the Commissioner of Welfare for HEW and the Commissioner of the Public Housing Administration to work together to support efforts by local housing and welfare agencies to implement a congregate housing program.

Because there was no statutory authority to provide Federal support to cover the costs of central dining rooms and kitchens, equipment, meal preparation, and other services, these early efforts were limited to pilot congregate housing projects in Alma, Ga.; Burwell, Nebr.; and Toledo and Columbus, Ohio—all of them communities where State and local support was strong and included contractual guarantees to provide meals and other services. In all cases, local hospitals provided the meals service.

The Toledo and Columbus, Ohio, Developments [1]

The two congregate public housing developments approved for Toledo and Columbus, Ohio, accommodated elderly patients relocated from State mental institutions as well as elderly persons from the community. The State accepted responsibility for the additional construction and operating costs of supporting the dining service, provided staff for recreation and health programs, and guaranteed the provision of supportive services for the full 40-year financing period of both developments. These experiments were successful and proved to be economical to the State. In Columbus, the Department of Public Welfare's Homemaker Service is headquartered in the development and is available to tenants at no cost. The homemakers also assist with bathing or dressing upon request. Approximately 50 percent of the tenants avail themselves of the housekeeping service. The Toledo

[1] Program detail was contributed by Patrick J. Feeny, director, Columbus Metropolitan Housing Authority, and by staff and personnel of the Ohio State Mental Hygiene and Correction Department and the Ohio Commission on Aging.

project boasts one dining room while the Columbus project has a series of small dining rooms in different locations in an attempt to simulate a family-size grouping, a concept imported from Sweden and more expensive to operate. (Additional design and operational information on both are provided in appendix 1, p. 41.)

In Toledo, 30 of the 100 residents were dischargees from the Toledo State Hospital and 56 of those in the 256-unit Columbus project were from the Columbus Hospital or from nursing homes. Since more massive services were provided in Columbus, the age of the tenant group was higher, averaging 84 years at initial occupancy. In each project all staff concurred that without a development of this kind with three essential services—meals, housekeeping, and personal assistance when needed—at least 50 percent of the residents would have to turn to nursing homes. Indeed numerous occupants have been transferred from public housing for independent living to congregate housing as their need for services became essential to continued residential living.

The Alma, Ga., Development [2]

The Alma, Ga., project is a one-story development with 40 units of congregate housing (without kitchens) and 12 housekeeping units with kitchens. The tenants in congregate housing are provided a full meal service for $45 per person per month; those in housekeeping units may also participate if notification is made to the kitchen. A strong buddy system exists between the hale-and-hearty older persons and others less able. The development is located next to the county hospital and a nursing home. The meal service (originally provided by the hospital) is now provided under a private contract and prepared in the kitchen of the project. The congregate units with no kitchen do have a small refrigerator and a counter for a hot plate, coffee pot, toaster, et cetera. There are no formal housekeeping services; heavy housecleaning is performed by the maintenance staff. (For further details, see appendix 2, p. 52.)

The Burwell, Nebr., Development [3]

This 50-unit project, occupied in 1967, consists of 30 housekeeping one-bedroom units in five brick buildings and 20 new housekeeping units in the congregate living area which is part of the community building with recreation room, community living room, and kitchen for tenant gatherings and events. Occupants are provided a living-sleeping room, bath, and storage. Meals are prepared and delivered three times a day, 7 days a week, by Community Memorial Hospital and Nursing Home located a block from the project. Meals cost $2.70 a day. Income limits for occupancy are $3,500 for one person and $4,000 for two persons. Areawide recreation and craft programs are provided under title III of the Older Americans Act. Featured in the community dining room are a double fireplace and round tables with captain's chairs. (Additional details are provided in appendix 3, p. 58.)

Experience in Burwell and in Alma, towns considerably smaller than Toledo and Columbus, evidences the ability of congregate public

[2] Information contributed by Wilfred B. Smith, executive director, Alma Housing Authority, 801 12th Street, Alma, Ga.

[3] Contributor: Dorothy Van Diest, executive director, Housing Authority, P.O. Box 899, Burwell, Nebr.

housing in all sizes of communities to provide a residential environment which includes services required to assist impaired, but not ill, elderly tenants to maintain or return to a semi-independent lifestyle and thus avoid institutionalization as they grow older. As the manager of the Burwell congregate development stated: "All tenants living in the congregate facility would be in a nursing home if it were not for this type of housing and the services provided."

Additional Experience in South Dakota and Texas

Two other congregate public housing developments in South Dakota and Texas, while not part of the original experiments undertaken in the mid-1960's, should be noted as well.

The Felix Cohen Memorial Building on the Pine Ridge Indian Reservation in South Dakota is composed of a large community center for many reservation activities and is combined with a limited number of rooms with bath for elderly Indians.[4] Furnishings, art, and sculpture were contributed by friends and associates of the late Felix Cohen. Meals are prepared and delivered by the adjacent hospital. The operation of the facility, which is part of the family public housing on the South Dakota reservation, is more related to the culture of the Oglala Sioux than to the usual congregate concept, but it has served and continues to serve a need.

In Texas the Housing Authority of Mineral Wells leased a number of rooms with bath in a vacation-type hotel typical of the city for the permanent use of low-income older tenants. The room rent is contracted for and the hotel provides a full meal service commensurate with the ability of tenants to pay.

STATUTORY AUTHORITY FOR A NATIONAL PROGRAM

It was not until 1970 that a nationwide congregate public housing program was enacted into law as a supplement to successful low-rent residential developments for independent living for the elderly. Recognition of this gap in housing and its tragic personal consequences for those not needing or desiring institutional care led to the enactment of the program in section 207 of the 1970 Housing and Urban Development Act.* Section 114 of this act also provided for congregate housing by private groups under FHA sections 221(d)(3) and 236.

Provisions in the law relating to low rent public housing read as follows:

50 STAT. 895; 42 U.S.C. 1415

Congregate Housing for the Displaced, Elderly, and Handicapped

SECTION 207

Section 15 of the United States Housing Act of 1937 is amended by adding at the end thereof a new paragraph as follows:

[4] The late Felix Cohen was a distinguished scholar of Indian affairs and a strong advocate of their rights. He is credited with securing voting rights for all Indian tribes.

*This section was suggested and sponsored by Senator Harrison A. Williams, Jr., of New Jersey, then chairman of the Senate Special Committee on Aging and a member of the Senate Banking, Housing and Urban Affairs Committee.

"(12) The Secretary shall encourage public housing agencies, in providing housing predominantly for displaced, elderly, or handicapped families, to design, develop, or otherwise acquire such housing to meet the special needs of the occupants and, wherever practicable, for use in whole or in part as congregate housing: Provided that not more than 10 per centum of the total amount of contracts for annual contributions entered into in any fiscal year pursuant to the new authority granted under section 202 of the Housing and Urban Development Act of 1970 or under any law subsequently enacted shall be entered into with respect to units in congregate housing.

"As used in this paragraph, the term 'congregate housing' means low-rent housing (A) in which some or all of the dwelling units do not have kitchen facilities, and (B) connected with which there is a central dining facility to provide wholesome and economical meals for elderly families under terms and conditions prescribed by the public housing agency to permit a generally self-supporting operation. Expenditures incurred by a public agency in the operation of a central dining facility in connection with congregate housing (other than the cost of providing food and service) shall be considered one of the costs of administration of the project."

Statutory authority was now provided for a congregate housing program which included coverage of the costs of the dining facility and equipment. No subsidy, however, was provided to cover any deficit caused by the inability of low-income elderly tenants to pay the full cost of meals and other services. This meant that tenants would have to be selected according to their ability to pay rather than on the basis of their need for housing with services. This fact, as well as a widespread lack of experience in a new kind of housing management which required relating housing and services to the functional capacity of each tenant, probably have made most housing authorities reluctant to enter this field. As a result there has been little production of congregate housing and little encouragement to do so.[5] If responsibility for aspects of service and care were shifted to State and local agencies skilled in these areas, the building or acquisition of appropriate congregate housing facilities would undoubtedly be accepted willingly by local public housing agencies, the majority of which have programs for the well elderly but few local service-oriented facilities in which to relocate tenants who can no longer maintain fully independent living.

After enactment of the program, releases from the Department of Housing and Urban Development emphasized that "congregate housing will serve those who cannot sustain or do not desire independent living in housekeeping units." It was acknowledged that although this type of housing must be free of architectural barriers, its success would be related primarily to the range and quality of services available to tenants. With regard to the meals service, the HUD Management Guide for Congregate Housing (H.M.G. 7460.1) stated that "many of the congregate housing tenants will not be able to afford the entire

[5] In contrast, housing authorities have responded well to the need for conventional housing for the elderly: 3,511 of these authorities operate in 4,676 localities throughout the United States, with developments especially for the aged operating in more than 3,000 localities.

cost of the food service program. Some sources of regular subsidy—State or local, public or private—will have to be found in order to make the food service in congregate housing financially feasible."

In 1971, as one effort to solve this problem, meetings were held with the Department of Agriculture to obtain permission to use food stamp coupons to pay for meals in congregate housing. Although not prohibited by law, this use was not permitted by departmental policy which restricted food stamp use for meals prepared outside the home to those prepared in restaurants. This ruling was changed as of July 1974 to allow elderly persons over the age of 60 to use food stamps as payment for prepared meals in noninstitutional settings and communal dining facilities if the meals service was approved by the Food and Nutrition Service, was nonprofit, and did not use federally donated food in meal preparation. Part 270.2(m), chapter II, title 7 of the Code of Federal Regulations was amended to include communal dining facilities as consistent with section 10(h) of the Food Stamp Act of 1964, as amended.

In 1972, with the passage of the National Nutrition Program for the Elderly, some public housing developments which had the necessary space began serving free meals to their tenants and to older persons in the neighborhood. However, the scope of this program did not provide the long-term guarantees for food and other services required in congregate housing to assure its financial feasibility. As a result, building or remodeling facilities to accommodate the provision of food and other services could not be justified.

Delegates at the 1971 White House Conference on Aging again called for a national statement of goals on providing a spectrum of housing for the elderly which would respond to the level of assistance they required at various stages of the aging process. These included long-term facilities for the sick; facilities with limited medical care and with food and homemaker services for those who needed continual supervision and assistance; congregate housing with food and personal services for those who required some assistance but not medical care and who sought independence with security; and housing for independent living with recreational and activity programs provided.[6] With regard to the recommendation on congregate housing, Dr. Wilma T. Donahue, director of the International Center for Social Gerontology and one of the planners of the 1971 conference, observed:

> It is significant that these recommendations were made nearly a year after the Congress had passed a bill, which the President signed on December 21, 1970, making provision for congregate housing for the elderly. It is perhaps because there was a long lag in implementing the act that the delegates to the conference in December 1971 did not address themselves to its provisions and possibilities.

STATUS OF THE PROGRAM TODAY

The inability of many low-income older persons to pay for food and other services, in addition to rent, remains the major barrier to the nationwide implementation of the congregate public housing pro-

[6] *Toward a National Policy on Aging,* Proceedings of the 1971 White House Conference on Aging (Washington, D.C.: U.S. Government Printing Office), volume II, p. 32, recommendation IV.

gram on a grand scale. Despite statutory authority for it, we can today expect little effort to develop this type of housing without local or State support for food and services being reasonably guaranteed. Until this support is assured, imaginative housing agencies should proceed to develop such needed living arrangements by devising ways that State and local service agencies can provide the necessary funds to supplement construction dollars available from HUD.

Whatever final decisions are made on the public housing program the need for congregate housing in one form or another will grow, not only for elderly tenants in public housing, but also for persons in other income groups. Recognition of this is evidenced by the increasing interest of States, cities, and public and private developers in providing such facilities for a range of income groups. The International Center for Social Gerontology, a nonprofit research organization, has studies underway to more clearly define the congregate housing concept, the potential occupants, and services needed. In November 1975 it will also hold the first national conference on congregate housing, or assisted residential living, to delineate the services needed, the resources to provide them, the costs in relation to incomes available to afford this type of living, and the market and need for this housing program.

Without administrative or legislative action at all government levels, institutional care facilities will continue to be the final living environment for too many older persons who could maintain an independent lifestyle with a minimum of assistance. Yet there is little doubt that the glaring gap in the housing continuum for some of the older population is the need for a program that is residential in nature, provides community orientation for the occupants, and also provides those supportive services that maintain the resident in this living arrangement despite chronic conditions or frailty. Adding years to life but depriving the elderly of the opportunity to remain active in society to the fullest extent of their capacities creates self-pity, apathy, and despair among many older people. It also robs the community of the presence and contributions of its most experienced citizens. Primarily then, the concept of congregate housing should be seen as the most viable solution to premature reliance on institutional care when that level of medical supervision is not required.

PART 2

THE POTENTIAL RESIDENT POPULATION OF CONGREGATE PUBLIC HOUSING

An understanding of the probable characteristics of the potential resident population must underlie the design and operation of congregate housing. It is obvious that no single type of housing will provide an adequate response to the diversity of need among this segment of the older population. Instead, efforts must be made to offer a variety of housing types and residential settings oriented to consumer need and preference. This chapter identifies some characteristics of the population for whom varying types of congregate housing would be appropriate. Subsequent chapters discuss the planning and design of facilities to accommodate this group as well as factors involved in congregate housing operation and management.

SIZE, AGE, HEALTH, AND INCOME CHARACTERISTICS OF POTENTIAL POPULATION

There is no way to assess specifically the current need or demand for congregate public housing except by inference from our experience, observation, and knowledge of the housing needs of older people at various stages of the aging process. Specific numbers, income levels, and housing adequacy alone do not reflect the potential market for congregate housing among the older population who might choose this type of residence if it were readily available. However, given the realities of growing old and considering the early results of surveys undertaken by the International Center for Social Gerontology (referenced in the preceding chapter), a valid assumption can be made that an increasing number of older people will require a supportive environment to offset premature reliance on an institution or to afford them an opportunity to leave one and relocate elsewhere.

Population Size

Data are not available from which to predict the number of older people in the United States who need or prefer living quarters that include provisions for both independence and some nonmedical personal services. According to the 1970 census, 593,000 persons aged 60 and older were living in group quarters that did not provide nursing care. Another 238,000 resided in "other" types of group quarters, including mental and other hospitals. Some portion of this latter group might be enabled to live outside these facilities if appropriate shelter and social environments were available. The same might also be true for some portion of the 277,000 persons living in old age homes that

offer nursing care even though not all residents may need it. Of the 27 million persons over age 60 living in housing units, it is estimated by one authority that 200,000 to 300,000 would choose to relocate in congregate housing each year. Most of this number would probably be single or widowed women, a group which has demonstrated a strong desire for companionship, independence, personal service, and security in their living accommodations.

Numerous studies of elderly occupants of nursing homes, care homes, and State institutions indicate that a number of them had no choice of any other residence because there were no alternative accommodations adapted to their levels of competence. A recent survey of nursing homes stated that:

> . . . an astonishing number of the people should not be there at all. Every critical student of nursing homes has come to that conclusion, they vary only on the percentage of healthy patients. The U.S. General Accounting Office, after studying a sample of patients in Michigan, concluded that almost 80 percent (297 out of 378) did not require skilled nursing care. A 1971 study of New York City medicaid patients in nursing homes, by the State comptroller's office, found that from 53 to 61 percent of the patients did not need to be there. Daphne Krause of the Minneapolis Age and Opportunity Center, which has studied homes in that area, gave a figure of 30 to 40 percent. In Cleveland, the head of the nursing home medicaid program put the proportion of patients unnecessarily in homes under her jurisdiction at 90 percent.[7]

A study in England determined that 95 percent of the elderly could live independently, i.e., not in institutions, if adequate home care and other services were provided. A Danish study of the aged divided them into three groups: Group 1, representing 80 percent of the elderly, were able to manage fully on their own; the 10 to 15 percent in group 2 needed some help but not that provided by an institution; and only the 3 to 4 percent in group 3 needed institutional care (this latter group compares with the 5 percent of older Americans in institutions). In Denmark, housing and service programs are designed to remove or prevent difficulties which cause the aged to be classified in group 3. Among the many programs there which bolster independent living are special vacations for those in group 2 to help them avoid any slide into group 3 through a loss of interest in life precipitated by inactivity or withdrawal.

