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PROBLEMS OF THE AGED AND AGING

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HEARING

BEFORE THE

GENERAL SUBCOMMITTEE ON EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH CONGRESS

SECOND SESSION

ON

H.R. 10014

AND RELATED BILLS ON AGED AND AGING

PART 2

HEARING HELD IN SOUTH BEND, IND., APRIL 14, 1962

Printed for the use of the Committee on Education and Labor

ADAM C. POWELL, *Chairman*



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PROBLEMS OF THE AGED AND AGING

SATURDAY, APRIL 14, 1962

HOUSE OF REPRESENTATIVES,
GENERAL SUBCOMMITTEE ON EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
South Bend, Ind.

The subcommittee met at 10 a.m., pursuant to call, in South Bend, Ind., Hon. John Brademas (acting chairman of the subcommittee) presiding.

Present: Representatives Brademas and O'Hara.

Present also: Ted Ellsworth, consultant.

Mr. BRADEMAS. Will the committee room please come to order?

Today in South Bend, Ind., we are conducting this hearing of the General Subcommittee on Education of the House Education and Labor Committee on legislation that has been introduced by Congressman John Fogarty, Rhode Island, together with other Members of the House of Representatives with respect to the establishment of a Federal Commission on Problems of the Aged and Aging.

We are pleased to be here in Indiana, and, of course, I am especially glad that this hearing is being conducted in the Third District of Indiana, and I am pleased that my colleague, Congressman James G. O'Hara, of the Seventh District of Michigan is in Indiana today also.

I would like to say something, at the outset, about the way in which our hearing today will be conducted. We have scheduled a very large number of witnesses and our time for concluding these hearings is 4:30 in the afternoon. Because of the large number of witnesses, we are not likely to be able to give more than 15 minutes to any individual witness, and we should like to request, therefore, of the witnesses who have already been scheduled that if their statements are longer than 10 minutes, they try to summarize the statements for us so that we can have an opportunity to ask questions.

Would each witness please give his full name, his address, and if he is representing an organization here today, the name of the organization that he is representing. I hope that those witnesses who have prepared statements will be kind enough to leave them on the desk up here. If it is necessary for a witness to summarize a statement, we wish to assure him that his entire prepared statement will be included in the printed hearings.

One of the major reasons, of course, for consideration of this kind of legislation is the great increase in the number of Americans who have reached the age of 65 or over. In 1900, only 4 percent of our population was 65 or over. Today, however, some 17 million men and women in the United States, over 9 percent of our total population, are in the 65 or over group. There are, as everyone in this room knows, certain specific kinds of problems that affect our elderly

citizens. One of those problems, maintaining adequate retirement income for those persons who live on fixed incomes or pensions, was highlighted by the announcement of yesterday that there would be no price rise in steel.

I would just like to say that in my own view, yesterday's announcement was a great victory for the public interest. I am confident the American people overwhelmingly approved President Kennedy's leadership on this matter for several reasons.

In the first place, a factor which is directly relevant to the hearing that we are having here today an increase in steel prices would have stimulated inflation with its harsh effect on the pensions of older citizens and others who live on fixed incomes.

Second, a rise in the price of steel would have encouraged the competition of foreign steelmakers.

And third, a price rise in steel would undoubtedly have slowed our economic growth at a time when there is still too much unemployment in our country.

Many conferences have been held on the problems of the aging in the United States in the last 3 or 4 years, including State, local, regional, and White House conferences on the aging and many recommendations have come out of these various conferences. One of the recommendations that was made in a number of conferences was that the Federal Government should establish an agency or a commission to deal with, to coordinate existing programs in the field of the problems of the aging.

One of the committees that made this recommendation was the special Senate committee chaired by the Senator from Michigan, the Honorable Pat McNamara.

In order to give our hearings a little background today so that we can all be aware of the basic problems that we are discussing, I would like, if I may, very briefly to quote from the report by the Subcommittee on Problems of the Aged and Aging to the Senate Labor and Public Welfare Committee with respect to the establishment of a U.S. Office of the Aging. May I say also at the outset that neither my colleague, Congressman O'Hara, nor I have taken any position on this legislation. So we are not here to grind an ax for or against this bill or similar proposals but only to find out your views as interested parties on it and on other problems affecting the aging.

The McNamara subcommittee report states:

A major need of America's aged and aging is a central agency in the Federal establishment to represent them in their problems. As of now there is no single office to serve as a clearing point of contact for expressing the views, needs, grievances, and desires of the elderly. Witnesses before the subcommittee pointed to the great need filled when the Children's Bureau was created as a spokesman and focus for children's problems everywhere. It was pointed out much of the advance in reducing child mortality could be attributed to the educational and stimulatory role undertaken by the Children's Bureau.

The subcommittee feels an agency to serve the aged and aging is required today.

It recommends that legislation be considered in 1960 to establish a U.S. Office of the Aging concerned full time with the full range of problems of America's senior citizens.

The aged of this Nation have been buffeted from agency to agency, from committee to council in a fragmented fashion. They are ready for and require a high level, congressionally created agency concerned with the interrelationship of their problems and speaking out for them.

Without objection, the remainder of the McNamara committee statement which sets forth the basic argument or a basic argument for the establishment of a U.S. Office of the Aging will be included in the record.

At the present time individual departments of the executive branch carry out certain responsibilities for the aging within their particular spheres. A small special staff on aging attempts, through committee activity, to stimulate an interest in aging among the various bureaus and offices of the Department of Health, Education, and Welfare and to undertake internal informational services. A Federal Council on Aging was formed as an interdepartmental committee for discussion and coordination of problems of the aging among the interested departments and agencies. It is not, however, a full-time agency and faces the problems inherent in all interdepartmental committees. In total, aside from the collection and disbursement activities in the Bureau of Old-Age and Survivors Insurance and the administration of grants within the old-age assistance programs, there is no agency which has sufficient funds, personnel, and authority to devote full time to a national problem involving 16 million people over 65 and 49 million over 45.

The subcommittee is aware that a number of similar proposals were offered both in the House of Representatives and in the Senate in previous years. They are laudable attempts to meet an urgent need. The subcommittee has benefited greatly from these earlier studies and any future progress will be based on them.

The creation of a U.S. Office of the Aging will not automatically solve the problems of senior citizens. It should not be visualized as a substitute for action on such matters as financing medical care, increasing social security benefits, meeting the housing needs. It will, however, establish on a permanent basis an agency with authority to undertake positive action nationally and develop cooperative relations with States and local communities in programs for the aging.

The U.S. Office of the Aging should work closely with similar State and local agencies, making available information, consultative services, professional assistance of all kinds in developing community programs for older persons. It could make funds available through grants-in-aid to comparable agencies in the States for the stimulation of coordinated older persons services in the States and local communities where the real action must ultimately take place and where stimulation is urgently needed.

Some of the State conferences propose that an independent commission should be established for the aging. Other persons have recommended that an office be set up in this field in the Department of Health, Education, and Welfare, and bills have been introduced in the House and Senate that incorporate both approaches. Our subcommittee will report to our full committee on these bills. And as I have indicated, our members are interested in getting information from various areas of the United States and from various segments of the community, from the elderly citizens, and ordinary citizens and experts and professionals in the field.

Some of the questions that we will consider here today are the following: Is there a need for an agency on aging at the Federal level? Is there a need for Federal financing to encourage State, local, and non-profit projects? Is there confusion because of lack of coordination among the agencies and because no one agency is totally responsible? Are there programs that are needed that are being neglected because of lack of funds or because no agency at the present time exists to stimulate action? If these problems do exist, and if there is a need, then what type of agency is needed? What type of Federal support and encouragement is needed?

Those are some of the questions to which we might address ourselves today with other comments or suggestions that any of the witnesses

or persons present might like to make with respect to problems of the aging generally.

Before I call on our first witness, I would like to read into the record the following telegram which I have just received from the Governor of Indiana, the Honorable Matthew E. Welsh. The telegram addressed to me says:

I regret that a previous commitment which cannot be changed prevents me from appearing before your committee Saturday. I want you to know, however, that I am interested both personally and officially in the work your committee is doing.

There is a growing awareness among Hoosiers of the problems of the aging and aged. There is also an increased understanding that the efforts of a variety of agencies and governmental levels as well as voluntary groups are required to ease the problems of housing, health, employment and other challenges of age.

In the field of hospitalization and nursing home expenses, you should know that our Democratic State central committee has by resolution endorsed unanimously the program of President Kennedy. You can be sure the Indiana Democratic Party stands firmly behind the President in this constructive effort to meet these needs.

Our State and county welfare programs undergo almost constant scrutiny as we seek ways to meet the very real and developing needs of the older segment of our population. Our State commission on the aging and aged is active and effective in focusing public attention on these problems and in coordinating efforts to meet them.

I want to assure you, and I hope you will convey this assurance to the committee, that the State of Indiana is actively concerned with this problem and seeks to meet its full responsibilities to these senior citizens.

MATTHEW E. WELSH, *Governor.*

I am now pleased to call as our first witness the distinguished chairman of the Indiana State Commission on the Aging and Aged to which Governor Welsh has just made reference in his telegram, Dr. George E. Davis.

Dr. Davis, we are very pleased to have you here this morning.

STATEMENT OF DR. GEORGE E. DAVIS, CHAIRMAN, INDIANA STATE COMMISSION ON THE AGING AND AGED

Dr. DAVIS. Congressman Brademas, ladies and gentlemen, my name is George Davis. I am a member of the staff of Purdue University and I am chairman of the Indiana Commission on Aging and Aged.

I note in your reference to the presence of experts and I want to clarify that I am not one of them. If I had any feeling of expertness, I had it all taken out of me a few years ago when I attended a convention down in Dallas, Tex. I had come down to breakfast one morning without my glasses and was having a little difficulty with the bill of fare. Not too much. You can tell from my style of architecture that I was going to get something to eat, but I was having a little difficulty, and I saw a waiter and I called him to my side and handed him the menu and said, "George, what does this say," he smiled as wide as possible, showed his white teeth, and said, "Boss, you are going to have to excuse me. I am just as ignorant as you is." So I submit, I am ignorant about a great many things and certainly in this field it is almost abysmal in spite of the fact we have been working since 1955 as a commission on the problems of the aging and aged.

I also assumed, Mr. Congressman, that it was pertinent in this hearing to refer to other pieces of legislation as well as the McNamara bill and Fogarty-McNamara bill.

Mr. BRADEMAs. We would be pleased to hear from you.

Dr. DAVIS. So consequently, I am referring to a couple of others.

Mr. Chairman, in my testimony in this hearing, I represent the interests of that segment of our population generally known as the aged. This term means different things to different people but has reference to those who are spoken of as our old people. In addition, I represent the aging, for the Indiana commission of which I am chairman is designated by legislative act as the State commission on the aging and aged. I may arbitrarily include those between the ages of 40 and 65 as the aging and those above 65 as the aged.

I will move from the general to the specific and would refer first to H.R. 8732, known as the General University Extension Education Act of 1961. In this bill, section 2(A) under the heading, "Findings and Declaration of Purpose," I find the following statements:

In addition, it is imperative to the Nation's security and defense in this era when an international ideological struggle is being waged for men's minds to carry on a continuing program to further educate the greatest possible number of people with respect to our history, traditions, and institutions.

And a second quote from the same bill:

The Congress further finds that the economic and social conditions resulting from such factors as unemployment caused by technological changes, and mobility of our population, and their attendant problems, and the increasing amount of personal time available to large segments of our population, make it essential to the general welfare that solutions to problems resulting from such factors developed by our scientists and scholars be made directly available to people confronted by them and those who are training others to cope with these problems.

Educational programs that may be made possible by the passage of this bill will obviously include enrollees from the aging and aged group who stand in great need of such programs.

This is especially true in view of the changed economic and social conditions resulting from unemployment caused by technological changes; due to our rapidly becoming predominantly an urban rather than a rural society; due to the shortened workweek, which leaves free time for retraining, for recreational opportunities, and for further general education. Many programs developed as a result of the passage of this act will relate to the maximum use of the talents of our aging and aged population in such a way that they may make their contribution to society and enjoy the knowledge that they are giving of their talents rather than predominantly getting benefits largely because of aging.

Our land-grant colleges are prepared to make a decided contribution to the overall education of the aging and aged.

H.R. 10860, designated as the Basic Education Act, drawn by Representative Perkins, if passed, would be of material assistance to the aging and aged.

Mr. BRADEMAs. I might just interrupt you to say that our Committee on Education and Labor within the last 2 weeks has favorably reported that bill.

Dr. DAVIS. The Perkins bill?

Mr. BRADEMAs. Yes, sir.

Dr. DAVIS. Fine. Then I will skip that part.

Mr. BRADEMAs. You might, if you wish, simply summarize its purpose.

Dr. DAVIS. All right. I have only a few lines in here.

This act would provide an educational program for those of our people who are illiterate or whose education is less than of the sixth-grade level. The desirability of eradicating illiteracy seems obvious, the need to raise the level of all whose education does not exceed the sixth-grade level is equally obvious. Older people with such a limited education fall easy prey to those ideologies that give democracies great concern. They cannot be used in our highly technical industries, their retraining is obviously difficult; they are at a loss to use their free time advantageously because of their limited education and they are the first to be relegated to the unemployed group. The highest percentage of the total number of our citizens with such a limited education is to be found among the aging and aged.

Another bill I would like to comment upon is the bill on aging introduced in the Senate by Senator McNamara and in the House by Mr. Fogarty.

The Fogarty-McNamara bill would provide grants to each State for the establishment or improvement of State agencies; for the development of programs; and for special projects which would coordinate and expand activities in the field of aging. It would also provide such amounts of money as needed to assist the States in administering this program.

The bill would also authorize direct Federal grants to public or nonprofit private agencies for demonstration, research or training programs relating especially to education, welfare, recreation, and other problems of older persons. The entire program would be administered by a bipartisan, three-member commission appointed by the President.

I want to assure you that, as chairman of the Indiana State Commission on the Aging and Aged, I wholeheartedly support the objectives set forth in the Fogarty-McNamara bill. They are the goals toward which the Indiana commission has been working ever since it came into existence in 1955. I want to say that I am in full accord with most of its provisions and that the sooner provisions like these are incorporated into our Federal programs, the sooner we shall be meeting the broader needs of our rapidly growing number of older people.

There are two provisions, however, with which I cannot agree and I should like to state my reasons for not supporting them.

The part of the bill which we in the commission, and I must pause to say that I should not have used the word "we," I am testifying as an individual, I have not polled the members of the commission and I am, therefore, not reflecting the thinking of the members of the commission.

Mr. BRADEMAS. Thank you, Dr. Davis.

Dr. DAVIS. The part of the bill with which I strongly disagree is the provision to create a separate commission on aging which would be set up to administer grants and supervise programs. It is my opinion that establishing a commission having such responsibilities within the Federal governmental structure would be breaking long and well-established precedent. Other Federal commissions are regulatory in nature, are designed to study and make recommendations regarding a specific problem, or to give visibility to the Government's concern about a particular situation or issue. A Presidential commission can do these things very well but it is doubtful that it is the most

effective instrument for supervising and carrying out an operating program.

I am very much afraid we should find that the creation of a separate commission on aging, responsible only to the President, would tend to be duplicatory in nature and, hence, difficult to administer. To superimpose such a new agency on top of the several departments and agencies now providing services for older people would almost surely make for confusion and inefficiency.