Age

The 1970 census figures also give us some insight into the current trend toward longevity among older Americans. They should provoke serious analysis of our existing housing programs for the aged and should reinforce our efforts to provide a spectrum of varied living arrangements for this growing number of older people who will live longer and will manifest a greater diversity of housing preferences

[7] Mary Adelaide Mendelson, *Tender, Loving Greed* (New York: Alfred A. Knopf, Inc., 1974). Distributed by Random House, N.Y.

and functional competencies. Although competence was not a factor in the census statistics, conclusions were drawn which foretell the dimensions of the emerging need for congregate housing with service components:

> From what we know now, we can count on large numbers of elderly in the future. They will be better educated, and probably more affluent than today's older people. Fewer will be working. Unforeseen breakthroughs in medicine—especially in the fields of heart ailments and cancer—could mean longer life expectancy.
>
> In the decade 1960–70 there was a 13 percent increase in the total population but a 21 percent increase in the elderly. In just half a century there has been a gain of 20 years of life for the average person. In addition, the average age within the elderly group has also increased. Those 75 years of age and over represent 38 percent of the elderly group.[8]

Another view of the increasing life span among the aged (which speaks to the size, age, and health of the potential occupants of congregate housing) is: half of all people now 65 and older are age 73 or more. Of every 100 older persons today, 63 are under age 75; 31 are between ages 75–84; and six are 85 or more years old. It has been calculated that there has been a 700 percent increase in the population aged 65 and over from 1890 to 1970. It appears that the maximum increase in the elderly population in the years ahead will be in the over 75 and over 80 age categories. Medical research has shown that about 80 percent of persons at about age 85 have some type of disability usually trouble with posture, balance, or mental alertness.

Health

Although a complete health profile of potential occupants of congregate public housing is not possible to document, it may be helpful to consider a national health survey that illustrates some of the health conditions which limit activity among the elderly.[9]

Arthritis ranked second after heart disease as the major cause of activity limitation among older people. About 271,000 arthritics are in nursing homes. Yet only 28 percent of nursing home patients with arthritis were bedridden. A 1962–63 survey showed that over 50 percent of all middle-aged men and women had some degree of arthritis. Of those between ages 65–79, some 50.3 percent of the men and 44.9 percent of the women had moderate or severe forms of arthritis with some limiting effect on mobility. On the basis of these findings we can assume that for many or most, including the nonbedridden in nursing homes, there is sufficient mobility along with general good health to permit occupancy in congregate housing, although extensive arthritis may require some assistance in bathing and provision for the use of mobility aids, an important consideration in physical and program design.

[8] U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, "We the American Elderly" (Washington, D.C.: Government Printing Office, June 1973), pp. 5, 14.

[9] U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics, "Health in the Later Years of Life" (Washington, D.C.: Government Printing Office, October 1971).

This same survey showed that 3.1 percent of the men and 6.9 percent of the women in the 65–79 age group had diabetes; 47 percent of the men and 55 percent of the women had lost all natural teeth but had satisfactory dentures; 17.7 percent of the men had moderate to severe eye defects, 49 percent had mild defects, and 33 percent had good vision. With respect to orthopedic defects, 17.4 percent of the men and 19.7 percent of the women were affected.

The problem of incontinence in later years is erroneously thought to be widespread. Yet the survey of occupants aged 65 to 74 in nursing and personal care homes revealed that 77 percent had no problem; 7 percent had a partial problem; and 16 percent had complete disability. In the group aged 85 or older, 68 percent were not affected by incontinence.

Diminished hearing is another characteristic of the older age group. The rise of impairment in hearing as people age is quite dramatic—the rate of impaired hearing for persons 65–79 is about 40 times that for those 18 to 24 years of age. The percentages of people with some hearing impairment range from about 7 percent for the middle-aged group to 30 or more percent for the older group. Many cases of hearing impairment can be improved by a hearing aid. Among those 45 or older with a hearing loss in both ears, about one in five uses a hearing aid, according to data from household interviews in the survey.[10] This characteristic also has design and operational implications.

Also of significance in considering tenant characteristics is the statement in the survey that:

> . . . the most striking change in recent mortality trends is the widening gap between the death rate for men and that for women in the older age group. For example, among white men at ages 45–64 the death rate in 1940 was about 50 percent higher than for white women. In 1950 it was about 80 percent higher and by 1968 it was more than double the rate for women. A similar but narrower divergence characterizes the rates for men and women of races other than white.[11]

Perhaps the most significant statistic is the walking status of occupants 65 years of age or older of nursing and personal care homes: 61 percent had no walking problem; 17 percent had partial disability only; and 22 percent were completely disabled.[12]

Despite these and other health aspects of persons in the older age category, the health survey report showed that a comparatively small percentage were limited in normal activity due to chronic disease. A full reading of the statistics leads to the conclusion that congregate housing with food and other services could indeed serve a large group of elderly persons who are capable of substantial, though not total, independence, given a housing design and a staff sensitive to their needs. It is only logical to conclude that the benefits of improved medical care and treatment that have resulted in prolonged life should also result in the opportunity for continued independence even with some limits on mobility. If this is to be a reality for low income older per-

[10] HEW Public Health Service, National Center for Health Statistics, "Health in the Later Years of Life," p. 28.

[11] HEW Public Health Service, National Center for Health Statistics, "Health in the Later Years of Life," p. 7.

[12] HEW Public Health Service, National Center for Health Statistics, "Health in the Later Years of Life," p. 51.

sons, congregate public housing is one answer. It should be made available in some relative proportion to the number of dwellings for fully independent living and be located in the same neighborhood.

Income

On the subject of income (which relates to the ability to pay for institutional care) the 1970 census indicated that 19.2 percent of the 7 million elderly heads of households had annual incomes below the poverty level in 1969.[13] The older population had exactly half the annual income ($4,200) of the population as a whole, while older persons not living in families had median annual incomes of only $1,813.[14]

The census also showed that of the Nation's 63.4 million occupied housing units in 1970, 17.5 million were headed by a person aged 60 or older.[15] Of these, 12 million were owner-occupied and 5.5 million were rented. The largest group of the elderly lived in the central cities of metropolitan areas. Proportionately, however, the aged formed a larger segment of the population in small towns than they did in cities, suburbs, or farms. In towns of 1,000 to 2,500 inhabitants the elderly represented 13.6 percent of the population.[16] These figures indicate that in planning housing programs, we should not overlook the need to build in small communities to enable older persons to continue to live among friends and relatives in their own home towns or in towns where they have resided most of their adult lives.

Statistics for New York City reveal yet another profile of the plight of some older Americans in securing housing and services. Out of 947,878 persons aged 65 and over (12 percent of the city's population), one of every three was age 75 or older; three-fourths suffered one or more chronic health ailments; over half had incomes of $3,000 or less; and a third received $2,000 or less a year. In testimony before the U.S. Senate Special Committee on Aging, New York City officials said that older people needed a wide range of services in their homes and neighborhoods, yet such services were almost nonexistent or too expensive. They concluded:

> The kind of environment in which an older person lives out his retirement years, his level of income, and the opportunities for constructive use of leisure time are as essential to positive physical and mental health as are the number and quality of hospitals, doctors, and nurses. Older people, given a decent income and a range of supportive services within the community, have shown that they can live with chronic illness and still function positively as members of society.

Congregate housing with services was recommended, with provisions for these services to be made available to the elderly living in the neighborhood as well as to tenants.

From these statistics and observations on the age, health, housing, and income of the older population, it can be readily inferred that congregate housing programs assisted by Federal, State, and local

[13] U.S. Department of Housing and Urban Development, "Older Americans: Facts About Incomes and Housing" (Washington, D.C.: Government Printing Office, October 1973), p. 7.
[14] U.S. Department of Commerce, "We the American Elderly," p. 12.
[15] U.S. Department of Commerce, Notice to Correspondents, November 16, 1973, on "Housing of Senior Citizens," HC (7)–2.
[16] U.S. Department of Commerce, "We the American Elderly," pp. 6, 7.

governments are essential to help meet the shelter and service needs of many low income elderly. These programs serve as a backup to housing for the well and active elderly and help make public housing agencies more responsive to the needs of the growing number of persons living well into the older age categories, at a time when their meager savings are being eroded by inflation and their need for services is increasing. Although there are always costs to consider in launching any comprehensive program, it should be evident that congregate housing will help save some of the funds now spent to provide institutional environments for many who do not need that kind of expert care.

WHO CAN BE SERVED

No single definition can encompass all applicants for congregate housing, but it can be expected that they will represent various age groups (usually those more advanced in years), different levels of health, and a broad range of functional capacities. Some will be able to maintain an independent life style with only minimal use of supportive services; others more dependent will require a variety of social, personal, and health services to carry out daily activities. Among them there will be successive stages of decline in energy and mobility levels and, as a result, a lesser degree of self-reliance and possibly self-confidence. But most will have consciously selected a congregate living arrangement because they desire to live as independently as they can and are willing to utilize services to sustain that life style. Managers and staff should be aware of this positive motivation for self-reliance and reinforce it regularly, especially to counter any symptoms of withdrawal which may occur among those who become discouraged by advancing age and the limitations on mobility which often accompany it.

Can the robust and vigorous aged be combined with the more limited and successful in a congregate housing development? There is no categorical answer either way. No doubt the less competent aged will apply in greater numbers because they need the kind of services available. Applicants may also include the mentally retarded, the physically handicapped, and those with one or more chronic health problems, but all of them can be expected to be motivated by a desire to remain active in the community to the limit of their ability. It is suggested that if the hale and hearty elderly are housed with the more frail and impaired, the percentage of the latter should be kept well below that of the well and active. Among applicants there undoubtedly will be a large proportion of widows, some of them just beginning to adjust to living alone and welcoming the kind of warm and stimulating friendships that often flourish in group living situations.

Although this report focuses primarily on congregate public housing for the elderly, it should be noted that this type of housing can also provide the shelter and services needed by the moderately and severely handicapped as well as mildly retarded adults, many of whom are now unnecessarily in institutions. It can offer a familial setting with surrogate parents and services. It can be a resource for professional organizations whose members are skilled in the delivery of services to particular groups and recognize the importance and need for the

most normal possible community-based living environment. Provision of this type of housing can be accomplished through leasing arrangements with local housing authorities under which these organizations would retain full responsibility for management functions or through agreements under which the housing authority would contract for or perform the managerial functions. The restraints might be those pertaining to income limits on eligibility as well as occupancy and construction standards. Since the 1974 Housing and Community Development Act specifically covers the housing needs of the developmentally disabled, congregate housing would serve those needing assistance with daily living activities. Other physically or mentally handicapped persons could sustain completely independent living arrangements.

It must be emphasized, however, that while many handicapped persons need only the removal of architectural barriers to be able to live in the usual types of housing and environments, the more severely handicapped or retarded would require a more concentrated residential milieu in order to ensure the provision of needed services. The 1974 Housing and Community Development Act now makes it possible for unrelated persons to share rooms and bath in HUD-assisted developments, thus permitting a most sensible solution for meeting the needs of such groups. Group housing programs are usually recommended for the physically or mentally handicapped who need assistance with normal activities. Experience in European countries has demonstrated the social and economical advantages of such housing, especially when its costs are compared to those of institutions. Community-based housing in a normal neighborhood undoubtedly is the preferred solution if training programs for normalization are to yield their expected dividends.

In addition to generating the construction of new facilities, it is suggested that interested organizations or individuals investigate the use of well-located existing housing, including foreclosed or HUD-acquired housing, and encourage local public and private housing sponsors to respond to the special housing needs of these groups as part of the recommendations of the housing assistance plan required as a condition of HUD-financed assistance.

The underlying principle of congregate housing—providing living arrangements with supportive services—is viable for many physically and mentally handicapped persons. Of course, the emphasis in design, operational details, and staff training will require some adaptation and modification.

GUIDES TO MEASURE FUNCTIONAL CAPACITY

The functional level of applicants can be measured in part by careful health screening procedures. Their ability to remain independent with an assist from services should be certified by a physician, preferably on a standard form developed by the local housing authority. This is important because the applicant or his or her family may not recognize or acknowledge the presence and influence of seriously diminished capacities which could hinder a successful adaptation to a congregate living environment.

It is obvious that the selection of tenants should be made according to a thoughtful and sensitive plan. In general, the policies and procedures for screening and selecting tenants should be related primarily to the functional capacity of the applicant. Preference may be given to older people whose health is good and whose expectations, as a result, are essentially different from those who are ill. An individual's potential for living harmoniously with others should be weighed seriously.

There are some relatively objective guides to help direct the process of tenant screening and selection.[17] Although developed for use with patients in institutions, they suggest practical measures by which to assess a person's level of function and degree of competence. The first of these guides is the Physical Self Maintenance Scale developed at the Philadelphia Geriatrics Center to measure a person's capacity for personal self care. The second, also developed at the center, is the Instrumental Activities of Daily Living Scale which measures the capacity of an elderly person for continued living in the community. The third scale, called the Index of Independence in Activities of Daily Living (ADL), measures the relationship of functional capacity to the accomplishment of daily activities. It provides a means to evaluate functional independence or dependence in six categories: bathing, dressing, toilet performance, transferring (from a prone to an upright position and back again), continence, and eating.

An evaluation process similar to that guided by these three scales, in particular the ADL Index, would be useful in setting standards to guide tenant selection as well as facility design and activity programs in congregate housing. On the highest scale (independence in all six categories) the applicant would obviously be able to live independently but might require congregate housing with services to compensate for a weakness such as impaired vision. Those independent in all but one category might be eligible, but those dependent in all six would require alternative housing arrangements. (These variations underscore the importance of utilizing skilled intake procedures.)

The evaluation of an elderly person's locus on the independence-to-dependence scale could be made in three stages. For example, with regard to bathing, a person would be independent if he or she could bathe alone in a sponge bath, tub, or shower. On the other hand, he or she may need help in bathing only one part of the body, such as a leg or the back, or may need total help to bathe at all. If ranked in these latter two categories, however, he or she still should be considered eligible for congregate housing.

With respect to dressing, a person may be able to get dressed without help; he or she may be able to get fully dressed except for tying shoelaces or fastening a back zipper, or may need total help. Being ranked in the first two categories should not exclude an applicant from congregate housing, but being in the third and final one would. In the third ADL category—toilet performance—it is reasonable to require applicants to be fully independent. When continence is considered as a factor in selection, full independence should be required although an occasional accident might be expected. With regard to transfer ability, a person would be considered independent if he or she can get in and out of bed or a chair alone even with the use of a cane or some other support. If the person is not ambulatory to some degree,

[17] For a description of these guides and their development and rationale, see papers in the section, "A Symposium on the Assessment of Functions of the Aging Adult," *The Gerontologist*, Vol. 10, No. 1, Spring 1970, pp. 18–53.

he or she should not be in congregate housing. In the final ADL category—eating—complete independence would be required except for such simple aids as cutting meat portions for those with arthritis or temporarily providing meals to an ill person in his or her room.

It is suggested that a doctor or other person attending the applicant (such as a nurse in the care home if he or she resides there or a home health aide who serves the person who lives in the community) verify his or her competence in performing activities of independent living and identify any other serious health problems he or she may suffer.

Although not measured on the ADL Index, an individual's social and psychological characteristics as well as his adaptive abilities should be evaluated in the screening and selection process when they need to be considered in making a thorough, informed determination of suitability. The essential concern in judging these and physical factors is to ascertain what type and how much assistance a person needs to function adequately in congregate housing. In this regard, the sponsoring housing authority should manifest as much, if not more, concern for the individual as for a successful housing operation.

In summary, while exact figures are unavailable, there is a substantial portion of the older population who are able to live independently provided some degree of assistance is readily available. The growing need for the limited assistance offered in congregate public housing is caused by the increasing number of elderly persons who are still relatively healthy but frail, who have low incomes, and who cannot afford to buy the services needed to support independent or semi-independent living. For those elderly persons with some, but not complete, functional impairment, congregate housing should be made available in relative proportion to the number of local dwellings for fully independent living and should be located in the same neighborhood.

PART 3

GENERAL PLANNING AND DESIGN CONSIDERATIONS

Allow me to emphasize again that congregate housing for the aged is neither a care home nor a medical facility. It is a residential environment offering services to sustain self-reliance. The services assure not only material comfort but also social, recreational, and cultural activities adapted to a wide range of individual functional capacities. As a result, provisions for a service component should be included throughout the process of planning and designing congregate housing facilities. The range, type, and extent of services to be provided will be determined generally by the characteristics and needs of that portion of the aged population to be accommodated. Some of the types of services that might be matched to tenant needs are listed in the following chart.

NEEDS AND SERVICES FOR CONGREGATE HOUSING RESIDENTS

Needs		Services		
Survival	Satisfaction and social	Supportive	Developmental	Protective
Food, clothing, shelter, income, health, security.	Love, recognition, belonging, creativity, recreation, participation, achievement, meaningful activity, self-respect, self-sufficiency, social status.	Financial, health, housing, nutrition, transportation, information and referral, legal aid, homemaking, counseling, day care, discount services.	Recreation, employment, education, crafts, religion, cultural events, social activities, library services, volunteering, telephone reassurance, friendly visiting, resident organizations.	Service to assist individuals seriously impaired by mental or physical dysfunction. Similar to supportive services.

Although aging people are changing people, their personalities, long established preferences, and psychological need for continuity in social relationships persist and should be respected in designing any type of living environment for them. Architectural criteria developed for public housing for the well elderly will also be applicable to congregate housing, with special added emphasis on safety from accidents, accessibility for the handicapped, and simplicity of arrangement to ensure minimal housekeeping requirements and compactness for convenience and economy. This chapter discusses other special factors related to site selection, size of the development, apartment kitchens, bathing arrangements, and general spaces which should be considered in the design of congregate housing.

SITE SELECTION

The selection of a site for congregate housing should be based primarily on its proximity to health, social, and recreational facilities, shopping areas, and public transportation. Because this type of housing is designed to assist less energetic people to continue to participate in the community, it should be in an active area where there is easy orientation to various age groups who reside, work, shop, and play in the area. If shopping is not convenient, serious thought should be given to including the essential commodities in the development. The planner must also remember that because there may be crippled or handicapped residents, excessive slopes and the need for steps should be avoided. Changes in levels should not be included unless they can be negotiated on minimum ramps.

Since the environment must be adapted to those with lessening mobility and a decreasing sense of orientation, the location of structures and spaces becomes more important. There also should be more attention to the exterior social environment to encourage residents to move around outside and not remain sedentary indoors. Attractive walks around the grounds with benches for resting and conversation as well as displays of scheduled events all help offset the tendency to withdraw. Plants, kiosks, open-air restaurants, fountains and basins, aviaries and fish ponds, flower and other markets as well as attractions on the main thoroughfare might be considered. A day center in the building or nearby which attracts older neighbors could be planned as part of the environment to broaden contacts and interests.

All places where tenants gather, indoors or out, should enable them to observe and be stimulated by the ongoing behavior of more active people. The coming and going within a development is as important as activity associated with the street scene. We should expect that congregate housing sites will be clustered near maximum traffic areas rather than in isolated areas even though the latter may be beautifully planned and furnished.

Another important factor in site selection is its proximity to a health facility to handle crises as well as provide convenient access for diagnosis and treatment of residents. This would permit tenants to use the health facility without assistance, would alleviate the necessity for an in-house health component, and would provide a resource to housing and service staff for consultation.

There are two contrary views about the relationship of medical facilities to congregate housing. Some feel strongly that health care is the proper concern of the community and its resources; that geriatric facilities should be used as a base from which to deliver home care services to the community. Why then, they ask, should health-oriented facilities be placed in housing as a potential detraction from the residential atmosphere and as a daily reminder of disease and death? In-house services shared with no one from the outside, they add, may also cause or reinforce a sense among tenants that they are isolated from the community. Some argue that small scattered medical programs in housing facilities would lead to an underutilization of scarce medical personnel and, even if staffed by doctors and nurses, would render only limited care. Proximity to a hospital, particularly one with a geriatrics wing and an outpatient clinic, would serve a range of chronic problems with more expertise, they conclude.

Others counter that, given the chronic health problems of tenants, trained health personnel are essential to handle crises and to provide minimal health-sustaining services such as giving shots, taking blood pressures, supervising or administering medication, and providing consultation and referral to appropriate health centers when needed, including placement in a skilled nursing facility if required. Podiatry and dental care should be included among these minimal services. It is argued that a medically trained person on the premises would give residents a greater sense of security knowing that competent help is at hand when needed. This assurance alone, benefiting their mental health and often affecting their physical well-being, justifies any extra cost, it is concluded. Dr. M. Powell Lawton of the Philadelphia Geriatrics Center states a general principle with which these proponents agree: "The capacity of the individual to seek medical care or to participate in his own treatment is a critical item in any decision about an appropriate living situation for him." Alternatives to an in-house health component include office space in the development for private physicians or a focal point on the premises rented to a person trained to handle health emergencies.

DEVELOPMENT SIZE

Experience in other countries strongly indicates that small developments of 20 to 30 units are more desirable for residents of congregate housing. Simple scale is essential if each tenant is to be familiar to the manager and staff and to have his or her needs adequately met. This does not mean that congregate housing must be one type only. There can and should be variations from a small planned home to group housing of varying size and design. A concierge plan, enabling the manager to see everyone who comes and goes and to be responsible for each resident, has been used with success abroad. In some places a number of large homes have been remodeled into small bed/sitting room flats. Some older houses have been combined with new structures containing activity and service centers. Through convenient, easily-managed accommodations and through encouragement to do as much for themselves and for others as possible, it has been found that older people gained confidence which led to greater independence and fuller, happier lives. Experience abroad indicates that one housekeeper to seven or eight residents was adequate for managerial duties in several developments.

The British Ministry of Housing has set standards for building old people's homes so that properties containing more than 75 units are very rare. This ruling has the added benefit of dispersing the elderly in small groups rather than packing them into large concentrations. Economic considerations apparently make it increasingly difficult to build such housing in less than 100 units in this country. Yet experience dictates that a set of small buildings is preferable to one structure whose size alone conveys an institutional atmosphere. Studies in Belgium and the Netherlands include mention of a "care home" for the frail elderly surrounded by small units for those who are well. The services of the care home are available to both groups.

In any event, congregate public housing should be "homey" and uncomplicated, putting the least possible demand upon the resident and providing him or her with a world of familiar objects and spaces.

Although economy of scale can be justified in housing for the well elderly, the emphasis in congregate housing should be on tenant need, on managerial capability to have knowledge of each tenant, and on programs which offset any feeling of isolation from society. The impersonal atmosphere often prevalent in large developments could well defeat the purpose of congregate housing. Moreover, the older person who is experiencing some decline in functional competency is more sensitive to change in his or her environment than are middle-aged or fully active older people. A small place where one is known and where one feels a sense of belonging tends to bring happiness, joy, and comfort.

The proven value abroad of small intimate structures or groupings might suggest to this country a wider use of rehabilitated existing dwellings for congregate housing for the aged, when properly located and economically feasible.

KITCHENS AND BATHING ARRANGEMENTS

One area of controversy in congregate housing is whether or not to provide individual kitchens or kitchenettes in each apartment. The law governing the program permits them to be in all apartments or in some or in none. Despite the requirement of a central meals service in the development, many social scientists believe that it is important to include at least a minimal kitchen in individual dwellings. They regard it as particularly significant for former housewives, long accustomed to cooking, to be able to prepare some snacks between meals or refreshments for visitors. Thus a semblance of independence is reinforced. The kitchen area is seen as important also because it may include a refrigerator for cold drinks and ice and cabinets for storage of one's own china, glass, and favorite coffee pot. From this viewpoint, the kitchen is a sustaining aspect of everyday life and permits a degree of self-respect, self-management, and personal identity sometimes lost in communal dining.

Others argue that if one is too frail to shop and prepare his or her own meals regularly, one would be ready to release the full responsibility for these tasks to management and rely on staff expertise to assure nutritious balanced diets. In addition, at times there may be danger to the tenant and others by exposure to a stove or hotplate in an apartment kitchen. The gas may be turned on, but not ignited; the electric stove may be on but, if not glowing, may well burn an unsuspecting tenant or guest with diminished alertness and agility. Forgetfulness and temporary disorientation can be expected to occur among tenants from time to time. There has been ample experience of the need to remove cooking equipment from some units as the tenant ages. There may be occasions when the extra costs of kitchen plumbing, space, and equipment in individual quarters will cause congregate housing to exceed feasible limits. Without individual kitchens, the development then becomes a hotel or club living arrangement.

Two solutions to this problem have been developed in Europe. The first is to provide a snack bar (generally related to the dining room) where hot or cold drinks, ice, cookies, fruit, and other pick-up items may be obtained at all hours. Food may be consumed in the immediate area or taken to one's room. This concept has been found to promote

sociability among tenants and guests. Snack kitchens located on each floor have not proved feasible primarily because of the problem of identifying and safeguarding the individual's food to prevent its use and consumption by others. Floor-by-floor kitchens have proved to be a management problem and have not achieved their purpose.

The second alternative is to furnish apartments with small portable equipment that can be easily removed when tenants become too frail or disoriented. Wide fireproof shelves with convenience outlets and a small cupboard are provided to hold hotplates, small ovens, toasters, coffee pots, and refrigerators, with the water supply drawn from the bathroom. Kitchen equipment should be easy to remove or to be disconnected when safety requires it. In Europe small equipment is less expensive than larger models, but in this country we can expect that small equipment produced for special luxury purposes might not represent an economy.

Another area of concern in the dwelling unit is the bathing arrangement. Most older women today prefer a tub. However, if concern is for safety and self-management, a sit-down shower appears essential, given the impaired mobility to be expected among some tenants. If there must be soaking for therapeutic reasons, one tub for general use may be installed. However, this arrangement tends to be institutional and the tub is rarely used unless lifts, operated by an attendant, are available. Every effort must be made to design a bathroom that most can use without assistance.

A 24-hour switchboard is a preferred emergency alert system, but if this is not possible, an alarm bell should be in the bathroom as well as by the bed and should be monitored 24 hours a day. The bell system also should automatically open the apartment or room door.

Finally, it is of the utmost importance that, if a unit is to be occupied by a married couple or by two persons, there must be two connecting rooms to permit privacy from one another due to different time and activity schedules and also to permit isolation during illness.

DINING AND OTHER SPACES

Because the nature of congregate housing differs from that of housing for independent living, the spaces allotted for staff and other activities will differ. There must be room to accommodate managerial and maintenance functions, housekeeping functions, possibly a general laundry and sewing room for clothing repair, a central dining room and kitchen, and possibly one general bathroom with a lift or hoist. If medical facilities or therapy rooms are provided, these add another dimension to consider in assigning space.

In spaces intended for group activity the main concept must be to bring people together and not isolate them from each other, even when different activities are underway. Adequate space is needed for participants and observers alike. All activity spaces should be visible, easy to find, and on the ground floor. Color coding of the walls and floors plus the use of graphics, plants, and other distinctive objects will be helpful in pointing out directions and decreasing disorientation and fear of embarrassment.

Design of the dining area is of particular importance. Large spaces in the room should be broken up either by walls or half-walls, planters,

furniture, or other devices. Ten to 15 people in an area encourage social interaction and rapport. Large spaces are more impersonal and lonely. Tables should vary in size, ranging from those accommodating two persons to those for eight. Small round tables are pleasant for intimate dining and chairs with handles are recommended. Tenants should be allowed to choose their dining companions. Decorations should be gay and cheerful, and be changed occasionally to spark interest. Fresh flowers always are enjoyable. The dining room should be open to natural light, have a view of the outdoors, and be near the lobby or its extension to afford a view of the street scene and to provide a space for waiting before meals. Dining is the main occasion of the day for many, and groups may be expected to form and stay together in the adjoining lobby before and after meals for conversation and other activities. Lobby space also can provide overflow space for dining guests.

Opinion is divided as to whether meals should be served or offered cafeteria style. Many frail elderly, especially the handicapped with mobility aids, may not be able to manage their trays without help. Having meals served at one's table adds a touch of dignity, particularly at the dinner meal, and especially if the waiters or waitresses are teenagers. One achievable combination that provides food selection without having to carry a tray is the popular salad, dessert, and beverage tables with the entree served. (For additional details, see part 4.)

In summary, the ideal to aim for in planning for general spaces as well as other previously mentioned features in congregate housing is to provide the right home, in the right place, at the right time, with the right services. Rightness, as discussed here, means planning the design, location, and interior atmosphere to fit the age, health, and personal preferences of the frail elderly.

LICENSURE

Another complicating factor is the term "congregate housing" which refers to many different kinds of living arrangements with a wide range of functions, and this creates confusion. Some States may require licensing of housing which provides service elements. State laws vary both in concept and in semantics. If licensing is required, this may entail more construction costs to provide institutional design features even though the Department of Housing and Urban Development stipulates that congregate housing is to be distinctively residential in character and not institutional. Under licensing regulations, unnecessary and rigorous qualifications for staff would be required, thus boosting operating costs.

Federal and local building standards should suffice since congregate housing is not conceived of as a "care" or "health" facility as defined by the nomenclature used by most States. The HUD Guide on Congregate Housing Management states on the subject of licensing: "Where licensing requirements are imposed by State or local licensing officials, the sponsor will submit evidence that the proposal will meet the applicable State or local agency guidelines and requirements." Since licensure may make congregate housing infeasible, the sponsor should make clear that its project is a residential development with services and not an institution.

PART 4

OPERATIONAL CONSIDERATIONS

The success of the day-to-day operation of congregate housing requires attention to several factors: the special relationship and responsibilities of management and staff to the individual tenant; the food and housekeeping services; a mix of group activity programs; and knowledge of and familiarity with local resources to tap in establishing and maintaining linkages for the provision of shelter and services. This chapter touches briefly upon major considerations in each area.

ROLES AND FUNCTIONS OF MANAGEMENT AND STAFF

Because congregate housing is designed to provide a residential environment in which older people can receive services to sustain independent living, its management and staff will assume roles and functions different from their counterparts in the management of housing for the well elderly. In addition to their usual responsibilities for the care of property, rent collection, and personnel selection and training, managers will have overall charge of the:

—Screening and selection of suitable tenants.
—Development and/or supervision of a nutritious food program.
—Arrangement and overseeing of housekeeping and personal services delivery.
—Provision of leisure time activities related to tenant capacities and local resources.
—Arrangements for 24-hour surveillance.
—Development of procedures for handling emergencies.

While warmth, understanding, and mutual respect are characteristics of all successful housing management, in congregate housing there is required an additional awareness of the health profile and functional competency of each tenant. Occupants will be further reassured by the ability of the manager and staff to respond to any health or accident emergency due to age or partial disability. In order to know and use nearby medical facilities, managers and staff must establish cordial relations and specific arrangements for assistance with hospitals, nursing homes, and other health resources when these are not available in any in-house medical unit.

It is obvious that 24-year surveillance by the resident manager or an alternate is essential in congregate housing. After office hours the emergency call system should operate in either's quarters. At no time must the alert system be unmanned. Many have found that the 24-hour switchboard is the best solution, with the telephone provided by the

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development as a utility service comparable to gas, lights, and water. If the manager or the alternate do not have a health services background, training should include some time spent in health or institutional facilities to learn basic approaches to emergency care. Doctors, nurses, medical corpsmen, and hospital aides may be available to offer this training in emergency care to housing management or even to act as housing managers.

Once a resident's feeling of insecurity in time of need is supplanted by a sense of being secure, needed, and wanted, his or her spirit tends to revive, causing a heightened interest in daily living and a decrease in the scope and volume of daily complaints. All occupants will be relieved of the necessity of daily meal preparation and heavy housekeeping in compensation for their frailty. With their personal possessions retained in a cordial atmosphere, tenants will feel a sense of continuity with their former lives, while the manager and staff will tend to be regarded as an anchor to windward, a strong leadership symbol for security and stability as well as for the stimulation and provision of activity and creativity within an environment free from tension. In performing these functions it is suggested that the manager and staff regard tenants as younger people grown older but retaining the habits, virtues, and failings of a lifetime of working, loving, and living.

To reiterate, by providing various degrees of support, congregate housing should help relieve nursing homes and other care institutions of those who do not require medical or nursing care and should offer another housing resource to sponsors of housing for independent living whose tenants may need a "next step" type of residence. For tenants, congregate housing and its management should provide opportunity to maintain relationships with the community and should serve as a shield from the stresses of intergenerational friction or dependence.

Particularly sensitive areas for management and staff concern are tenant selection and the occasional need to terminate occupancy.

Tenant Selection

One area of critical and sensitive concern is the tenant screening and selection process which will be determined largely by the characteristics of the aged population to be served. As factors in the process these characteristics cannot be neatly defined. Some applicants might be able to sustain themselves in housing for independent living, while others may be closer to the need for a care or medical facility. Tenant selection cannot then be a routine process based solely on age, income, or other legal eligibility criteria. The major determinant instead must be a judgment on the applicant's ability to remain self-reliant with the aid of services offered in the housing development. Since each applicant will see his or her own state of health and competence differently, a careful and objective screening process is required.

Since the characteristics of tenants in congregate housing will vary tremendously, and no precise general definition is possible, we can assume that a housekeeping service, at least once a week for heavy cleaning, should be part of the operating plan for the development. Some tenants may need help with bathing, dressing, and other personal services. As time passes, valet service and care of clothing may be required in addition to meals served in the room during illness. In other countries we find such tasks performed by "matrons" or "wardens" substituting for the services that would be provided in a family setting. Finally, the cost of rent, food, and services must be within the paying ability of the tenant if the selection of tenants is to continue to give priority to those with the greatest need. Food subsidy or a sharing of food costs may be essential to operational feasibility for the elderly at or near the poverty level.