I would have grave doubts about the ability of such a commission to function as a line operating agency. A similar view was expressed by the Senate Subcommittee on Problems of the Aged and Aging, Mr. Chairman, in Report No. 128, dated March 28, 1961. I quote:

The history of State and Federal organization provides ample evidence that the effectiveness of an agency in the determination of public policy is directly related to its place in the established departmental structure of government. The use of independent commissions—outside of a regular department—is helpful for making studies and recommendations on a temporary basis. They are not, however, ordinarily employed for sustained contributions once the period of extensive study and reporting has taken place.

Now I am well aware, Mr. Chairman, that this position may seem contradictory coming, as it does, from one who is the chairman of an independent commission on aging at the State level. The explanation for my position lies mainly in two major facts which I regard as compelling differences between the situation in the Federal Government and in the States.

First, we must recognize that the Federal structure is already overwhelming in size and complexity. To add a new, independent agency with line functions would complicate further the Federal structure and add to the burdens of the Presidency, which are already far too great.

My second objection to the establishment of a Federal commission on aging is that it would destroy the present organization of programs and services which has, in my judgment, wisely placed most of the activities on behalf of older people within a single broad operating agency—the Department of Health, Education, and Welfare.

We are all aware that within this single Department there are now concentrated most of the programs for income maintenance, health and rehabilitation, control of foods and drugs, education, support of research and training, and the important and expanding activities of the special staff on aging. I have had a long period of growing and satisfying relationships, not only with the special staff on aging, but also with most of the operating agencies of this Department. On the basis of this experience, I should like to say, Mr. Chairman, that I firmly believe a new program, such as that provided in this bill, would be handled exceptionally well by the special staff on aging.

This staff is expanding its competencies as it increases in size. One of its major assets is that it is located within the Office of the Secretary where it is able to draw on the resources and experience of the entire Department. It has shown its ability repeatedly to achieve a high degree of cooperation, not only among the agencies of its own Department, but also among the several Federal departments and agencies having programs for older people. To disrupt this smoothly running and increasingly effective arrangement by drawing important functions off and placing them in a separate and independent commission

would seem grossly inefficient and would set back progress just when we most need to move forward.

Two other provisions of the bill would provide one-time planning grants to the States, much like those made in connection with the White House Conference on Aging, and annual grants to aid in the stimulating and coordinating functions of State commissions on aging. With those, I should like to say, Mr. Chairman, that I am in full accord.

I have just returned from a conference of State executives on aging called by the Secretary of Health, Education, and Welfare and conducted by the special staff on aging. Virtually all of the 53 States and territories were represented. I was greatly impressed with their readiness and their eagerness to move forward. There are now 22 States with commissions or councils on aging that have budget and staff. It is my opinion that the number will grow rapidly if the Department of Health, Education, and Welfare is authorized and given the funds to assist the States in the establishment and maintenance of these planning and coordinating groups. The States moved ahead under the stimulus of the White House Conference grants and I am confident they will continue to do so if this type of support is provided. It would encourage every State to make a continuing assessment of the needs of its older people, to maintain a continuing inventory of its resources to meet these needs, and to work with administrative agencies and communities in the development of programs aimed at helping older people to lead self-sufficient, satisfying and contributory lives.

The Fogarty-McNamara bill goes still another step forward. It would also authorize grants-in-aid which would enable the States to support projects developed by local communities and organizations. And, in addition, it provides for support of research, demonstration, and training projects directly from the Federal Government to public and nonprofit agencies and organizations in the States and in communities.

I should like to say, Mr. Chairman, that we are entirely convinced of the need for grants of the latter type. The same readiness that I reported earlier among the States exists within many of our communities and organizations. We believe that here in Indiana, as well as in many other States, there are communities which have well-defined plans for action and that they will move forward with pilot and demonstration projects if financial help becomes available.

When we get to the matter of training professional and technical personnel, we come to one of the most critical problems in the entire field. I am fully convinced that we are severely handicapped and that we shall continue to be severely handicapped until there are adequate numbers of people with a knowledge of aging to carry out the programs we are trying to develop.

There is, as I see it, an urgent need for what we may term generalists in aging, individuals possessing broad knowledge of the characteristics and circumstances of aging people and of the societal aspects and implications of aging, and who are also skilled in program development, communication, and community organization. Furthermore, there are equally insistent demands for professional personnel with specialized knowledge of aging for work not only within the already heavily involved fields of health, welfare, and re-

habilitation, but also in the more recently involved fields of college and university teaching, adult education, recreation, environmental planning, and the management of housing and related living facilities for middle-aged and older people.

At the present time, Mr. Chairman, I favor the direct project grants from the Federal Government as opposed to those that would be made through the States. While I am aware that many States, like our own, are well advanced in their assessments of needs and that they know what actions are required, we have real question as to whether a sufficient number are now prepared to make effective use of an extensive grant. Until a considerable majority of the States are further along in their thinking and planning, I must, in good conscience, favor the plan which would provide for the support of demonstration and pilot programs on a selective basis and for the encouragement of training programs.

In conclusion, may I say again as I said at the outset, that I firmly believe the Fogarty-McNamara bill represents a long step forward in the direction in which we must move. We strongly support its objectives and wish to urge upon the Congress the importance of most of its provisions. Where we have disagreed, I suggest that my position is aimed at increasing efficiency and economy.

Finally, it is my opinion that favorable action on H.R. 8732, the General University Extension Education Act, will materially strengthen the programs designed for the aging and aged in the several States as well as will favorable action on the Basic Education Act. I have set out my objections to the passage of the Fogarty-McNamara bill previously. Thank you.

Mr. BRADEMAs. Thank you. Mr. O'Hara?

Mr. O'HARA. Dr. Davis, I want to express my feeling that you made an excellent statement which demonstrates a good deal of thought on the subject of how the Federal Government can most effectively operate in this field. I might add for your information that we have had a number of witnesses before this committee in Washington, California, and other places who share your view with regard to an independent commission on the problems of the aged and aging. Others believe that having the coordinating group within HEW is not as good a solution as having an independent group. At any rate, that is a problem that we are going to have to wrestle with as we move along. I did appreciate your comments with regard to the possibility of stimulating State and local and private action through these Federal project grants. You evidently feel strongly on that subject.

Dr. DAVIS. Very strongly on that, I surely do.

Mr. O'HARA. And I think you would also agree with most of our witnesses that solutions to the problems of the aged would probably be hastened or at least helped by a more effective job of coordination and planning.

Dr. DAVIS. This I would completely agree with.

Mr. O'HARA. Thank you very much, Dr. Davis. You have presented a very fine statement.

Mr. BRADEMAs. Dr. Davis, I would just have one or two questions, if I may. You say in your statement when you make reference to the special staff on aging which is located within the Office of the Secretary of Health, Education, and Welfare, that it's a smoothly running and increasingly effective arrangement. But there are others who say

that this special staff has accomplished very little indeed and I think Senator McNamara's committee was told in hearings across the country that professionals and older people both felt that a more dynamic force was needed to get action in this field. Do you really feel they are doing enough under the existing circumstances, that they can do the job?

Dr. DAVIS. With the resources, I think they are doing an excellent job. With additional resources, they can do a better job. I am fully aware of the fact that there is division of opinion on the efficacy of the special staff. I happen to be among those who think a special staff is doing a good job. I know there are others who think otherwise.

Mr. BRADEMAs. Thank you very much indeed, Dr. Davis, for taking the time to be with us. We are very grateful.

Our next witness is Dr. Morton Leeds, who is the secretary of the Commission on the Aged and Aging of the State of Indiana.

Dr. Leeds, we are happy to have you with us this morning.