As has been repeated many times throughout this report, the chief concern of management and staff should be the well-being of each tenant, responsiveness to his or her needs, and measures to ensure his or her safety and comfort. A tenant's life may depend on prompt action by trained staff in the manager's absence. As in all aspects of congregate housing, the management must recognize that for some tenants there will be a thin line between independence and dependence, at least temporarily. But independence should be bolstered and dependence discouraged for any length of time if the residential character of the facility is to be maintained.

Unless housekeeping aid is a traveling service, another staff person may be a "matron" or "housekeeper" who has charge of scheduled housekeeping assistance, whose day and time for work is known to and expected by the tenant. This home aide might also provide the required personal care such as help in bathing or dressing for a temporary period or on a regular basis for some, e.g., those with arthritic arms or backs or the handicapped. Concern for grooming, care of clothing, or help in writing letters might be included as well in staff duties. In any event, the housekeeping aid should be carefully scheduled and understood by the resident.

While such assistance may be minimal or temporary, its need should be anticipated. Some of the "family-type" services could be performed by volunteers, including other tenants organized to offer small services to their neighbors. This buddy system may sometimes be more welcome and acceptable to tenants than aid from staff or volunteers who are strangers. Tenant groups can also be formed to alert management and staff to the needs and problems which arise among the tenants themselves.

As the physical or mental capacity of the tenant lessens, counseling becomes more significant for meeting financial, health, legal, burial, or other needs, with the management substituting for the family if none is available or calling upon local specialists to handle situations as they arise. At least one private counseling room should be provided and be large enough to accommodate family members. If this is not possible, the manager's office should be used to ensure privacy.

The focus of service programs in congregate housing will be on aids to independent living in order to offset reliance on medical facilities except in those cases where the individual's health has deteriorated beyond the capacity of the nonprofessional, in-house health unit or staff to resolve. The type and limitation on services should be clearly outlined to the applicant and his or her family prior to occupancy. Careful handling is needed when a tenant must be removed from congregate housing and transferred to a higher level of care when more intensive services are needed. If possible, the manager should

investigate local resources and facilities, as well as associated costs, against the time when temporary or permanent removal may be required, in order to offer appropriate advice. This should be part of the preoccupancy management plan.

Terminating Occupancy

Permanent relocation outside the development is a sad and difficult period. Family, friends, ministers, doctors, and others interested should be consulted and involved in the transfer process. This should not be the full responsibility of the housing manager even though he can provide valuable aid. In case of death, the manager can help in the disposition of the tenant's possessions. Most probably a physician should make the final decision on relocation. It should never be necessary to resort to legal eviction.

The housing authority should formulate specific rules to govern temporary removal: how long the apartment or room will be kept vacant awaiting the tenant's return; what rent will be paid during the absence, and by whom; and what procedures should be followed for proper notification when the waiting period is over. If there is a possibility that the tenant may return, 3 months is suggested as a minimum for holding the premises, providing the rent is paid during this period. Keeping his or her home bolsters the tenant's hope of return. If there is a reasonable hope that he or she will return, the peace of mind of the absent ill resident should take precedence over a potential new occupant.

In summary, although there is no sharp line between strength and frailty, the presence of services which characterize congregate housing should not decrease the special residential atmosphere created by such practices as having the key to one's own door, the right to come and go at will, and the right to expect courtesy, cheerfulness, and security. Management and staff will soon be aware that the elderly, despite chronic health problems, possess a variety of strengths and resources for meeting their own needs but too often are not encouraged to utilize them fully.

CONGREGATE MEALS SERVICE

Since congregate dining is a central feature of this type of housing, a full meals service with required tenant participation is recommended whether or not some of the dwellings have kitchens. Whereas housing for the well elderly may include some meals service at the discretion of tenants, it must be remembered that in congregate housing balanced, nutritious meals are one of the essential services provided to maintain health and energy among tenants. As a result, the requirement to participate in the meals service and to meet some of its costs should be fully discussed and understood by the applicant at the time of leasing.

As in all aspects of housing management, it should be possible to have tenant input with regard to meals and the food they enjoy and prefer. Although certain types of food are necessary to provide essential daily nutrients, such expression of dietary preferences should be encouraged. This is obvious for those on specially prescribed diets, those with chewing or digestive problems, and others with lifelong regional or ethnic tastes. During the 1971 White House Conference

on Aging, for example, it was noted that many older people of Chinese origin suffered much unhappiness in nursing homes because they were not served the kinds of food they were accustomed to and could not develop a taste for other diets. This may be only one example, but variations in tastes can be expected and adequate responses should be planned.

Meal preparation and service is a highly specialized profession. It may be contracted for with caterers, may be supplied by other housing developments with expertise in this area, or may be negotiated with hospitals, schools, or other similarly equipped organizations. It should not be perceived as a service which volunteers (including tenants) can provide regularly even though they may be excellent cooks. Continuity of the meals service must be assured as part of the management plan. Food served should meet the standards for required daily nutrients as determined by a dietitian, and the premises should be operated in keeping with local health regulations. Because meals are part of the housing service, tenants have a right to expect them to be handled professionally. Volunteer assistants, however, can be helpful at times. For example, tenant-prepared meals could be planned for those occasions when professionals are off duty or for special events or holidays.

Of course, alternatives should be explored before deciding how to provide the meals service. Will it be less expensive to have meals brought in and perhaps only heated or kept warm in the kitchen? This would offer a savings in space and equipment. In this regard, it is best to consult experienced food handlers who do not have a stake in providing meals to the development. Other housing developments that serve meals might also be an initial contact. Another could be a local hospital which may be willing to provide meals at cost. A fourth alternative would be other local institutions that have learned how to take advantage of the economy of scale in providing food. Probably the largest "institution" serving meals is the United States military; aside from any advantage it may enjoy in food purchasing, its experience would be invaluable. Restaurant associations could also help explore the options, showing which methods would be more successful at less cost. In congregate housing for low income elderly, economy in food costs will undoubtedly be one determinant in choosing a food service method. However, arrangements should be made for the development to be the occasional recipient of delicacies which the food budget would not regularly support, such as gifts of special foods for festive occasions.

Because a cafeteria provides a greater range of choice, is informal, and saves the work and expense of table service, housing managers and some tenants opt for it. However, in making this choice, the probable characteristics of most tenants should be kept in mind as well as the probability that frailty may increase. Some will not be able to handle a tray in addition to a mobility aid. Those in wheelchairs may not be able to see or reach the food, causing an embarrassing dependence on attendants or neighbors. Uncertain steps, ambling gaits, or trembling hands may cause apprehension and spillage. On the other hand, having meals served at individual tables can add a touch of graciousness to dining, especially if the menu offers some room for choice and if, as previously mentioned, the waiters or waitresses are teenagers (at least on weekends). As a compromise, the entree could be served and a buffet table set up for salad, dessert, and beverages.

Too often the hours for serving meals are determined by staff requirements and not by tenant preferences. As a result, meals may be scheduled too early or too close together. Experience indicates that in most housing developments the main meal is preferred in the evening. This gives tenants something to anticipate, continues a lifetime custom, and enables them to assemble afterwards for socializing. Dinner should be no earlier than 6:30 p.m. Scheduling it between 5 and 6 p.m. is regarded by many as characteristic of an institution and can be embarrassing when guests are invited. People also have fixed patterns about the hour for breakfast. If possible, this should be flexible to accommodate both early risers and late sleepers. A self-service arrangement open from 7 to 10 a.m. is most acceptable and may require only one staff person to oversee and replenish stock. It has also been found that those who eat breakfast late usually do not want lunch but will wait until dinner to eat, thus settling for only two daily meals with small in-between snacks. Others will want three meals a day, and these should be offered, although a light lunch (a sandwich with soup or salad) is acceptable.

The best way to discourage hoarding of food in rooms is to provide an accessible snack bar with fruit, cookies, and drinks open at any and all hours. Vending machines could be set up to offer additional choices. A portion of the dining room may provide a comfortable place to sit and snack and, without question, could become a familiar spot for socializing. It may even become the space most used, with music added to enhance its relaxing qualities. In one development, the dining room is only cleared at 4 p.m. to provide time for dinner arrangements. It is a favorite gathering and sitting place.

From time to time it will be necessary to provide meals to sick or convalescent tenants in their own rooms. The critical decision involved is when to terminate this service. In one housing development, for example, room service is stopped after 3 days unless there is a physician's statement to the contrary. If the tenant does not return to the dining room even though the doctor certifies that he or she can do so, only tea and toast are delivered to the room. A checkoff system at mealtime is a good way to be alert to absenteeism and any possible need for assistance.

MEETING THE COSTS OF MEALS AND SERVICES

Because the law does not provide a subsidy for food and service costs (although kitchen and dining equipment may be charged to administrative expenses), the local housing authority must select tenants according to their ability to defray food and service costs in addition to rent. Although the legislation foresaw the need for supportive services to sustain the less vigorous elderly in a residential setting, no housing funds are available to provide them. As a result, the local housing authority must rely on local service agencies to ensure the operational feasibility of congregate housing developments.

The title VII nutrition program for the elderly might offer a solution in some locations if the scheduling of completion of congregate housing can be meshed with the availability of nutrition funds and with reasonable assurance that they will continue over the years. Logically, this should be required as a condition for approval of the kitchen

and dining spaces. There also may be an added cost for footage and construction because use of nutrition program funds requires serving eligible low income elderly from the neighborhood as well as occupants in the development. Selective modernization of existing housing with a more reliable estimate of the date of occupancy might prove more feasible in determining food and other service arrangements under Federal programs subject to annual appropriations. State and local funds could help resolve this dilemma particularly if the need is included in the State plan for the use of funds made available under title XX of the Social Security Act.

An increasing number of housing authority developments offer space for use in providing the meals service funded under title VII of the Older Americans Act. In other sites informal arrangements have been made for a part-time meals service (generally, a lunch served 5 days a week) provided by a local service agency.

In a study, completed this year, comparing the operations of public housing for the elderly and those of the 202 direct loan program, Dr. M. Powell Lawton found that meals were less expensive at the former. The mean cost of lunch in public housing (the only meal offered with any frequency) was 58 cents, while in the 202 projects the mean cost of breakfast was 54 cents; for lunch, 88 cents; and $1.41 for dinner. Factors contributing to the lower cost of meals in public housing were the type of personnel preparing meals, the type of meals service, and the subsidy for meals consequent to their provision by local service organizations. Tenants prepared meals at 65 percent of the public housing sites offering them; only 10 percent of the 202 sites had tenant-prepared meals, while 83 percent employed staff or a concessionaire to cook. Cafeteria-style service was utilized in 75 percent of the public housing sites as compared to its use in only 28 percent of the 202 sites. Waitress service was also used more frequently at 202 sites.

The study also indicated that at 94 percent of the public housing sites meals were paid for restaurant style, i.e., at each meal served; at 50 percent of the 202 sites meals were paid for as taken; at 25 percent they were mandatory and their cost was automatically included in the rent; at 6 percent meals were optional but if taken their cost was included in the rent; while at 19 percent there were other arrangements for payment, such as billing once a month for meals taken.

GROUP ACTIVITIES

Congregate housing should provide space for group and socializing activities not unlike those spaces provided for the well elderly. Although we can expect that the activities undertaken will be less vigorous and that there will be more observation and less participation, the need of tenants for stimulating activity should prompt serious consideration of the variety of social, mental, physical, and cultural stimulae appropriate to their capacities. There should be opportunities in this environment to perform tasks, to have recreation, and to be self-maintaining. In-house activities should range from those directed toward occupants with considerable potential for independence to those suited for persons with limited personal resources. Dr. M. Powell Lawton puts it very well when he states that "the resident's physical

and mental well-being depends on his not being challenged beyond his resources."

Other psychologists have stated that remaining active in some social role affects a person's longevity on physical, psychological, and social levels, thus improving the quality of his or her life. The richer the program and the more opportunities it offers, the more fully does it satisfy the need for security, affection, and stimulation. Naturally we can expect some programs to be more attractive to the elderly who feel "as young as they ever were" and less so to those who feel entitled to special advantages and treatment because of advancing age or disability. Programs which tend to pacify may alienate residents and block their potential to organize around issues vital to them. Psychologists tell us that artistic, mechanical, and judgmental capacities remain reasonably intact until late in life; verbal and reasoning skills are highly stable; and the facility for long-term recall of information is retained except among a small minority where the lapse is related to specific physical health problems. As a result, activity programs should provide residents with normal alternatives to their shrinking world which is diminished by change at different points in the developmental processes of aging. In short, residents have needs and desires which they do not have the resources to fulfill alone. Activities help provide a means to achieve this fulfillment and usefulness.

There is little basic data available to differentiate between activities for the vigorous, well elderly and those for older people who require supportive services. Institutions which also serve the well elderly might be the richest resource for guidance. The characteristics of the tenant body will largely determine the type and scope of activities. However, a few general observations are in order.

There should be emphasis on maintaining interest in community affairs to offset isolation. The management should encourage tenants to participate. A preference could be placed on quiet games which do not require sustained energy. The housing development may include an auditorium with comfortable fixed seats since movies, lectures, musicals, church services, plays, and sing-alongs are staple entertainment appealing to many.

Because the youngest of the elderly in public housing (with an average age of 72) were born in the early 1900's, adult education programs on communications, transportation, labor-saving technology, and general life sciences would be of genuine interest to keep them abreast of contemporary and future changes.

Gardening may still interest many. The development could provide a potting room for house plants, a wall garden for those who have difficulty stooping, and small plots (perhaps around trees) for miniature gardens. Garden lectures and shows will also prove popular.

The elderly also need to nourish a continuing sense of adventure. Opportunities for outdoor activity, especially in groups, should be provided, including walks into the community with something to enjoy upon arriving at their destination. Holidays and special occasions, such as birthdays, offer an excellent chance for outings and should be observed through group planning.

Activities such as listening to the radio or watching television may require more restrictive time schedules than in other types of housing. Observance of a quiet nap period may also be indicated, but care should

be taken not to develop more than a few essential regulations. Management and staff will be working with experienced adults, not delinquent children who need to be disciplined. One successful housing development of this type has only one regulation: "You may not smoke in bed."

LINKAGES FOR HOUSING AND SERVICES

Since enactment of the Older Americans Act in 1965 and subsequent amendments, all States and most communities have a number of service agencies concerned with the well-being of older citizens. A knowledgeable local committee or board of professionals in these services is essential in planning and operating congregate housing. Success must be built on a solid base of knowledge regarding the consumer. While aging means change, to live is to function and retain a sense of being a part of the human community as well as retain control of one's own life for as long as possible. Providing this opportunity to older persons is the joint responsibility of the housing and service agencies. This in turn offers a chance for both groups to develop more program integration on behalf of the aging whom both desire to serve well.

The responsibility of service agencies is no small one in congregate housing since neither the local housing authority nor all tenants will be able to defray the total cost of meals and other services. Some local housing authorities may choose to release full operational authority to an agency or agencies following the pattern of many senior centers in housing developments and to their boards and staff who are trained in mobilizing community support resources and in conducting group activities. The directors and staff of local institutions for the care of the aged also represent a valuable, experienced resource in service methodologies at the least cost and with maximum efficiency. Some of these techniques may be applicable to the operation of congregate housing. They are also a potential resource for trained staff or for aid in training staff in the service aspects of congregate housing. Finally these organizations may, as needed, provide the diagnostic expertise to determine the degree of services needed by tenants or the potential time sequence when they must be institutionalized and be helped to adjust to the relocation.

PART 5

CONCLUSION

Walt Whitman has wisely observed, "It is provided in the essence of things that from any fruition of success, no matter what, shall come forth something to make a greater struggle necessary."

The success of low rent residential developments for the well elderly and the expansion of institutional care facilities for the chronically and terminally ill have led naturally to the exposure of the limitations of both to respond to the entire range of shelter and service needs among the elderly throughout the aging continuum. This gap in housing can and should be filled by congregate facilities for the frail elderly.

The low rent public housing program enjoys the deep subsidy needed to house the elderly with low incomes, and it is to this program that we must look to provide housing developments which offer meals and other services to sustain an independent life style for the poor and the near poor. Launching a congregate housing program requires local housing authorities to reassess their functions and their potential contributions to the needs of all older persons in the community, including tenants in housing for independent living. It also involves matching facilities and services to needs in a rapidly changing personal and social situation rather than limiting service to a single category, that of the well and active low income elderly. Perhaps because this type of housing is a departure from the traditional concept of landlord-tenant responsibility, only a few local housing authorities have responded to the need and challenge of the congregate housing program enacted in 1970. Although there may be reasons causing them to hesitate, probably the most prevalent one is the awareness that this type of housing depends for its successful operation on firm, contractual linkages with local service agencies.

It is understandable that the ramifications of housing, food and housekeeping services, and personal aids for large numbers of older people not in institutions are virtually unknown in public housing except among a few pioneers. Unless we are more willing to meet this drastic need (and we now have statutory authority to do so), we may never know if congregate housing can offer a viable residential alternative for low income frail elderly. The other alternative is continuation of unneeded institutionalization, whatever the social or economic costs. If the latter should be true, our efforts should be to "residentialize" institutions, a less happy and more difficult goal. On the other hand, just as public housing with its rents related to ability to pay can remove financial apprehension for many low income elderly, so too congregate public housing with its provision of meals and other services can remove anxiety about obtaining help when needed, with

confidence that the individual resident's interests will be paramount in determining the aid sought and received.

The difficulties facing boards and staff at local housing authorities should, however, be recognized, analyzed, and resolved. First of all, we may ask if the responsibility for further development of congregate public housing should remain with existing local public housing agencies with years of experience in providing housing for independent living, or if a new agency should be formed in the community to discharge this task. One city—Holyoke, Mass.—has chosen to set up a geriatrics authority to build and operate any facility with a medical or potential medical care component. This authority enjoys the full powers of a local housing authority and is charged with providing a range of care under established State standards. Congregate housing in this community might be expected to be assigned to the geriatrics authority.

Congregate public housing most certainly is within the province of local housing authorities and other sponsors, not only by statute, but also by the standards of logical and sound social planning, if responsibility is shared with the community in coordinating housing and services. This competency is implicitly acknowledged when constructing housing for the well elderly, all of whom are at least 62 years of age upon occupancy. In housing well elderly persons, however, it is logical to plan alternative housing arrangements as they age and become less active. While most of the harshest human losses and adjustments accompany the later years, none cuts so deeply into an individual's strength of spirit as does the necessity to leave a familiar home and environment, friends and neighbors, and move prematurely to a distant facility where support is provided. How much more sensible it is if, when selecting sites for independent living arrangements, we also plan to locate a congregate housing facility nearby to reduce or alleviate the traumatic experience of uprooting, loneliness, and abandonment. The current HUD policy of limiting the time for holding property excess to the needs of a specific development should, in the case of housing for the well elderly, not only be changed but also logical use of this contiguous land or acquisition of sufficient land for congregate housing should be encouraged and, in time, required. It is significant that the States have special advantages over local sponsors in the section 8 subsidy programs under the 1974 Act. They are given top priority, have less competition to have plans approved, and do not have to go through as much red tape or checking procedures as of this writing. The status of the section 8 program in the movement for congregate public housing is still untested, as are the special advantages awarded the States. However, since housing authorities are creatures of the States, and since all States are seeking suitable alternatives to costly institutions and have control of the distribution of service funds, the climate appears favorable for a close partnership that could relate to both State-Federal financing and State-provided services.

Congregate housing legislation per se does not speak to all the elements needed to achieve a successful program through public or private sponsorship, even though all the elements for a successful national program of congregate housing are both legislated and funded. The central problem is the fact that a variety of agencies

are responsible for pieces and parts of the total. Unless they are brought together, this desperately needed type of living arrangement cannot succeed. Coordination can be commanded by the Congress, by executive departments, and by State governments. Or reliance can continue to be put on voluntary commitments by State and local agencies to achieve a workable program, even at the loss of some autonomy by individual agencies. But for the future, the congregate housing program will be only a limited national resource insufficient to accommodate increasing demands and need for it, unless it is planned and funded as a housing/service program.

RECOMMENDATIONS

Congress

Should make provision for a food and service operating subsidy for congregate housing sponsors if such services are not now available in the community or cannot be programed by service agencies in proposed congregate housing for the low income elderly.

Department of Housing and Urban Development

Should explore ways to work with and through appropriate State agencies to encourage and assist local housing authorities to undertake congregate housing programs with services assured.

Should develop acceptable design criteria related to the special occupants in order to assist them to cope with the environment and thus avoid or delay institutionalization (in short, develop standards beyond those dictated by structural considerations).

Department of Health, Education, and Welfare

Should identify, marshal, and encourage the use of funds now available from all sources to underwrite costs of food and other essential services, specifically in support of planning and funding congregate housing. As an alternative recommendation, funds should be transferred to HUD and earmarked for use in the food and service components of congregate housing when proposals are cleared for construction funds.

State Governments

Should catalog the funding and service resources available within the State as well as those from HUD and HEW to enable them to respond to requests from local housing authorities seeking use of resources essential to the success of congregate housing.

Should appropriate funds as needed to supplement service costs of potential low income residents of proposed congregate housing.

Local Housing Authorities

Should plan for congregate housing by identifying potential occupants (some of whom may be now residing in housing for the well elderly), plus the local availability and cost of services required. The planning and operations budget should set forth local service availability and costs, if any, as well as assurance of continuing support. Knowledge of all local and State program potentials to achieve a feasible operation should be explored.

The Future

At present the provision of and funding for congregate housing must be the mutual responsibility and goal of Federal, State, and local service and housing agencies, working together to ensure the support needed for food and other services essential in congregate housing. Such coordinated action by housing and service agencies at all levels will decide the future life style of many of the Nation's older persons now deprived of opportunities to retain and enhance their independence as they grow older. What will that future be?

APPENDIXES

Appendix 1

CONGREGATE HOUSING DEVELOPMENTS IN TOLEDO AND COLUMBUS, OHIO

The congregate housing developments in Toledo and Columbus, Ohio, have several experimental or exploratory aspects:

—To determine the need for and the utility of such developments for the elderly who need or want meals, housekeeping, and other services to maintain residence in a semi-independent "home" setting.

—To determine whether community-based public housing for the elderly is a viable alternative for elderly persons unnecessarily committed to the State's mental institutions or released after treatment and rehabilitation.

—To explore ways to coordinate Federal-State-local elements of a plan to provide shelter and services to elderly persons in the community and to elderly patients discharged from State mental institutions.

In all three aspects these developments have been and continue to be successful, both socially and financially.

The Ohio effort began with contractual agreements on financing between the Federal Government and the State of Ohio. The two public housing developments for the elderly (100 units in Toledo and 246 in Columbus, both furnished and unfurnished) were designed as efficiency and one-bedroom housekeeping units with kitchens. It was agreed that the allowable community space was insufficient to accommodate the supportive services, in particular, the central dining room and kitchen, as well as the usual space for recreation and leisure pursuits. The State of Ohio, therefore, contributed the land for both projects valued at $376,000 in Columbus and a like amount in Toledo, both parcels in prime locations. The savings in land costs to the housing authority and the Federal Government were then applied to the cost of the additional needed space, primarily the central dining room and kitchen (for the provision of which there was no statutory authority in the mid-1960's when these developments were launched).

As a further contribution, the State accepted responsibility for providing all needed services under a 40-year contract guarantee for occupants in each project. Staff of State mental institutions screen elderly patients and select those whom they feel could adapt to community living and mix comfortably with non-institutionalized elderly tenants drawn from the community. (Hospital dischargees comprise

approximately one-third of the total tenant body.) The housing authority manages the properties in each project, but all services are provided by the State through the Hospital, the Commission on Aging, the Department of Public Welfare, or other State resources.

Rental income goes to the housing authority; the State receives payment for other services including food (two meals a day, 7 days a week, at $45 a month for individuals and $55 a month for a couple). Milk, bread, butter, and fruit may be taken from the dining room for snacks between meals. While all tenants at Worley Terrace in Columbus must pay for their meals whether taken or not, the Toledo plan does not require this (except for dischargees from the hospital who are encouraged to take a full meals service at least during the first month of occupancy). The major food components are prepared at the hospital in each city and then delivered to the project. (Article B of this appendix outlines the additional services provided in the developments and by whom.)

The melding of resources for funding and services has represented an economy to the State and a more wholesome and acceptable living arrangement for older persons.

At the conclusion of a recent survey of these developments by the International Center for Social Gerontology, Washington, D.C., the interviewer summed up the findings as follows: While the frail elderly from the communuity benefited from these programs, the real focus is on providing an alternative to institutionalization for residents whose mental health requires a supportive environment to enable them to manage independent living. Both developments provide excellent examples of the extensive array of services that can be mobilized from existing community service agencies which, supplemented with basic services, can create an assisted residential living environment that still manages to focus on independence to the maximum extent possible.

In Ohio it appears that sharing responsibility—with Federal support for congregate housing construction and State support for the provision of services—has offered a workable solution to problems encountered in offering congregate housing to older persons as an alternative to institutional living or as a preventive measure making institutionalization unnecessary. Similarly, in smaller towns, such as Alma and Burwell (cited in part 2 and in appendixes 2 and 3), the combined resources of the local housing authority and other agencies willing to underwrite services have helped to make this type of program a workable alternative to institutional living. The congregate concept in housing can also be applied to housing for some of the physically or mentally handicapped now living in institutions.

The Ohio developments, as well as others cited in part 2, are still operating successfully. They can serve as a valuable resource in future efforts to research and evaluate the benefits of congregate housing to low income elderly with some degree of physical or mental impairment and to those agencies that sponsor and support it as an additional community service.

Articles A and B that follow provide a more detailed description of one of the Ohio developments—Worley Terrace in Columbus—and of the range of services available to residents. Articles C and D present samples of contracts and lease agreements related to the Toledo project.

A. WORLEY TERRACE, COLUMBUS: "A PLACE WITH A PLAN FOR TOTAL LIVING"*

The Place

Worley Terrace is a new approach in housing for the elderly. It is a demonstration project—a pioneer venture—in providing surroundings, activities, nutritional meals, services, and programs at a low cost to enrich the lives of older persons; to provide a life of dignity and self respect; to offer an opportunity to alleviate loneliness, and to provide privacy. These are normally available only to persons with much higher incomes.

It will serve as an example for the whole country showing what can be done to help keep residents well and happy by preventing physical and mental problems through suitable housing and availability of varied services.

THE LOCATION

On a broad meadow in a park-like setting south of West Broad Street on the west side of South Central Avenue, Worley Terrace is within walking distance of a number of churches; public transportation and shops are a mere two blocks away in either direction—to the north at Broad and Central and to the south at Sullivant and Central.

THE APARTMENTS

The beautifully designed efficiency and one-bedroom apartments, located in four one-story buildings and in a six-floor building, are owned and managed by the Columbus Metropolitan Housing Authority, and the services are provided through the State of Ohio, Department of Mental Hygiene and Correction. Lounges for the use of the residents are available in each building, and resident dining rooms for meals and facilities for laundering are conveniently located.

Each apartment has a kitchen with electric range and refrigerator, draperies in colors and patterns coordinated with the apartment color scheme, private bath, and ample closet and storage space. Utilities are furnished and on-site parking is available.

THE COMMUNITY CENTER

A center by location as well as by name, the community center is surrounded by the garden areas, pools, patios, and covered walkways that separate it from the dwelling buildings. Here are the craft rooms, the auditorium, the clinics, the meeting rooms, all the facilities necessary for the provision of a total service program for the community.

The Plan

The community services are provided through the State of Ohio Department of Mental Hygiene and Correction. In this exciting concept for a total living plan, these services are provided:

—*Meals*, two nutritious meals a day, lunch and dinner, planned by a dietition.

*Excerpts from a brochure distributed by the Columbus, Ohio, Metropolitan Housing Authority.

—*Health care* through a regular program of examinations and medication by physicians, psychiatrists, podiatrists, and dentists in the health clinic.
—*Barber and beauty shop* service.
—*Social and recreational programs* that provide a choice of leisure time activities covering everything from ART to a trip to the ZOO.
—*Furnished Apartments* (optional) including carpeting, plus almost everything else (soap, tissues, mop) needed for total living.

THE COST

25 percent of income for rent.
Plus $45 per month for meals, $90 per couple.
Plus $15 per month for furniture, $25 per couple.

YOU ARE ELIGIBLE IF:

—You are 62 years of age or older.
—You are disabled.
—You are a resident of Franklin County.
—You receive a net annual income of not more than:
$4,700 for one person,
$5,500 for two persons.
—You have assets totaling less than $12,500.
—You wish to take advantage of this brandnew plan for total living.

B. STATEMENT OF SERVICES PROVIDED TO WORLEY TERRACE RESIDENTS BY THE STATE OF OHIO, DEPARTMENT OF MENTAL HYGIENE AND CORRECTION, MAY 1, 1970

The Department of Mental Hygiene and Corrections provides personal care services, furniture and furnishings, and meals for occupants of the Worley Terrace, Golden Age Village, as follows:

I. Personal Care Services

Personal care services are primarily for social orientation, to keep residents well, to give them a feeling of security and well-being, and to enable individuals to live independently longer than would otherwise be possible.

A. *Health services.* A registered nurse or licensed practical nurse is on duty 8 hours a day, 5 days a week, and will give (1) routine health assistance; (2) assistance to residents in procedures prescribed by the doctor; (3) make appointments with a physician or specialist for specific health needs when indicated; and (4) assist the doctor in the health clinic. Clinic service does not include nursing care services.

By appointment with the clinic nurse, the following health care will be provided at designated times: routine medical visits to the health clinic; routine dental, podiatry, including minor treatment; general physical examination once a year, if necessary or desired; immunizations as necessary and advisable throughout the year; emergency visits

to units by nurses as indicated; therapy consultation as need indicates. Screening programs as deemed necessary.

The resident will be responsible for the fee for professional services covered by plan A and/or B of the medicare program and/or title 19 of the Social Security Act.

B. Assistance will be given the resident to help with individual problems, including welfare and social security.

C. *Recreation and leisure time activities.* Residents will be encouraged to participate in a variety of programs designed for their enjoyment and to alleviate loneliness, stimulate interest, improve mental and physical health, and be of general benefit to them.

These will include instruction in arts and crafts, development of hobbies, dances, movies, and other recreation and educational pursuits. There will also be opportunities to help others through community services.

D. *Barber Shop and Beauty Parlor.* The beauty and barber shop will be open on specified days. Service will be by appointment with the beautician and barber in the community facilities building.

Under this agreement, men will receive one haircut every 2 weeks; women may have one hair wash and set every 2 weeks, one hair trim once a month, and two permanents a year. Any additional beauty or barber shop services will be made between the resident and operator and paid for by the resident.

II. Furniture and Furnishings

Furnished units will include adequate and appropriate furniture as well as furnishings such as: sheets, pillow cases, bath and hand towels, and wash cloths. In addition, a pillow, blankets and bedspread will be furnished. Soap, toilet tissue, and detergents for laundry will also be provided and issued on a scheduled basis.

III. Meals

Two nutritious meals a day, planned by a dietitian, will be provided. Assistance in selection and substitution of foods will be given by the food service personnel to control special diets.

C. SAMPLE OF THE CONTRACT EXECUTED BETWEEN THE STATE OF OHIO AND THE TOLEDO METROPOLITAN HOUSING AUTHORITY AND APPROVED BY THE FEDERAL GOVERNMENT

This Agreement, entered into this —— day of ————, 19—, by and between the Toledo Metropolitan Housing Authority of Toledo, Ohio, herein called the "Local Authority," and the Ohio Department of Mental Hygiene and Correction, Columbus, Ohio, herein called the "State,"

Whereas, the Toledo Metropolitan Housing Authority is a body corporate and politic created, organized and existing by virtue of the laws of the State of Ohio; and

Whereas, the Ohio Department of Mental Hygiene and Correction is a Department of the State, created, organized and existing by virtue of the laws of the State of Ohio; and

Whereas, the Housing Authority and the Department of Mental Hygiene and Correction may enter into contracts with each other by virtue of State law; and

Whereas, the Local Authority has received from the Public Housing Administration approval for a proposed project of one hundred (100) dwelling units for elderly persons of low income and approval of a site for said units which is located near and southwest of downtown Toledo and consists of an area of 7.50 acres bounded by State-owned land on the east and north, the Southland Shopping Center on the west, and Glendale Avenue on the south; and

Whereas, the Local Authority proposes to enter into one or more contracts with the PHA for loans and annual contributions in connection with the development and administration of such low-rent housing for elderly persons, all pursuant to the United States Housing Act of 1937, which Act, as amended to the date of this contract, is herein called the "Act," and pursuant to the provisions of the "Housing Authority Law" of Ohio; and

Whereas, the Local Authority is desirous of accomplishing the within project by obtaining the assistance and cooperation of the State in such undertaking; and

Whereas, to obtain such assistance and cooperation, the State must perform certain obligations in accordance with the provisions of the Act to comply with the applicable provisions thereof; and

Whereas, the State has determined that it would be advantageous in furtherance of the program to provide for elderly persons in Community facilities, in conjunction with and in cooperation with the Local Authority in the mutual development of the within referred to project on the within referred to site; and

Whereas, by said mutual development, the PHA, through the Local Authority, will contribute financially to the development of the Community Facilities to the fullest extent provided by the rules and regulations of the PHA;

Now, therefore, in consideration of the mutual covenants and promises set forth in this agreement, the Local Authority hereby agrees to the following:

SECTION I

1. Acquire the necessary site for the construction and development of not less than one hundred (100) low-rent dwelling units to house elderly persons and for the Community Facilities, which site is set forth and described in the approved plans on file in the office of the Local Authority and referred to as an area 7.50 acres, more or less bounded by State-owned land on the east and north, and Southland Shopping Center on the west, and Glendale Avenue on the south.