STATEMENT OF DR. MORTON LEEDS, SECRETARY, COMMISSION ON THE AGED AND AGING OF THE STATE OF INDIANA

Dr. LEEDS. I would like to concur with much of what Dr. Davis has said, but I do disagree on one or two points, and I would like to state these.

Last November I was selected to be a member of a six-man national planning committee to help set up a national conference of State executives on aging, the one that Dr. Davis referred to during the course of the planning meetings. I was commissioned by the Department of Health, Education, and Welfare to do a special analysis of the progress in all the States relating to aging. The analysis was to be based on special reports asked of the States by the Federal Government, and my final report was presented as a keynote address this past Monday, April 9, in Washington, D.C., before all the representatives of the States and many officials of the Federal Government itself.

About 2 months were spent in this analysis, with a detailed examination of thousands of facts. I was asked to determine trends in State activity in a wide variety of fields from local community organization, to health, research, housing, employment, legislation, publications, as well as structure of the State commission themselves. All of the State reports were made available to me, and some technical help was given that made the task of analysis easier.

Now this is not the place to discuss the details of my presentation which will be printed soon as a part of the conference report. However, some aspects of my conclusions bear directly on the hearings today, and I should like to share my thinking of the past few months.

First of all, I was impressed with the very sad fact that 10 States have no commission on aging, and another 10 States have temporary commissions that average about \$1,500 per year available to them for all expenses. And this is only 15 months after the White House Conference on Aging, which passed as one of its resolutions the wish to see permanent State units on aging in each of the States.

Second, I noted the enormous burst of activity that took place everywhere in the United States when \$15,000 was allocated to each State to participate in the White House Conference.

Third, while tallying specific activities in the States in areas such as participation in the Kerr-Mills Act, the Hill-Burton program, the Community Health Facilities Act, the housing the elderly program, the older worker counseling program, waiver of employability in the vocational rehabilitation program, I noticed that if these programs were to be abolished, then a majority of the States would have nothing to report in activity in the State for 1961.

Now the conclusion is clear. If we expect some kind of ongoing permanent commission structure at the State level, as we have in Indiana, to become a part of the national picture, some form of Federal seed money and subsidy for a time will be necessary. The Fogarty-McNamara bill provides for just such a program, and I should like to heartily endorse this feature of the bill.

Another important feature of the bill deserves some discussion, too. This relates to the creation of a Presidential commission. There is an analogy here, with Governors' commissions on aging, which being appointed by and responsible to the Governor stand above the operating departments. This permits the commission to work well with the departments of government, and yet be no threat to any of them. If the coordinating unit is set up within one department, other departments are not happy. As I said in Washington last Monday, "Department heads do not like to be coordinated by other department heads, and even less so by their subordinates." They will, however, work with a coordinating group set up by the Chief Executive.

In the Federal Government, there are three major agencies that are concerned with the aged, aside from the Department of Health, Education, and Welfare. These are the Department of Labor, the Housing and Home Finance Agency, and the Veterans' Administration. This bill provides for an interdepartmental Council on Aging, under the Commission Chairman. This arrangement is quite satisfactory and is superior to the current Federal Council on Aging, which is not functioning, and has not for several years.

My opinion in regard to the foregoing is based on nearly 7 years' experience as secretary of the Indiana State Commission on the Aging and Aged, and as chairman of the State interdepartmental committee on aging. In my considered opinion, the Fogarty-McNamara bill is sound and would move us forward considerably in our organization to meet the needs of the aged throughout the United States.

There is one other matter I should like to discuss before concluding my testimony here today. It concerns still another bill before Congress, the King-Anderson bill.

For nearly a decade now, I have directed a nonprofit home for aged here in Indiana. Before that, I worked in another philanthropic home. We are a relatively enlightened group, which does not take admission fees or assign an applicant's property to the home. We are very fortunate in being a beneficiary of two major fundraising organizations which have helped to keep us operating for 60 years. We charge our residents and their families a fair amount per month, based on ability to pay and, of course, a number of them are totally unable to pay.

Where the family is able, we also encourage them to take out some health insurance, but few of them can do this. Since we are medically oriented, although not a hospital, more than a third of our entire

budget is for doctors, medicine, and nurses. And since the field of medical care is getting quite expert, we keep many people alive who would have died without this assistance. Digitalis at the right moment has saved many a resident with a heart attack; penicillin and streptomycin have pulled many a sick person out of pneumonia.

Our institutional experience has been that the cost of medical care alone is rising steadily from less than \$400 per person per year in 1952, this is just for the medical items, to more than \$1,000 per person in 1961. This was reflected in serious deficits for 1960 and 1961 which were only paid by an unexpected bequest.

For our residents who have to go to the hospital, every 3 to 4 years, they must manage with inadequate care at the county hospital, or must face bills which, over the last six admissions, have averaged over \$500 each. The families of the middle generation, with children of their own to support, have very great difficulty paying this.

Examining this situation overall, I am fully convinced that a national plan of health insurance such as is proposed in the King-Anderson bill, will do precisely what is needed. It will help ease a burden for older people and their families, while compelling saving during the working years to pay for this insurance. In a sense, it is another variation of social security that will help to cover the difficult problems of medical care in the very last years of existence. It is not a cure-all or a panacea, but rather another help for those who need it at a critical moment.

Thank you.

Mr. BRADEMAs. Thank you very much, Dr. Leeds.

Mr. O'HARA?

Mr. O'HARA. Dr. Leeds, I trust the chairman didn't arrange it this way, but we have presented right in the very beginning of our hearing, and I might add very ably presented, the two viewpoints with regard to how this coordination that is needed is to be provided. I appreciate your remarks further with regard to the King-Anderson bill. The McNamara committee, as you well know, had as its major finding the fact that the No. 1 problem of aged persons in our society today was financing the expenses of a serious illness. I think that probably every one of us in this room has had some experience with that problem either in his own case or in the case of some member of his family.

Do you believe, Dr. Leeds, that the lack of coordinating function has caused the various Federal programs with regard to the aging to be less effective than Congress had intended and hoped they might be?

Dr. LEEDS. Yes, I do. I think if some of the pulls and strains that were apparent at this conference, in fact we noticed a division within the special staff itself on this very issue, some of them, of course, would prefer to keep things as they are; there are others, however, who very strongly feel that a reorganization is called for at the next higher level of government to pull into the program with very real co-operation the VA, the Housing and Home Finance, and Department of Labor. The full Federal Council on Aging has not met for a period of more than 3 years. We found that there are stresses and strains.

The problems of departmental structure are very real and very, what shall I say, the department is exclusive, it has a self-perpetuating tendency, and it tends to resent intrusions upon its own operations and its own structure. The only one that they will really listen to is the

boss, and in State government, the boss is the Governor, and in the Federal Government, the boss is the President; and my conviction is, at this point, having, incidentally, discussed it, this entire week, with the people involved, my feeling is that this may be very, very needed at this point in order to move us forward.

Mr. O'HARA. Doctor, I, as a resident of another State, a neighboring State, I wish to compliment you and the State of Indiana on the fact that I believe you have made substantial progress with your State commission and your entire departmental operating group, and I would hope that one of the things that passage of whatever bill might come out of these hearings would accomplish would be to assist and encourage the growth of groups such as these I have referred to and their more effective operating at the State level.

Mr. BRADEMAs. Dr. Leeds, you are an expert in this field, and we are not; because of the great national interest in this whole problem of health insurance, hospital and nursing home insurance for the aged, it would seem to me that a fair question is, and I don't know if you agree, that the chief issue between proponents of the King-Anderson bill and proponents of either no bill or some other form of bill is whether or not this insurance should be provided through the social security system. Is that fair or not?

Dr. LEEDS. Yes, this would embody much of the discussion at present.