2. Construct and develop on the site area not less than one hundred (100) dwelling units to house elderly persons and construct and develop community facilities on said site, all in accordance with Public Housing Administration and the Toledo Metropolitan Housing Authority approved plans and specifications on file in the office of the Local Authority; provided, however, that all plans and specifications used as a basis for contract award shall be submitted by the Local Authority to the Director of the Ohio Department of Mental Hygiene and Correction, Columbus, Ohio, for his approval prior to any solicitation of bids for the construction contracts by the Local Authority; and that all proposed changes in plans and specifications involving areas outlined in Exhibit "A" must first be submitted to said Director for his approval prior to the operation of the changes.

3. Provide furniture and equipment for the community space to a maximum cost of $10,000.

It is further promised and covenanted by and between the parties as follows:

SECTION II

1. That the Local Authority will assume and bear all costs and expense for the construction and development of the low-rent dwelling units to house elderly persons, and other facilities, to the maximum extent permitted by PHA regulations and standards, and that the State will assume and bear all costs and expenses for the construction and development in excess of the above provided amount as provided by the following distribution:

	Square feet
Total square feet in nondwelling facilities building	8,550
Total square feet in the lounge areas (497 square feet times 4)	1,988
Total (actual)	10,538
Local housing authority can provide:	
Management	500
Clinic	500
Maintenance	800
Community facility space	2,250
Total square feet on nondwelling facility space (allowed)	4,050
Total square feet in nondwelling facilities building and lounges (actual)	10,538
Total square feet provided by local housing authority (allowed)	4,050
Total square feet to be provided by the State	6,488

	Cost
Total estimated cost, 10,538 square feet times $16.50	$173,877
Structures, $173,877 times 61.6 percent	$107,108
Administration, $40,507 times 6 percent	2,430
Planning, $102,023 times 6 percent	6,121
Site improvement, $54,800 times 6 percent	3,288
Total	$118,947
State will also provide:	
Community facility kitchen equipment	$25,000
Community facility air conditioning	10,000
Community facility furniture and equipment (additional)	10,000
Change in 50 efficiency dwelling units (increasing glass area; door to exterior patio; outside patio; exterior dwelling unit division wall): Increase ($500 per dwelling unit times 50 efficiencies)	25,000
Total State will also provide	$70,000
Estimated grand total State will provide	$188,947

The above estimated State cost is 11.5 percent of the total project development cost of $1,638,378.

2. That the Local Authority will lease to the State, certain areas as indicated on the attached exhibit "A" for a term of *forty-four (44) years or the term of the Authority's bond financing, whichever is longer*, with an option to renew upon the same terms and conditions as set forth in the lease agreement, a copy of which is attached, marked "Exhibit A," and made a part of this agreement as though fully rewritten herein.

SECTION III

A. The State, in consideration of the mutual covenants of the parties herein, will pay the funds necessary for the performance of the State's part or parts of this agreement in accordance with the following schedule:

The total payments by the State shall be made in thirteen installments of which twelve installments shall be equal. Each of the twelve equal installments shall be determined by dividing the total State's payment by thirteen. The total State payment shall be as provided for in Section III herein, based on the construction contract award amount for the total project. The thirteenth and final installment shall be the above amount adjusted to the cost or credit of all changes in the plans and specifications as approved by the Director of the Ohio Department of Mental Hygiene and Correction, Columbus, Ohio, the Local Housing Authority and the Public Housing Administration.

The first installment shall be due and payable upon the award of the construction contract with succeeding installments due and payable upon written request to the Director of the Ohio Department of Mental Hygiene and Correction, Columbus, Ohio. Final payment to be due upon the completion and acceptance of the Project from the contractor.

B. *Termination or Failure to Complete Construction:* In the event the Authority for any reason discontinues, or fails to complete construction of the Project, the State shall have the right to receive a refund of its funds advanced under the provisions of this contract. The completion of the transaction fulfilling the election shall mutually release each party from the provisions of this contract.

SECTION IV

Prior to the use of any of the non-dwelling space by the State, and before construction is completed, the Local Authority and the State will submit to PHA for its review and approval the following:

A. The occupancy policy to govern tenant selection. Said policy will be the same one now being used by the Toledo Metropolitan Housing Authority for all other projects under its jurisdiction.

B. A service plan for food, health, medical, recreational, social and educational services.

SECTION V

A. SPECIAL CONDITIONS

1. *Non-discrimination:* There shall be no discrimination by reason of race, creed, color, or national origin, against any employee or applicant for employment qualified by training and experience for any work under this contract.

2. *Prevailing Salaries or Wages:* Any contracts entered into or arising from this contract shall provide for the payment of not less than the salaries or wages prevailing in the locality of the project, as predetermined under applicable federal, state, or local law.

3. *Officials Not to Benefit:* No member or delegate to the Congress or resident commissioner of the United States of America shall be admitted to any share or part of this contract or to any benefit to arise therefrom.

4. This agreement shall not become effective until it shall have been approved by the Public Housing Administration.

5. This agreement shall bind and inure to the benefit of the successors and assigns of the parties hereto.

In witness whereof, The Ohio Department of Mental Hygiene and Correction has caused its name to be signed to this instrument by ————, Director, and the Toledo Metropolitan Housing Authority has caused this instrument to be executed on its behalf by ————, Chairman, and ————, Secretary, on the day and year above mentioned.

OHIO STATE DEPARTMENT OF MENTAL HYGIENE AND CORRECTION

By _____
Director

TOLEDO METROPOLITAN HOUSING AUTHORITY

By _____
Chairman

By _____
Secretary

D. SAMPLE OF THE LEASE AGREEMENT BETWEEN THE STATE AND THE LOCAL HOUSING AUTHORITY (TOLEDO)

This Instrument of lease executed this —— day of ————, 19—, by and between the Toledo Metropolitan Housing authority, hereinafter known as the "Local Authority", and the Ohio Department of Mental Hygiene and Correction, Columbus, Ohio herein called the "State," WITNESSETH:

Now, Therefore, the Local Authority, in consideration of rents, covenants and agreements hereinafter stipulated and performed by the State, does hereby lease to the State the following described property:

The Commuunity Center Section known and referred to as the Community Facilities of Project OHIO 6–13 and five lounge areas, accessory grounds and site improvements, all of which are set forth on the approved plans and specifications on file in the office of the Local Authority.

To have and to hold the above described premises with all the appurtenances thereto for and during a term of forty-four (44) years,

commencing on the —— day of ————, 19—, at a rental of one dollar ($1) per year; said lease for the term of forty-four (44) years to be automatically renewable forever for successive terms of one (1) year each, unless terminated by the State upon written notice of one hundred eighty (180) days prior to termination.

The State as Lessee further agrees and covenants with the said Lessor, its successors and assigns as follows:

1. That it will conduct and operate the aforementioned Community Facilities and appurtenances thereto for recreation, educational and social purposes, primarily for the benefit of the tenants occupying the adjacent housing units. The Local Authority may periodically (not less frequently than one year) review and evaluate the program and services being provided, and the State will in all ways reasonable and consistent with its facilities, adjust and adapt its program in accordance with such findings.

2. The Lessee will pay gas, electric and water charges for the Community Facilities and will provide ordinary Maintenance and all janitorial services in all areas assigned under this lease.

3. That Lessee will not assign this lease, or underlet said premises, or any part thereof, without the written consent of said Lessor.

4. That Lessee will at all reasonable times permit said Lessor or its agents, to inspect and examine said premises, or any part thereof.

5. That the Lessee shall not discriminate against any employee or applicant for employment, nor uses of the Community Facilities, because of race, creed, color or national origin. This provision shall be included in all subcontracts.

6. That the Lessee shall comply with the provisions of the Anti-Kickback Act (Title 18, U.S.C.A., Section 874, and Title 40, U.S.C.A., Section 276c) as amended.

7. That no member of or delegate to the Congress of the United States of America or Resident Commissioner shall be admitted to any share or part of this contract or to any benefit to arise therefrom.

8. That it is understood and agreed that this agreement shall not become effective until it shall have been approved by the Public Housing Administration of the Department of Housing and Urban Development of the United States Government.

It is further stipulated and agreed by and between the Parties that, in case of damage to the Community Facilities from an insured peril, the amounts received in payment of such damage shall be expended in repairing, rehabilitating or restoring such facilities.

It is further agreed by said Lessee that failure to substantially comply with any of the foregoing covenants or conditions shall at the option of said Lessor void this lease, and render the same null and void and shall constitute a ground of forfeiture and ejection.

The Local Authority, for itself and its successors and assigns, hereby covenants and agrees that the State, paying the rents and keeping and performing the covenants of this lease on its part to be kept and performed, said State shall peaceably and quietly hold, occupy and enjoy said premises during the term of this lease and all renewal periods thereof, without hindrance or molestation by said Local Authority.

IN WITNESS WHEREOF, the Toledo Metropolitan Housing Authority has caused its corporate seal to be affixed and its name to be signed to this lease by its Chairman and Secretary, and the State

has caused its name to be signed to this lease by its Director on the day and year above written.

Signed and Acknowledged in the presence of:

TOLEDO METROPOLITAN HOUSING AUTHORITY

_____ By _____
Chairman

_____ By _____
Secretary

Signed and Acknowledged in the presence of:

OHIO DEPARTMENT OF MENTAL HYGIENE AND CORRECTION

_____ By _____
Director

STATE OF OHIO }
COUNTY OF LUCAS } ss:

Before me, a Notary Public, in and for said County, personally appeared _____, Chairman, and _____, Secretary, who acknowledged that they did sign said instrument as such Chairman and Secretary of the Toledo Metropolitan Housing Authority, and on behalf of said Toledo Metropolitan Housing Authority, and that said instrument is their free act and deed as such Chairman and Secretary of the said Toledo Metropolitan Housing Authority and their free and corporate act and deed of said Toledo Metropolitan Housing Authority.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my official seal this —— day of ————, 19—.

_____
Notary Public, Lucas County, Ohio

Commission Expires _____

Appendix 2

CONGREGATE HOUSING, ALMA, GA.*

A. PROJECT DESCRIPTION

Sun City Courts in Alma is a pilot project of elderly congregate housing. The congregate facility consists of 40 apartments, each with a living room, bedroom, and bath. These apartments are arranged around open courts and connected to each other and to the community building by covered walkways. Also in the same project are 12 elderly units designed as a contiguous related element. The 12 elderly units are not connected to the congregate facility by covered walks. Each apartment in the elderly units includes a complete kitchen, as well as living room, bedroom, and bath.

The community building is centrally located and contains the administrative offices, the dining facilities for all congregate units, a large lounge, a library area, an activity room, and a kitchen. Mail is delivered to this building where each tenant has a private locked mail box. Also in the project are two laundry-lounge buildings that contain a room which can be used for family gatherings and special occasion parties. Each is equipped not only with washer, dryer, ironing board and drying yard, but also a lounge and a small kitchenette. The community building, as well as the laundry-lounge buildings, are air conditioned year round, and each dwelling unit and other facilities are connected to a central television antenna system. Color television is provided in the library-lounge.

The site for the development was chosen because it is in the block next to the hospital, county health facility, and a nursing home. The congregate development was arranged so that each occupant can maintain his individuality and privacy, but still be part of a closely ordered community.

The units are equipped with special features for elderly persons such as lever-handled hardware, no steps between porches and interior spaces, showers with seats and safety glass, individual heating units, and a signal light system on the exterior to be used if help is needed. Also, each congregate unit has a plastic topped counter in the bedroom on which a hot plate can be used for heating soups and beverages.

The community building has an office for the Sun City Courts Director (who lives in the development) and offices for the Executive Director of the Housing Authority of the City of Alma.

B. RANDOM OBSERVATIONS

Congregate units with no kitchens are equipped with small refrigerators and a snack unit, i.e., a counter (under which a small refrigerator can be placed) for toaster, coffee maker, etc. The maintenance department keeps all units sprayed for infestation control. The cost of this mandatory service is 50 cents a month. This amount is collected with the rent.

*This appendix includes excerpts from materials submitted by Wilfred B. Smith, executive director, Alma Housing Authority, 801 12th Street, Alma, Ga. 31510.

Residents in units with kitchens are not eligible for meals in congregate units unless they are ill and unless prior arrangements have been made. Residents in congregate units may have guests for meals if advance notice is given. The charge involved in this case is $1 per person. Meals are served at 8 a.m., noon (the main meal time), and 5 p.m. (on Sundays and major holidays this meal is a sack lunch with a sandwich, milk, and fruit).

The State department of health will not permit tenants to work in the kitchen unless they have a health certificate. Therefore, we have a contract with a qualified person to be responsible for the food preparation and planning of meals. (A copy of this contract is included in article C that follows.)

Residents seem to enjoy helping with fresh vegetables for the meals or freezer, such as shelling peas, snapping beans, shucking and grating corn, cutting okra or anything that can be done in the community building. Youth workers in the CETA (Concentrated Employment and Training Act of 1974) program perform the garden work and gather vegetables. This is at no cost to us for 32 hours per week.

Applicants are advised that if they are on a special diet, the meals program cannot prepare special food for them; however, if they are selective in the cafeteria line, they can select food that will meet their requirements. We do not employ a dietitian, though we are careful about highly seasoned food and sweets. Meals vary from day to day. Each day of the week there are different meats (usually a choice of two), vegetables, and dessert. Offering a choice among foods has helped reduce complaints.

No housekeeping service is furnished except for heavy work, such as window washing and polishing floors. This is done by the maintenance department when needed. If a resident has a short-term illness, help is offered; only at this time would meals be sent to the bedside. If a tenant becomes ill during the night, an alarm system can be used to ring a warning in the adjacent apartment and to switch on a red light on the front porch. This is another aspect of the "buddy system"—neighbor helping neighbor. Each apartment also has a telephone in case a doctor or an ambulance must be summoned.

Applicants for congregate housing must be ambulatory and not on a special diet. In case of doubt, a doctor's certificate is requested. Otherwise, it would be left to the applicant to choose what type of unit he or she prefers.

When a tenant becomes ill or is otherwise unable to care for himself or herself, we contact a member of the family or a doctor. In most cases, he or she would be admitted to a nursing home. We will hold the apartment until the person's ability to return to congregate housing is determined by the doctor. However, the apartment rent and meal charges would have to be paid during this absence.

Combining the hale and hearty with the frail is one of the most pleasant features of the elderly program. Tenants seem most happy to help one another when needed. They enjoy the fellowship and programs together. Tenants in congregate housing are paying for meals

and other services, therefore, we see no feeling of lesser status among them or on the part of other tenants.

In our opinion the occupants of congregate housing live a happy life after they become unable to prepare a well-balanced meal by taking advantage of congregate housing. Otherwise they would have to resort to a nursing home. The most difficult time is the adjustment period for an elderly person who has for many years lived with his or her family and now must adjust to our rules and regulations, meal schedule, and new neighbors.

The many programs for the elderly have been most helpful. The Older Americans Act was utilized for social services for the elderly as long as funding was available. We have continued this service under the model cities program and now under the financing of title VI programs of the Social Security Act (title VI has now been folded into provisions of title XX of the same act). We have two fulltime workers for social services and activities. SSI (the supplemental security income program) has helped tenants meet the need for cost of living increases in many areas, even though our meal cost has not increased. Rent adjustments have been made according to income. Rent has averaged $40 per month, exclusive of food and services.

The incomes of the 56 tenants in residence are derived from a variety of sources: 7 received only social security (SS); 17, SSI only; 13, a combination of both; 6 received SS and income from interest; 4, SS and a VA pension; 1, SS and a private pension; 3 received railroad retirement; and 1 each received the following alone—an annuity, a government pension, a VA pension, SS and earnings, and income derived from sale of home.

The oldest resident was born in 1886 and the youngest in 1927. Ten of the original residents (1967) are still in the project.

C. MEALS SERVICE CONTRACT BETWEEN THE ALMA HOUSING AUTHORITY AND AN INDEPENDENT CONTRACTOR

STATE OF GEORGIA }
COUNTY OF BACON }

This Contract and Agreement, made and entered into this —— day of ————, 19—, by and between Housing Authority of the City of Alma, Georgia, of the first part, hereinafter referred to as the "Housing Authority," and ————, of the second part, hereinafter referred to as the "Contractor."

Witnesseth:

That *whereas*, the Housing Authority operates what is known as Project Ga–133–4, designed and used specifically as living quarters for elderly low income families and individuals wherein centralized feeding facilities are provided, and

Whereas, the Housing Authority owns and has ready for use the requisite tables, chairs, stoves, tableware, pots, pans, and all other equipment and supplies and equipment necessary to prepare food for the residents of such project, and

Whereas, the Contractor is an experienced, well trained person, well skilled in the preparation and service of food and regular meals, who

will utilize the Housing Authority's facilities and prepare meals for residents of such project,

Now, therefore, it is mutually covenanted and agreed by and between the parties as follows:

1. The Housing Authority will make available to the Contractor for her use and the use of her employees, those portions of Project Ga–133–4, Alma, Georgia, now designated and used as a kitchen and dining area located in the central building, together with all necessary kitchen and dining room furniture, fixtures, equipment, supplies, and other personalty as is necessary in the premises.

2. The Housing Authority will at its expense furnish to the Contractor all of the foods, meats, soaps, cleaning materials, and other supplies and groceries, together with a menu or bill of fare describing in detail the various meals to be prepared by the Contractor.

3. The Housing Authority shall be responsible for the payment of all utilities necessary for the preparation of food and meals in the described kitchen, including but not limited to heat, lights, electricity, and such other forms of energy as are necessary and usual in the premises.

4. The Contractor, by the use of such facilities, will prepare the foods furnished by the Housing Authority, according to the menu furnished not less than 30 days in advance, and will daily make three nourishing meals available to all residents of the Housing Authority's Project Ga–133–4, regardless of number. She shall at all times keep the kitchen and dining area assigned to her care in a clean condition, carefully cleaning and storing all dishes and cooking utensils after each meal. Meals will be prepared under such conditions and in such manner as meet the requirements of the Health Department of Georgia and the Housing Authority.

5. The Contractor shall, at such times and upon such forms as the Housing Authority shall furnish, report the use and disposition of foodstuffs furnished her for preparation.

6. The Contractor shall personally prepare such food or shall personally supervise its preparation. She shall, at her own expense, employ such cooks, aides, and assistants as are necessary for the prompt preparation and service of such meals, and shall pay for herself and employees all taxes and assessments for Federal and State taxes and unemployment compensation, and all other legal charges against her compensation or the compensation or wages paid her said employees.

7. In consideration of the preparation and service of such food and meals and other services performed under the terms of this contract, the Housing Authority will pay the Contractor, promptly at the end of each calendar month wherein such services are performed the sum of One Thousand and Fifty Dollars ($1,050) per month.* Should this contract terminate at any time prior to the end of any month, there shall be an accounting between the parties, and the Housing Authority shall pay the Contractor the sum of $34.52 for each day performed under this contract, not previously compensated.

8. In addition to the consideration named in paragraph 7 and elsewhere in this contract, the Housing Authority will pay to the Contractor the sum of One Hundred Sixty Seven Dollars ($167), and shall

*Raised to $1,100 in 1975.

thereafter annually commencing on March 15, 1975 and on March 15 of each year thereafter so long as this contract remains in effect, pay to the Contractor One Hundred Sixty Seven Dollars ($167).

9. It is expressly understood and agreed that the payment of such sum annually is reimbursement by the Housing Authority to the Contractor for Workman's Compensation and Products Liability Insurance Premiums, which insurance is required by the Housing Authority. It is further expressly understood and agreed that should such insurance terminate during the policy period in any manner so that a return premium shall be payable, the Contractor will pay an amount equal to such return premium to the Housing Authority.

10. This contract may be terminated with or without cause by either party upon 60 days' written notice to the other. Unless earlier terminated, this contract shall terminate on the —— day of ————, 19—.

11. It is expressly understood and agreed that this contract does not create a relationship of landlord and tenant, employer-employee, or master and servant between the parties. The second party is an independent contractor. She covenants and agrees to hold the Housing Authority harmless from any and all claim, demand, damage, and liability in any way arising from the use of such kitchen, dining room, and premises used by her, or from the preparation and service of food and meals to residents of the described project and others served by her on the premises. She shall, from time to time, as required by the Housing Authority, account for all cookery and tableware and other items of personalty used by her in the preparation of food and tables. Representatives of the Housing Authority shall at all times have the right to enter upon premises used by the Contractor for the purpose of inspection and examination, and otherwise.

12. No agreement between the parties hereto shall be binding or have legal effect unless contained in this contract or endorsed hereon in writing.

IN WITNESS WHEREOF, the Housing Authority has caused its duly authorized officers to affix the name and seal of the Authority, and the Contractor has hereunto set her hand and seal, the day and year first above written.

Housing Authority of the City of Alma, Georgia (L. S.)

By: ————————————————

Chairman of the Board

Attest: ————————————————

Executive Director

(L. S.)

D. COST SAMPLES, CONGREGATE MEALS FACILITY, HOUSING AUTHORITY OF THE CITY OF ALMA, ALMA, GA.

Charts on the following pages include:

—Balance Sheet at December 31, 1974.
—Statement of Operations for the Year, January 1, 1974–December 31, 1974.
—Reconciliation of Changes in Congregate Meals Trust Advances Held by the Housing Authority of the City of Alma, Year Ended December 31, 1974.

COST SAMPLES—CONGREGATE MEALS FACILITY, HOUSING AUTHORITY OF THE CITY OF ALMA, ALMA, GA.

Balance sheet at Dec. 31, 1974				Statement of operations for the year Jan. 1, 1974, to Dec. 31, 1974			
Assets		Trust advances by city and county		Income		Expense	
Advance to housing authority.	$21,089.76	Total advances, Jan. 1, 1974.	$21,552.20	Meals for tenants.	$22,329	Management costs.	$11,767.00
Inventory—food	801.43	Add: 1974 interest income.	1,076.29	Meals for others.	268	Food costs	11,057.28
Inventory—supplies.	237.06	Deduct: Deficit from feeding operation.	(500.24)	Total	22,597	Miscellaneous supplies.	263.74
						Other costs	9.22
Total assets	22,128.25	Total trust advances, Dec. 31, 1974.	22,128.25			Total	23,097.24
						Net deficit for year.	500.24

RECONCILIATION OF CHANGES IN CONGREGATE MEALS TRUST ADVANCES HELD BY THE HOUSING AUTHORITY OF THE CITY OF ALMA, YEAR ENDED DEC. 31, 1974

	Cash	Investments	Congregate feeding accounts payable	Net trust advances held
Balance Jan. 1, 1974	$84.62	$21,243.30	($847.97)	$20,479.95
Transfer to investments, February 1974	(308.90)	308.90		
Interest income for year		1,076.29		1,076.29
Net deficit for year	(500.24)			(500.24)
Decrease in inventories	33.76			33.76
Decrease in feeding accounts payable	(11.23)		11.23	
Balance Dec. 31, 1974	(701.99)	22,628.49	(836.74)	21,089.76
Adjustment required: Transfer from investments	500.24	(500.24)		
Balances as adjusted	(201.75)	22,128.25	(836.74)	21,089.76

Appendix 3

PARK VIEW PLAZA,* BURWELL, NEBR.

A. PROJECT DESCRIPTION

This 50-unit housing project was financed and built by the Burwell (Nebraska) Housing Authority in cooperation with the Public Housing Administration. It was completed in March, 1967; partial occupancy was obtained earlier, and the first occupants moved in on January 12. There are 30 modern, attractive apartments, each with three rooms (living room, kitchen, and bedroom), plus a tiled bathroom and adequate storage. These are situated in five brick buildings located south of the city park and within walking distance of the business district. All apartments are furnished with drapes, electric stove, and a refrigerator.

The housing project also has the congregate living area, which houses an air-conditioned recreation room, community living room equipped with kitchen facilities for the use of all residents for social affairs, family gatherings, and entertainment, and the executive director's office. The congregate building also has 14 units, consisting of living-sleeping room combinations with private bath and adequate storage. There are six units with living room, bedroom, bath, and storage; persons living in these apartments are able to eat in a centralized dining room, where meals are brought in from the hospital and served family style. The daily cost of the meals is: breakfast, 90 cents; lunch, 85 cents; and dinner, 95 cents. All units are furnished with drapes. There is a master television antenna which is connected to each apartment.

Special features for the elderly include handle-type doorknobs, bathroom grab bars, and an emergency alarm switch in each unit.

Eligibility

To be eligible to rent an apartment, the applicant must meet the following requirements:

(1) Age: One member of the family must be at least 62 years of age.

(2) Income limits: Maximum income for one person is $3,500 per year; for two persons, $4,000 per year.

(3) No asset limit.

Rental

The project consists of 10 modified one-bedroom units (smaller), 10 one-bedroom units (larger), and two 2-bedroom units.

*The description of Park View Plaza with combined congregate and housekeeping units for the elderly and random observations on its experience were contributed by Dorothy VanDiest, executive director of the Burwell (Nebraska) Housing Authority.

Three factors determine the rent: (1) size of apartment; (2) number of persons in family; and (3) income. The rent, based on 25 percent of adjusted income, includes all utilities such as heat, electricity, water, garbage service, maintenance, and free laundry facilities, but does not include telephone. A maintenance man is hired by the housing authority for the care of the lawns, and to keep the walks and drives free from snow.

Management

The owner of the project is the housing authority of the city of Burwell. Commissioners are: B. W. Wagner, Sr., chairman; O. W. Johnson, secretary-treasurer; Leo F. Clinch, attorney; and William R. Beat, Floyd E. Demaree, and W. W. Bristol, directors. Frank Lindsey is maintenance man. The office is in the community building and is open Monday through Friday, 9 a.m. to 5 p.m.

Recreation and Community Programs

Recreation centers around the large community room in the community building and in the new recreation building northeast of the apartments. The housing authority has received $7,500 from the title III program to be used for an areawide recreation and craft program for all persons 60 years of age and older. Headquarters for this program is Park View Plaza.

About Burwell, Nebr.

Burwell, the county seat of Garfield County, has much in common with other midwestern county seat towns of similar size. It has a modern medicare-approved, 30-bed hospital, and two doctors who serve the area. A new 40-bed nursing home is under construction, joining the hospital on the north. This health unit is one and one-half blocks from the housing project. Burwell has a good public library, an efficient volunteer fire department, six churches, a modern swimming pool, a well-kept park and picnic facilities, and an active Wranglers Club. Burwell is the home of Nebraska's Big Rodeo.

B. RANDOM OBSERVATIONS

The incomes of tenants in the congregate living area range from $1,117 to $3,801 a year. Rents, based on 25 percent of adjusted income, range from $21 to $71.

Some tenants miss the kitchen but would not be able to cope with it or maintain a balanced diet. The community room has a refrigerator for the use of all congregate tenants. Some keep snacks in their rooms, but they are responsible for control of any insects these may attract.

Tenants in housekeeping units may dine in the congregate dining room by notifying the kitchen in advance. The kitchen, in turn, orders the amounts required from the hospital.

The hospital breaks even on the meals. As the costs of food and labor rise, so too does the price of meals. Special diets are provided if ordered by the doctor.

Tenants seem to enjoy the meals: they are varied and are served in a pleasant atmosphere on good china attractively arranged.

For those who are unable to do their own housekeeping but who can afford to pay to have it done, a housekeeping service is available. Payment is by the hour and is handled between the tenant and the housekeeper. For those who qualify (those with an annual income under $1,500), a homemaker service is available through the welfare office.

All tenants have their own linens. The laundry is located in the building and tenants are responsible for it.

The homemaker helps bathe one tenant who is crippled by arthritis. Tenants help one another in fastening zippers when needed. This is one example of tenants aiding each other. They seem concerned about those who are frail or ill, and run errands for them and visit them.

None of the tenants need nursing service. Congregate tenants are not thought of as frail. They are seen as elderly persons needing a friendly hand.

When applications are accepted, the person states what type of apartment he or she prefers. Three tenants moved from housekeeping to congregate units when it became apparent that they could no longer cope with the demands of shopping and cooking, etc. Most go to the nursing home of their own accord. Some have had to stay there for an extended period, but if their rent is paid, the apartment is held for them. This has been the case with five tenants. When they are ill and must go to the hospital, most tenants worry about keeping their apartments until they are able to return.

If a tenant needs a doctor at night, he or she rings the alarm and another tenant telephones the doctor. The doctor, in turn, summons the emergency unit which operates free for all residents of Garfield County. This unit is equipped with short wave radio for contact with the doctor and the hospital and is staffed by volunteer firemen with first aid training. This type of alarm and alert system has been less expensive to operate than one requiring a "live-in" monitor. The emergency telephone number is posted on all telephones so that tenants can dial for help from their rooms to a radio dispatcher who can then contact the doctor, the fire department, and the emergency unit.

Outside organizations are also involved in the life of the facility. Ladies from the Methodist church bring homemade pies once a month for dinner in the congregate dining room. Other groups hold parties and bingo, and the schools and 4-H clubs provide programs. The Future Homemakers of America have adopted a tenant as a foster grandparent, a reverse on the usual notion of a grandparent adopting a child with special needs. Talking books are provided for those with visual impairments. A local volunteer provides transportation to the local doctor or beauty shop for any elderly person in the city limits. Church services and Bible study are held once a week. Movies are shown once a month. The projector was purchased in 1968 with funds provided under title III of the Older Americans Act. There is also a library in the congregate lobby. Books for it are exchanged with the county library by the same volunteer who provides transportation to the doctor, and so forth.

○

facts about

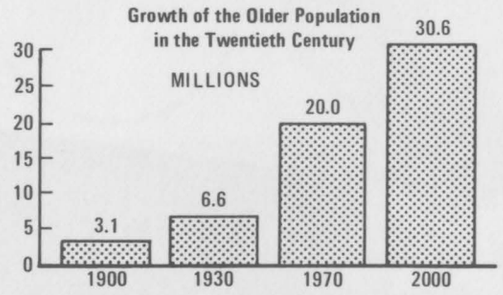
Older Americans 1975

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Office of Human Development
Administration on Aging
National Clearing House on Aging

DHEW Publ. No. (OHD) 75-20006

How many older Americans are there?

- In 1974, one in every 10 persons in the U.S. was 65+ (21.8 million men and women.)
- This number is about the same as the total population of the 20 smallest States and the District of Columbia.
- The proportion of the population 65 years old and over varied by race and ethnic origin: 11% for whites, 7% for blacks, and 4% for persons of Spanish origin.
- Between 1900 and 1974, the *percentage* of the U.S. population aged 65+ more than doubled (4.1% in 1900 to 10.3% in 1974) while the number increased about sevenfold (from 3 million to 22 million).
- At present death rates, the older population is expected to increase 40% to 31 million by 2000. If the present low birth rate continues, these 31 million will be 11.7% of the total population of about 262 million. If the birth rate should increase very significantly, they would represent 10.7% of a total population of about 287 million.

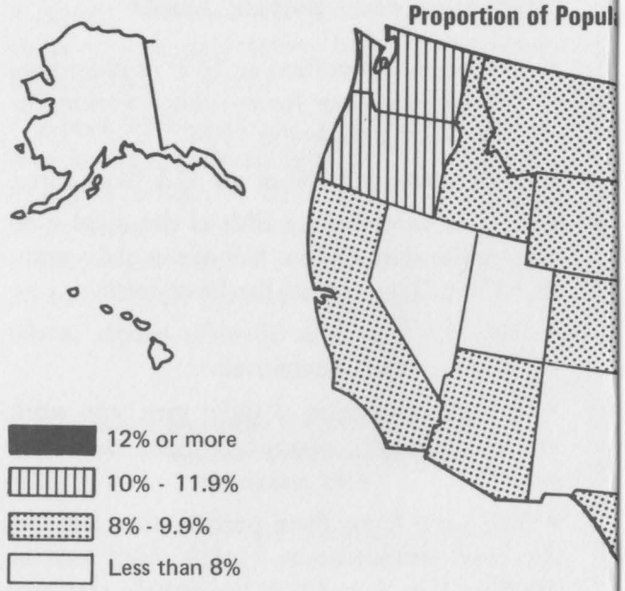


The Older Population in the Twentieth Century

Year	Total	Men	Women	Ratio Women/Men
1900	3,080,000	1,555,000	1,525,000	98/100
1930	6,634,000	3,325,000	3,309,000	100/100
1970	19,972,000	8,367,000	11,605,000	139/100
1974	21,815,000	8,966,000	12,849,000	143/100
2000	30,600,000	12,041,000	18,558,000	154/100

Where do older Americans live in the United States?