Mr. BRADEMAs. Well, now, there are those who suggest that if this health insurance is provided through the social security system, that this would mean that the program would be one of socialized medicine. As you know, this is a commonly made charge. I wonder what your reaction to that charge is?

Dr. LEEDS. I think this is a false issue. We have socialized medicine in the United States but in areas where the physicians would not care to admit it; for instance, VA hospitals are socialized medicine. The Government owns the hospital, hires the doctor, and you have no choice of physician. This is socialized medicine, and interestingly enough, in the VA hospital we get good medical care. The great problem under medical care is that you will get poor care if the recipient group is not organized and this would, for instance, occur where you are dealing only with poor people who are not organized, so in a county hospital, you may get poor medical care, but in a veterans' hospital, because the veterans are organized politically, you will get good care because they demand it.

The nature of the recipient group they serve means the nature of the care. There is nothing automatic that says you will get good or bad medical care because of the nature of the organization of the care. Now, this program, under the King-Anderson bill would provide essentially for a form of insurance very similar to that of social security. What it does is it spreads the cost of the insurance over the entire productive economy. In plain English, all of those in the middle years who are working would have to help pay for this, which would mean the premiums would be low. If the recipient group, the aged, had to pay the premiums and would be the only group covered, the premiums would be extremely high, as they are at present on the typical Blue Cross-Blue Shield plans which, incidentally, are not comprehensive, only partial plans.

Now, to my mind, this solution is a very sound solution. You are compelling a person, and the compulsory feature is not so tragic. I think social security is a tremendous blessing. The compulsory feature means when you reach 65 or 62, if we advance the age downward, you will be covered at the time you need medical care the most, and the fact that it is a governmentally guaranteed type of insurance, there is nothing terrible about that. This is an extremely useful form of coverage.

I can only think of those who served in the Armed Forces and have GI insurance. It's the cheapest form of insurance you can get, and it is soundly administered, and it is very adequate. The big kick most people have is that they don't have enough of it.

Mr. BRADEMAs. Let me ask you this question, Am I inaccurate in stating that this particular proposal does not cover doctor bills?

Dr. LEEDS. That is correct. However, if the hospital and the diagnostic work is up, and the home medical care such as nursing and so on are covered, the doctor is going to be paid a lot easier. In fact, I am not quite sure what the doctors are objecting to. They are going to make more money out of this than they ever did before. This happened with Blue Cross, and they were hollering.

Mr. BRADEMAs. I want to ask one other question because of two developments in Washington, D.C., this week, and also because some of us in the House of Representatives and the Senate get mail from our constituents, perhaps some in this room, saying the King-Anderson bill means socialized medicine because of its being tied to the social security system. Yet former Secretary of Health, Education, and Welfare, Arthur Flemming, who, as you know, was in that high position while Mr. Eisenhower was President, this week in Washington endorsed tying health insurance for the elderly to the social security system; in fact, I have in my hand a clipping from the Washington Post entitled "Medical Care Plan Held Inadequate by Flemming," the first line of which is:

The Kerr-Mills Act is not the solution to the problem of providing medical care for the aged, former Secretary of Health, Education, and Welfare, Arthur Flemming, said yesterday.

The Kerr-Mills bill is a good addition to the public assistance program, but that is all it is; it is not an answer to the problem.

Flemming said he favored a medical care program financed by social security contributions.

I know Secretary Flemming, have high regard for him. I wouldn't want to call him, especially as an Eisenhower appointee, a Socialist.

I think it's also good to point to another Washington event. Congressman John Lindsay, of Manhattan, our colleague, introduced Governor Rockefeller's proposal for providing health insurance for the elderly which is not the same insurance proposal as President Kennedy's, but is tied to the social security system and therefore is in accord with the administration proposal.

I do think it is important that we carry on our discussion of these important issues in a rational and fair-minded and moderate way without charging those Americans who may disagree with us of being disloyal to their country or wanting to socialize the country, especially when it's obvious that outstanding Americans in both of our great political parties are to be found on both sides of this particular issue. I know there are Democrats who think the King-Anderson bill is a

bad bill just as there are some Republicans who I know will vote for the bill if it ever gets to the floor of the House of Representatives.

Dr. LEEDS. I would like to comment, if I may, on the Kerr-Mills bill. The physicians who object to the King-Anderson bill keep saying let's give the Kerr-Mills bill a chance and then, in addition, on the other side they say but the King-Anderson bill isn't complete, it doesn't provide for those not under the social security system.

They remind me of my friends in the Army complaining about the quality of the food. They said the food is lousy and they further complain they don't give you enough of it.

Now, my feeling is this, that the Kerr-Mills bill covers one group, the group who are what would be called medically indigent. We estimate perhaps 5,000 people in Indiana will be covered by the Indiana analogue. We are not permitted to subscribe to Kerr-Mills, but we have a comparable program, so maybe 5,000 people will be covered by Kerr-Mills. I believe, as of a few weeks ago, we had 279 people in Indiana under the Kerr-Mills or equivalent, but this only touches the one group that would not normally be covered by social security, so I would suggest that the two bills are really complementary, they fit together. The King-Anderson bill covers those on social security; the Kerr-Mills bill covers the other group in many areas that would not be eligible for social security, and if you work the two together, you have a very good and adequate coverage for the group that needs it most.

Mr. BRADEMAS. Thank you very much indeed, Dr. Leeds, your testimony has been most helpful and we appreciate your taking the time to come from Indianapolis to be with us.

Dr. DAVIS. Are there comments from the floor?

Mr. BRADEMAS. I think because we are running behind, we will be glad to have some comments after we have tried to get through some of our witnesses. Is Father Royster here? Is Mr. Albert Lewis here?

Mr. Albert Lewis is the manager of the Social Security office in Gary, and I believe, sir, you are the chairman of the Northwest Region of the Indiana State Commission on the Aging and Aged?

Mr. LEWIS. Yes, sir.

Mr. BRADEMAS. We are very pleased to have you with us here this morning.

Mr. LEWIS. Thank you, sir. Before I start my remarks, I wish to state that Mr. Davis' views on this subject are entirely my own. I haven't consulted social security people. I have consulted a lot of people I have dealt with, the folks that get social security, nor have I polled the northwest regional conference, so again I repeat, his views are my own.

Mr. BRADEMAS. Mr. Lewis, we have had a call for you to speak more loudly from my friend, Mrs. Hillman, back here. Will you speak up a little more loudly?

STATEMENT OF ALBERT LEWIS, CHAIRMAN, NORTHWEST REGION, INDIANA STATE COMMISSION ON THE AGING AND AGED

Mr. LEWIS. It's appropriate for this Subcommittee on Education to hold hearings on legislation for aged and aging. Herbert Spenser, the great English philosopher, has defined education as follows: To

prepare us for complete living. That is exactly what the elderly people have to be prepared for, to continue complete living after they leave their usual employment. During the past 40 years, I have had close contact with many elderly folks. From 1922 to 1937, as agent, assistant manager and manager for a large insurance company; from 1937 to the present, as district manager for Social Security Administration, Gary office, in the Calumet area in Indiana.

In addition to that, I have spent thousands of hours as a volunteer, first as chairman of the Commission on Aging, Committee on Aging for the Gary Community Welfare Council, member and present time cochairman for the Lake County Committee on Aging, and active in the northwest region and present chairman for the Indiana Commission of Aging in the northwest region.

The problems of aging can be divided into three major parts, if this is possible, of course: physical health, economic status, and emotional characteristics.

The present King-Anderson legislation before Congress considering health services for the aged—incidentally, I want to mention, as one of the aged, I will give you an example of what happens to insurance after you reach a certain age. I have carried an accident policy, I shouldn't mention the company, it wouldn't be fair, for 40 years. When I reached a certain age, they obligingly sent me a letter. I am no longer insured and will not accept my premium. Another company who advertises volumes in newspapers and radio and all that, they furnish insurance to aged, when I reached a certain age, they sent a representative to cut my insurance to one-third and increase my premium by two-thirds. In other words, from \$100 a month, they cut it down to \$30 a month, and the premium went up three times as much as it was.

Now, this is the answer that they have given to me, I know that many aged people have had this same treatment from the very insurance companies who are now fighting the King-Anderson bill.

As I said before, the present King-Anderson legislation before Congress considering health service for the aged under social security insurance system should help in part to lift the burden of the cost of sickness which is a very serious problem for many older people, particularly in the middle and lower economic level. The old age survivors insurance and disability provisions of the Social Security Act help to solve a part of the economic problem of the aged. Here I would like to put in a plug for some legislation, I can't recall the bills, but I know that some of them are pending in Congress now, to increase the exemption on Federal tax for aged people after either 65 or 70. I would like to see it go up to about \$4,800, because they work hard for their money and their income is mostly from pensions and other means. Social security is not taxable or private pensions as well as civil service pensions are taxable, and this ought to be removed up to a certain amount. I would like to say a word in favor of the House of Representatives bill 1014. That is the one discussed here by Dr. Davis and Dr. Leeds, bill to establish a U.S. Commission on Aging. I personally would like to see it under the Department of Health, Education, and Welfare. After listening to the eloquent speech by Dr. Leeds, maybe I am changing my mind.

Mr. BRADEMAS. That is one of the advantages of these congressional hearings, or disadvantages, depending on your point of view.

Mr. LEWIS. At the present time, when a farmer has trouble with his crops or problems with his livestock, he can visit his county agriculturist or go to Purdue University and get the necessary information to have them solve this problem, but when an aged person has a problem, he's buffeted from pillar to post, and I have seen these people come into the Social Security office with their problems, couldn't do a thing, weren't insured under social security, weren't getting enough, we couldn't do anything. We had sent them to the Department of Public Welfare and so on down the line. Their problem hasn't been solved yet.

This Commission established under H.R. 1014 operated by experienced men and women in the field of aging, that is a problem for Dr. Davis to train these experienced men and women or men who haven't had experience, to train for that job in the field of aging would be a good start as enunciated by the objectives of the bill.

Now, the objectives, as some of you have mentioned here, I am repeating briefly: To provide for the aged, income, employment, opportunities, adequate health care, housing, independence in living arrangements, and develop a desire to participate in activities of civic, cultural, recreational, and community nature. Also, extend services to provide social assistance, research, and to improve their health and happiness, freedom and independence in planning their own lives and to coordinate Federal, State and private agencies to achieve these objectives. I think the coordinate may have been over-emphasized, but it's a very, very important situation that they are facing right now. There are so many agencies in this problem, and if they can be coordinated and well defined so that a man or woman at that category could walk over and say "Here's my problem, what can I do to help?" I think it would help a great deal.

Mr. BRADEMAS. Thank you. Mr. O'Hara?

Mr. O'HARA. Mr. Lewis, I think it's apparent from your testimony that it comes out of long years of experience in the agency. I think it's very valuable to us. I confess to the same uncertainty with regard to just how this Federal coordinating and stimulative group should be organized, if it is organized.

Mr. LEWIS. May I mention Dr. Davis' suggestion, if money is furnished directly to the projects, either in communities, that is at the level of the cities or county, I think it would help work out very nicely. We have a lot of volunteers that try to do something, but without money, it's pretty hard. I serve in the capacity where I should go to different places to help organize committees for aging, but it's not possible for me to pay the expenses without being furnished some money for expenses or to have someone volunteer to do those things. It requires a certain expense and certain amount of time, and I think it should be done by some relief from Federal or State governments.

Mr. O'HARA. Mr. Lewis, some suggestions have been made that these Federal grants, after the first year or two, anyway, ought to be on a matching basis in that the agency receiving the grant would be required to, as a condition to receiving it, to put up a certain amount of funds derived from other sources.

Witnesses before us have suggested that this is a very good device to stimulate more local activity. Would your experience cause you to agree with that statement or not?

Mr. LEWIS. I would agree, sir. I believe, take, for instance, I believe in Gary, we are trying to do something that I think the community welfare council or Red Feather agencies would come in with part allowance if we had a certain grant to carry out some of the projects that we would like to work on. I think it's a good idea to get the local community interested in matching.

Mr. BRADEMAs. I have only one question. You see, in your position, a number of older citizens. What is the problem that they talk to you about the most? I mean, what is their chief concern?

Mr. LEWIS. As I mentioned in my statement, three problems. The most—the thing that bothers them most, especially in the middle or lower level category, is sickness expense that may turn up at any time; even when they are well, they think about it. I think this King-Anderson bill might help solve part of it, but the thing that bothers a good many people, let me give you an example, a steel man, minor executive of a steel company, retired about a year ago. The first 6 months he had some money, traveled, and enjoyed it. Then he came in the Social Security office, "Hello, how are you getting along, what do you do now?" "Well, I'm my wife's helper." He has nothing to do. Here, 6 months before that, he was an important man, a cog in the wheel of industry; all of a sudden he's nobody. That is a great come-down and something ought to be developed, and I think a study should be made to help these people if they want to continue to function.

I had a man come in yesterday, he met me at the Rotary Club on Thursday, he's an ex-professor, he's getting social security. He's kicking about the fact that he earned \$2,600 last year and he has to pay back some to social security that he was paid. I think some relief could be given there. Those things should be studied and it was mentioned by Dr. Davis or Dr. Leeds that nothing is a cure-all for everything, but it could help if the position had been made clear.

Mr. BRADEMAs. Mr. Lewis, we thank you very much for taking the time to come over to South Bend today.

Our next witness is Mr. P. D. Pointer. I ought to say that it's a particular pleasure for me to welcome Mr. Pointer to our subcommittee hearing today because he was my high school principal long years ago. We are very pleased to have you here, Mr. Pointer.

Mr. POINTER. John was a very good high school student.

Of course, he mentioned the fact that I had retired from public school work, but I have been busier more since I retired than I was before. I have been interested in the problem of the aged and the aging—

Mr. BRADEMAs. Would you allow me to interrupt you, and you might state your title for the record.

STATEMENT OF P. D. POINTER, CHAIRMAN OF THE AGED AND AGING COMMITTEE OF ST. JOSEPH'S COUNTY

Mr. POINTER. All right. After I retired, of course, I went into a little politics as a sideline, was elected to the State legislature and then recently I was elected trustee of Portage Township in charge of—my big problem is the poor relief problem. You see, after I retired from schoolwork a few years ago, I was chosen as chairman of the Aged and Aging Committee of St. Joseph's County, and served as chairman of that committee for 2½ years, or little over 2 years, and I see in this

audience today several of those who were on this committee with me, on this aged and aging committee.

We concerned ourselves with the various aspects—I am sorry, I don't have mine written out here for you, but we concerned ourselves with various aspects of problems concerning the aged and aging, such as housing, such as recreation, social activities and various other things; but to me the thing that impressed me the most, as I talked to the older people and since my work in relief has convinced me more and more the problem which concerns the aged and aging is the health problem—what am I going to do when I get to the place where I have got to go to the hospital or nursing home when my resources are limited, I haven't any insurance to take care of me in my older days.

I think that is a real problem, and many, many of them are concerned very seriously about that problem, and I can see the reason for their concern because in the administration of poor relief of Portage Township in South Bend, we have on those rolls now, probably 1,600 families, and when we set up our budget for the year, our budget which amounts now to practically a million dollars a year, we set up a budget for health and all of its other activities connected with health, medical care, and hospitalization and nursing home care, one-fifth of the amount of money in our budget is set up for that specific purpose, which means about \$200,000 we are setting up for medical care. And that is a real problem.