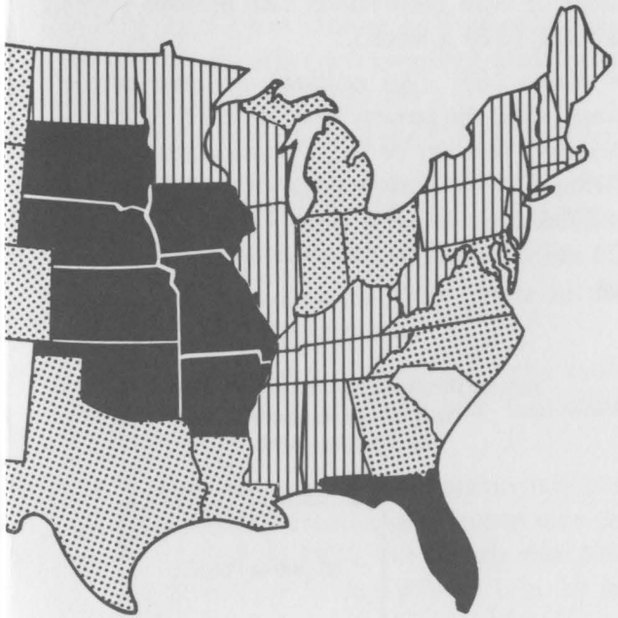
- In 1974, about half (45.4%) of persons aged 65+ lived in the six most populous States —California, Illinois, New York, Ohio, Pennsylvania, Texas—and Florida (the eighth most populous). Each of these States had more than one million older persons. The 65+ population in two States (California and New York) will soon reach 2 million.
- Eight States had an unusually high proportion of older persons (12% or more) in their total populations—Florida (15.5%), Arkansas (12.8%), Iowa (12.6%), Missouri, Nebraska, and Kansas (12.4% each), South Dakota (12.3%), and Oklahoma (12.1%).



Estimated Population Aged 65+, by State, 1974

State	Number (000's)	Percent of Total Population	Rank[1]	Percent Increase, 1970-74
Total	22,023	10.4	--	9.3
Alabama	365	10.2	24t	12.7
Alaska	8	2.4	55	14.3
Arizona	211	9.8	30t	31.1
Arkansas	264	12.8	2	11.4
California	1,986	9.5	34t	10.8
Colorado	204	8.2	44	9.1
Connecticut	314	10.2	24t	9.0
Delaware	48	8.4	42t	9.1
District of Columbia	71	9.8	30t	1.4
Florida	1,267	15.7	1	28.6
Georgia	413	8.5	41	13.2
Hawaii	53	6.3	51	20.5
Idaho	76	9.5	34t	13.4
Illinois	1,134	10.2	24t	4.1
Indiana	522	9.8	30t	6.1
Iowa	360	12.6	3	3.2
Kansas	281	12.4	4t	6.0
Kentucky	364	10.8	20	8.3
Louisiana	337	9.0	37	10.5
Maine	122	11.7	10	7.0
Maryland	333	8.1	45	11.7
Massachusetts	661	11.4	12t	4.4
Michigan	798	8.8	39t	6.5
Minnesota	432	11.0	17t	6.1
Mississippi	246	10.6	21t	11.3
Missouri	591	12.4	4t	5.9
Montana	73	9.9	29	7.4
Nebraska	191	12.4	4t	4.4
Nevada	41	7.2	49	32.3
New Hampshire	86	10.6	21t	10.3
New Jersey	749	10.2	24t	7.9
New Mexico	86	7.7	47	22.9
New York	1,998	11.0	17t	2.4
North Carolina	473	8.8	39t	14.8
North Dakota	72	11.3	14	9.1
Ohio	1,050	9.8	30t	6.1
Oklahoma	328	12.1	8	9.7
Oregon	251	11.1	15t	11.1
Pennsylvania	1,348	11.4	12t	6.4
Rhode Island	111	11.8	9	6.7
South Carolina	219	7.9	46	15.3
South Dakota	84	12.3	7	5.0
Tennessee	429	10.4	23	12.3

ıtion Aged 65+, 1974



State	Number (000's)	Percent of Total Population	Rank[1]	Percent Increase, 1970-74
Texas	1,120	9.3	36	13.4
Utah	88	7.5	48	14.3
Vermont	51	10.9	19	8.5
Virginia	410	8.4	42t	12.6
Washington	354	10.2	24t	10.6
West Virginia	206	11.5	11	6.2
Wisconsin	505	11.1	15t	7.2
Wyoming	32	8.9	38	6.7
American Samoa	1	3.4	53t	0.0
Guam	2	2.1	56	20.0
Puerto Rico	198	6.6	50	11.8
Trust Territories	4	3.7	52	15.2
Virgin Islands	3	3.4	53t	37.5

[1] States are ranked in order of decreasing percentages (highest percentage is rank 1, lowest is 51)

[t] Tied in ranking. States with identical percentages receive identical rank number with following rank number(s) skipped to allow for number in tie.

Has life expectancy changed?

- A child born in 1900 could expect to live an average of about 47 years; a child born in 1973 could expect to live 24 years longer—an average of 71 years. The major part of the increase occurred because of reduced death rates for children and young adults. More people now reach old age, but then do not live much longer than did their ancestors who reached age 65 in 1900.
- At age 65, life expectancy is 15 years—13 years for men but 17 years for women. As a result of this sex difference in life expectancy, which begins at birth, there were 143 older women per 100 older men in 1974 and the disparity continued to grow with age. (Assuming that the 1973 death rates do not change in the future, 80% of female children will live to the age of 65 as compared with only 65% for male children.)
- More than 1.2 million older people died in 1972, a rate of 59.2 per 1,000—73 for men and 50 for women. The death rate for the under-65 group was 4 per 1,000.
- Three-fifths of all of the deaths of older persons resulted from heart disease (45%) and cancer (16%).

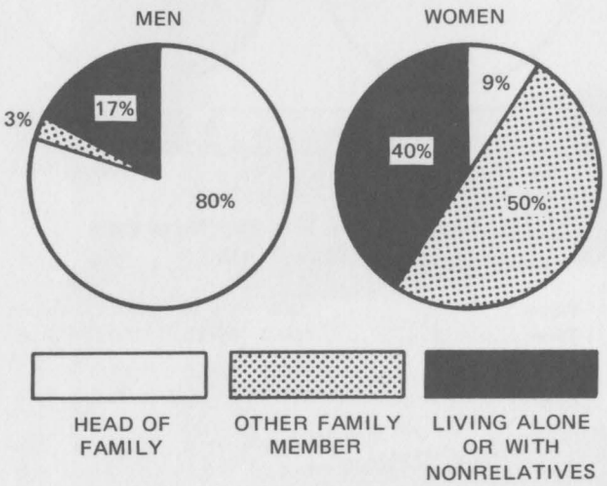
What are the costs of health care?

- In 1973, the Nation spent approximately 80 billion dollars for personal health care. About 28% of this amount was spent for older persons. The per capita health care cost for an older person was $1,052, over 2½ times as much as the $384 spent for younger adults. Benefits from government programs such as Medicare accounted for nearly two-thirds of the health expenditures of older persons, as compared with one quarter for adults under 65.

What are the living arrangements of older persons?

- About 5% or approximately one million older people lived in institutions of all kinds in 1974.
- Most older persons lived in a family setting.
- In the noninstitutional population, the numbers of older men and older women living in a family setting were about the same (7.1 million men, 7.2 million women), but since there are many more older women than older men (143 per 100), the proportion of older men in family settings was 83% and of women, 60%.
- More than one-third of all older persons (6.3 million; 1.4 million men and 4.8 million women) lived alone or with nonrelatives (40% of all older women but only 17% of all older men).
- Within the older population the proportion living in family settings decreases rapidly with advancing age.

Living Arrangements, 1974
(Noninstitutional Population)



What is the marital status of older persons?

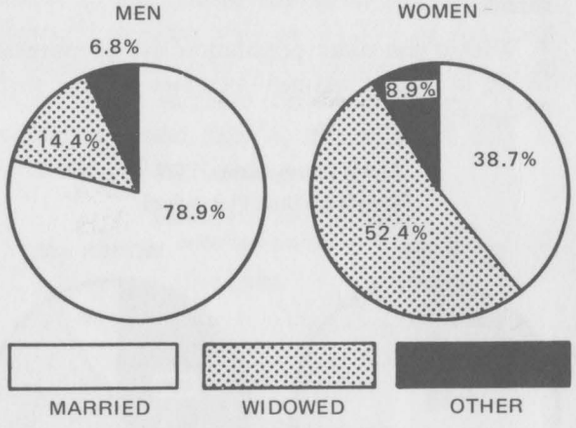
• In 1974, most older men (79%) were married; most older women (52%) were widows. There were more than five times as many widows as widowers.

• About one-third (36.4%) of the older married men had wives under 65 years of age.

• In 1971 the States* that participated in the reporting program for marriages reported 16,410 brides and 33,056 grooms aged 65+. These were first marriages for about 7% of the women and 5% of the men. Most were remarriages of older persons who were previously widowed (70% of the brides and 67% of the grooms).

* A total of 41 States and the District of Columbia.

Distribution of Older Persons by Marital Status, 1974



Distribution of Older Persons by Marital Status, 1900 and 1974

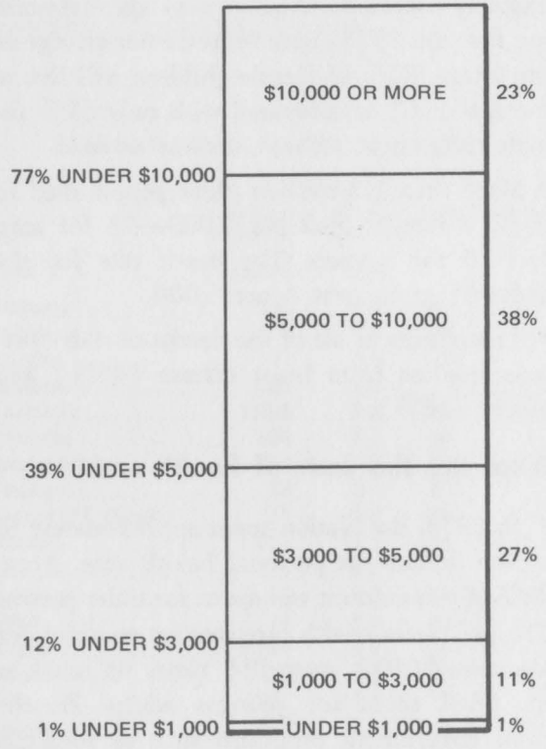
Status	1974 Men	1974 Women	1900 Men	1900 Women
Total	100.0	100.0	100.0	100.0
Married	78.9	38.7	67.3	34.3
Widowed	14.4	52.4	26.5	59.5
Other				
Divorced	2.2	2.6	0.5	0.3
Never married	4.6	6.3	5.8	6.0

What is the income situation for older persons? *

• Some are well off. About 1.2 million couples with 65+ heads had incomes of $10,000 or more in 1973. Some 2 million older couples had incomes between $5,000 and $10,000.

• Many are not well off. About 655 thousand couples had incomes under $3,000 ($58 a week).

Income Distribution of 5.3 Million Couples With Heads 65+, 1973

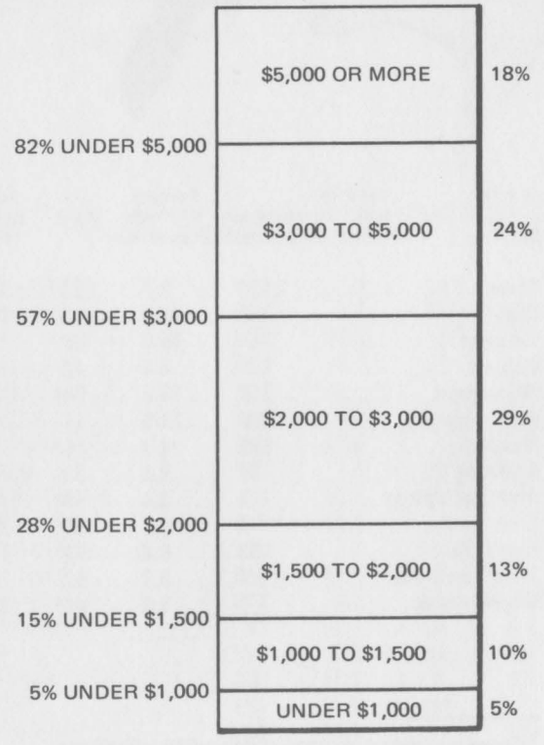


* Income data is tabulated by age of head of family or of a person living alone or with nonrelatives. Data presented above represent only couples (2-person husband-wife families) or individuals living alone or with nonrelatives to avoid factors introduced by presence of family members of other ages.

• About 944 thousand older persons living alone or with nonrelatives had incomes under $1,500 ($29 a week).

• About 16% (3.4 million) of older people were below the poverty level in 1973. Approximately 2 million or 60% of these poor were living alone or with nonrelatives; of these, 1.6 million were women, mostly widows. Of the 23 million poor persons of all ages, 15% were 65+.

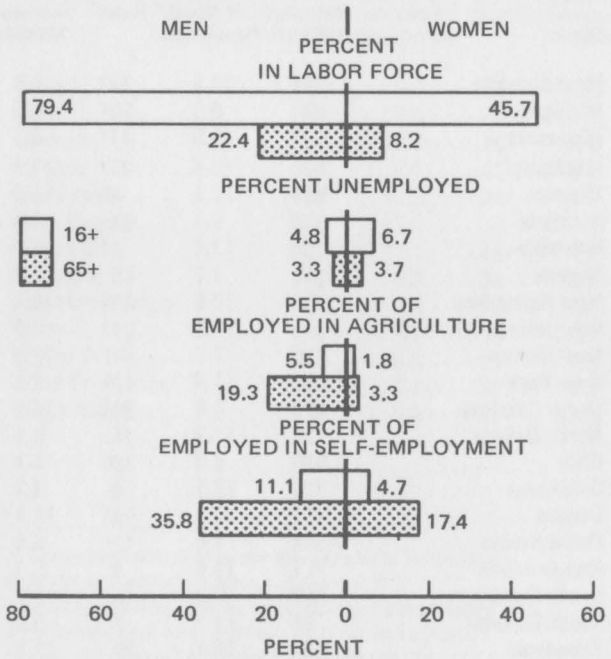
Income Distribution of 6.3 Million Persons Aged 63+ Living Alone or With Nonrelatives, 1973



How many older persons work?

- More than 2.9 million or 14% of older people were in the labor force—either working or actively seeking work—in 1974.
- They make up 3.1% of the U.S. labor force.
- Slightly more than a fifth of the older men (1.9 million) and about 8% of the older women (1.0 million) are in the labor force.
- Only 3.4% or 1 in 30 older people in the labor force were unemployed.
- A large proportion of older men who work are in low-paying agricultural jobs (see chart below).
- The male labor force participation rate has decreased steadily from 2 of 3 older men in 1900 to 1 in 5 in 1974; the female rate rose slightly from 1 in 12 in 1900 to 1 in 10 in 1972, but dropped to 1 in 12 in 1974.

Older Persons in the Labor Force, 1974



Health status and health care utilization

- Chronic conditions are more prevalent among older persons than younger. In 1973, about 38% of older persons were limited in their major activity (working or keeping house) due to such conditions, as compared to only 7% for younger persons.
- In 1972, about 18% of the 65+ group had an interference with their mobility due to chronic conditions—6% had some trouble getting around alone, 7% needed a mechanical aid to get around, and 5% were homebound.
- In 1973, older people had about a 1 in 6 chance of being hospitalized during a year, higher than for persons under 65 (1 in 10). The proportion with more than one hospitalization during a year was also greater for older people (3.8% vs 1.6%). Once in the hospital, older people stayed about 5 days longer than younger patients (12.2 vs 7.2 days).
- On the average, older people had one-third more physician visits than did persons under 65 (6.5 vs 4.8 visits) in 1973, with a higher proportion of visits occurring within the last 6 months.
- Half of the older population had either not seen a dentist for 5 or more years or had never visited a dentist. In 1971, dental visits of older persons were much more likely to be for denture work (36% vs 12%) and less likely to be for examinations or teeth cleaning (31% vs 42%) than for younger persons.
- In 1971, older people were twice as likely to wear glasses and 13 times as likely to use a hearing aid. About 92% of persons 65 years old and over wore eyeglasses or contact lenses and 5% used hearing aids.

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