I can see why some people are concerned about the situation because we have now three people, four people for whom it has cost us more than \$5,000 apiece, and there is no end to that care. Consequently, that is being taken care of by the taxes of the taxpayers of Portage Township. They look forward to the time when they reach the age and come out from under the emergency care, and to some other agency. They are concerned about what will happen to them, so my testimony here is in behalf of those people who are faced with that problem and to say that I firmly believe that the only solution or one of the main solutions of this problem is to arrange for some type of insurance such as proposed under the social security plan so that they can go into their old age feeling secure, they are going to be able to be taken care of and not have to exhaust all of their savings for this type of care.

That is about all I have to say.

Mr. O'HARA. Mr. Pointer, I would like to reminisce with you to see if you are really the one responsible for the qualities of leadership that the chairman here shows down in Washington, but I don't think that is appropriate to the hearing because I don't think he can be classified among the aged or aging.

Mr. BRADEMAs. I have been aging fast.

Mr. O'HARA. But I wondered, out of your special experience in education, if you might wish to comment upon another feature of this problem, and that has to do with the compulsory retirement provisions of so many professions and occupations today. Do you feel that some assistance to many aged persons could not be accomplished by working out of arrangements to permit aged persons who wish to do so to continue on a part-time basis, perhaps in their profession and to continue to be active in some way with the sort of activity that they have carried on all their lives.

Mr. POINTER. I had been very, very much in favor of that. I don't see any reason why, when a person reaches the age of 62, 63, 64, 65,

you must stop right then and there. I think that is absurd because I know people who can give long years service after they reach those ages and be as effective as they were before or maybe more so.

Mr. BRADEMAS. I might say I think the fact you retired after many years as a high school principal and are still giving great service to this community is a good point for your argument.

Mr. POINTER. The main thing is I thank the Creator I have had good health, excellent health.

Mr. O'HARA. Thank you very much.

Mr. BRADEMAS. Thank you.

Our next witness is Mr. Jesse Dickinson.

We are very pleased to welcome a gentleman who is very well known in our community and a friend of mine, Mr. Jesse Dickinson.

STATEMENT OF JESSE DICKINSON, MEMBER, INDIANA COMMISSION ON AGING AND AGED, AND EXECUTIVE DIRECTOR, HOUSING AUTHORITY OF THE CITY OF SOUTH BEND, IND.

Mr. DICKINSON. Mr. Chairman, I don't have a prepared statement this morning because of many activities, and you have had and will continue to have the advantage of experts, but due to the several activities in which I have—with which I have been involved, both on State and local levels, and to an extent on the Federal level, we have had the benefit of actual things. We don't have to dwell too much on philosophical and theoretical viewpoints. We can talk from that which has happened and is happening and is likely to happen.

Mr. BRADEMAS. For the record, Mr. Dickinson, would you give us a little of your background, your present position, and so on.

Mr. DICKINSON. Well, I am a retired State senator who worked in the area of aging and aged. That is the bills, this is one of my interests. I am also a member of the Indiana Commission on Aging and Aged, and presently I am employed as the executive director for the Housing Authority of the City of South Bend, and a major part of our program is housing for low-income retired people.

One of the things that I am most interested in, of course I think at first in offset we should consider that as has been said, that there is no particular program that is going to cover all of the needs. When a person gets into this last part of the life cycle, they have just as many interests and all of the things that pertain to people prior to that time still exist, even to the extent of education, employment, recreation, housing, etc. The problems attached to a lesser or greater degree depending upon the category in which you are dealing.

My principal interest as a matter of these propositions that are before us is the one on having the office that will be concerned, that is on a Federal level, that will be concerned with those problems and propositions confronting the aged. I will have to join the school of those, or the group feeling that there should be a separate office to handle the problems of the aged.

Now, I haven't been involved in government on a Federal level, but on the State level I have been for the past 20 years, and I would certainly have to agree with Dr. Leeds. Now, we aren't talking about the way things should be; we are talking about the way they are. It is certainly evident that whenever there is a department, a State de-

partment or any governmental department, there are certain areas that they do not like to be involved in. It's also difficult many times for them to support anything that seems to infringe upon their authority and so forth.

In the matter of government, it seems to me the first objective should be that activity that can serve the needs of the people; the office is secondary, and yet the people operate the offices. They have some—too much of the time personal feeling, and this is why I feel that the coordinating effort is valid, the philosophy is sound. Sometimes I am as much distressed about bureaus as anybody. However, if it takes a bureau to get a job done that has to be done, then, of course, we have to have it.

Many times I get calls from people who want information concerning some area that I know very little about. It may be in the area of housing, it might be in the area of employment service. Sometimes I know where to send them, sometimes I don't. If there was an office through which all of these things were channeled or into which all of them went so that the person would know just where they should go to get certain information, this would be of real value. And, as has been stated, it's appropriate, and I think almost necessary that the authority of this office should emanate from the Chief Executive.

Now, as I say, this possibly isn't the best proposition based on sound philosophy, but, in reality, this is going to be, as I see it, the only way you are going to have a really effective program. Fortunately, I think due to the fact that I am involved in a housing operation that includes about 100 units, family units, I think we are in a pretty good position also, and I must tell you that it is just difficult and you just cannot separate one phase of a person's life from another. Certainly, basically, we are concerned with shelter for retired people, but it's just impossible to not see and notice and be concerned about other phases of their living.

Again I say, Mr. Chairman, that I must be with those who say that there has to be a separate commission or office that would do this job. You cannot rely upon a full degree or adequate degree of cooperation between the departments, that is going into a coordinating office. It just seems to me contrary to, well, those things that make people act.

Now, there are several other phases that I could go into, but this is the one that I know there is a lot of discussion on. I wanted to give my point of view. If the objective, and again I say my theory is and has always been as a member of government or representative of the people, that if there is a job and it is determined that this is a job that has to be done, if it's too big for the individual, it's too big for the private group and yet we say the job has to be done for the general welfare of our society and for culture, and so forth, then this becomes a job of government, and when we get into the realm of government, we have to consider the most effective way within our structure and certainly I feel that we must not be frightened by the words "socialist system." This just doesn't disturb me at all because I recognize that this Government of ours, I think many people in the world will say it's the finest structure that has ever been tried, but we have become great because we were able to take various parts of governments, some of these ancient, and get them within our structure, use them according to the way that our structure would allow.

The socialism aspect of some of these matters just doesn't disturb me so long as they are within the structure of our Government. If this was the case, of course, we would have to throw out our public school system. Nobody wants to do that. We would have to throw out other phases of government. It's a thing within the basic concepts of the American way. This to me is the only thing that should govern and determine our actions.

Mr. BRADEMAs. Mr. O'Hara?

Mr. O'HARA. Mr. Dickinson, you certainly have had wide experience in these problems as a legislator and member of the Indiana Commission on the Aged, and with the South Bend housing program.

A number of California witnesses testified with regard to the new or relatively new direct loan program under the Housing and Home Finance Agency to assist in constructing housing for the elderly. I believe one witness before us had built the very first project under that direct loan program and, according to his testimony, there have been very few accomplished. He felt there had been a sort of slowdown in the handling of applications for direct loans and that the program was not being effectuated as best it might be.

I wonder if you have had any experience with a direct loan program for housing for the elderly, and what your experience might have been?

Mr. DICKINSON. Well, I have had no direct contact, that is as to implementation, but I have just yesterday, in fact, in this community there is a private organization making application for this kind of loan to build a facility for the aged. It is, to see, amazing. It isn't to those involved, but they have been trying to get off of the ground to get their own church or people who run their organization to get enough agreement so as to overcome this tremendous thing for Federal governmental participation, you see, and it was just within the last few days that this opposition was overcome to the extent that they could get what we call a majority vote so they could proceed. These, to me, are the first things.

In the Public Housing Act aspect, this is merely to take care of one segment, those people who are very low income. This is all it is for, but they don't even form the biggest percentage, and therefore there has to be this private participation, and I think that in most instances, or many instances, it has to have the benefits of the thinking that is presented by the new law. I think that the difficulty is, you see, there are those who feel governmental interference is bad. This isn't interference. This is governmental help, if you want it.

Again I say, in South Bend there is an application that is being made by a private organization, and I do know the problems they had in getting together themselves. This is good, and I feel reasonably certain that there is going to be many more applications in the very near future. Many groups are thinking about it, and this is going to make a tremendous contribution to giving adequate relief to people who are above the low-income level. A person's income might be just \$10, \$15, or \$20 over the limit, and they are out. It's a marginal case. Just as a number of years ago, I participated in getting a bill through to give certain tax relief to a certain person if their income was no more than \$2,250 a year. The thing that distresses me, that with \$10, \$15, or \$20 over the limit, his need was as great as the other

person, and yet nothing was done. This is the group that will be helped by the thing we are talking about.

Mr. O'HARA. I appreciate your views on this subject, and I commend you for your realistic philosophy and approach to these problems. I would hardly say it was oppressive Government interference when the people, through their own Government which they have created, which they are operating, decide to come to the assistance of their fellow citizens who are having difficulties. If I were drowning, I would hope whoever was there would throw me a line, whether he was a Government employee or not.

Mr. BRADEMAS. I just have two questions, Senator Dickinson. What is the rent that is charged to a person who lives in one of the housing units for the elderly?

Mr. DICKINSON. You mean local?

Mr. BRADEMAS. Yes, here in South Bend?

Mr. DICKINSON. Our minimum rent is \$30 a month, which includes utilities. They are allowed so many kilowatts of electric power and every 3 months, if they run over that, they have to pay the difference. The minimum rent is \$30, and they are graduated upward according to the person's income. The income limit is \$3,000. If a person—that is for an individual. If the income is greater than \$3,000, they are not eligible. However, I hasten to say that the average income in our group is something under \$1,300 a year. Many of our folks live entirely on social security which, in most instances, is less than \$100 a month.

We have people who are getting along reasonably well with incomes of from \$650 to \$700 or \$800. This is fantastic when you think of prices and so forth, but this is only possible because of the low amount of money they have to pay for their basic needs, such as rent, utilities. I may add this, I know the time is fleeting, but to give you an example, an applicant comes through, and this lady qualifies, and she finds that she is going to have \$27 a month more than she had from this \$80 a month social security stipend, and she said, oh, I am going to have a grand time next pay day, she said, I haven't had a new dress or new pair of shoes in 8 years. Just think, I am going to have \$27 to do some catching up. This is the sort of thing, many of the people, I have been able to determine, they were not able to buy food and so forth.

Mr. BRADEMAS. There is no provision for nursing home care or anything of that sort?

Mr. DICKINSON. No. When a person comes in, they have to have a sponsor. I get information as to their doctor, their ailments, so if there is an ailment, I will know who to call, and the doctor will tell me to send it to the hospital, and so forth. This is an area that will have to be done in other phases, whether they are private or public. We are merely concerned with shelter and those immediate activities concerned with shelter.

I did see one of our tenants this morning who evidently was very active in the field of social events before she came to us. We have very fine programing and this is done by the tenants. Everything that is done outside of shelter, they are doing themselves, and doing a marvelous job. By the way, sometime, Mr. Congressman, you should drop in and see us.

Mr. BRADEMAS. I will. I think I will do that. Thank you very much indeed, Senator Dickinson.

FROM THE FLOOR. How full are the houses?

Mr. DICKINSON. We are filled up. I have 250 standing in line, and I have the reservation to build 200 more units if you can get your city council to budget it.

Mr. BRADEMAS. Our next witness is Dr. Leonard Breen, Department of Sociology, Purdue University, Lafayette, Ind.

STATEMENT OF DR. LEONARD BREEN, ASSOCIATE PROFESSOR OF SOCIOLOGY, PURDUE UNIVERSITY, LAFAYETTE, IND.

Dr. BREEN. For the record, my name is Leonard Breen. I am an associate professor of sociology at Purdue, and also coordinator of research of gerontology.

I regret very much I don't have a prepared statement. Having learned of the hearings only very recently, I have only had opportunity to review the pending bill, and thought that I might be of greatest assistance by suggesting some of those things that underlie the development of bills of this kind. Others have said already that they speak only for themselves. Being a college professor, I say right off the bat, I don't speak for myself, but for all the people that I have been in touch with when I have carried on research, with students whom I am in contact with all the time.

As we think about the need for coordinated activities at the Federal level, we think of those things toward which these activities are directed, as I am sure you do, too, in the attempt to develop those bills which are most appropriate to the problems. Aging we recognize as a physiological fact, but it has very important social consequences, and these social consequences come to us for a variety of reasons, partly because of the increasing expectation of life, the increasing automation, therefore decreasing work opportunities; partly because of the rapidly expanding cities.

Now, this latter notion I think is especially important and is not often considered enough. With cities expanding as rapidly as they are, with housing units growing smaller, with the kind of mesocity developing that we have in our country, people lose their sense of identification, and this becomes increasingly important for older people because what happens with this kind of change is that people no longer count in our society for what they can do, but only in terms of the physical work that they do, that they in fact carry on.

The problem is that at one time people counted for what they were, what they were able to do, that which they carried with them. Now they count for the things they do every day. With work being removed is an important area of expression for older people. They no longer count. This is one of the realities. To talk about the great potential of older persons is very important, but we must, at the same time, recognize that we have not, for a long time now, taken advantage of that potential, nor do we show any evidence at the moment of trying to take advantage of it.

The very fact we have to argue about a feeling of worth for older people, about developing the climate in which they have a place and sense of worth is an obvious recognition that this does not exist now and therefore we need to do something about it.

Well, we always make judgments about what older people are like, and older people respond to these judgments. Therefore, one of the

important components of the aging itself is simply the social setting within which older people find themselves. That is the expression of expectations by the people at large and their response to those expectations.

The Federal Government, in a great variety of ways, has tried to do something about this. Obviously the most important effort was the White House Conference. I was privileged to be a part of that Conference as a consultant and participate at the Conference itself. A great many important things came out of that Conference which went beyond the mere alerting of people in the country to some of the problems that exist; and some of the things that went on that were especially important were the kinds of things toward which this bill is focused. One of the most important problems that we social scientists have recognized is that as these matters of social expectations and inability of persons to perform as they would like to perform in our society; that is, older persons, as these things become more and more obvious, more and more important, the social sciences have been able to make a greater contribution to understanding those things and there, with interested persons, do something about it.

At the Federal level right now, virtually all of the research interest was expressed; however, not through any of the concerns of the social sciences, but only through the health fields. The social sciences come into use only when they have a health overtone, so that the economists, the psychologists, the sociologists are called into play and into use only when they can demonstrate that what they are doing has relevance for the health needs of persons.

What I recognize in the research that I have done, and found to be especially true in one project we carried out, a community study here in Columbus, Ind., was that while the health needs are basic, it's the social place in which older persons find themselves that needs to be understood and dealt with more and more. We then look for an opportunity for doing this at the Federal level. One is a committee on aging. I must say that this bill is one of the most carefully thought through pieces that I have seen. It takes into account a great variety of problems in a systematic manner, but I must say quite candidly that I am no expert in the development of the mechanical means for the alleviation of social ills in public, and therefore, I don't know if the commission form is the best form to pursue. What I do know, however, and I know this very definitely, is that coordination is needed. There are a great variety of activities going on through HEW, through the Department of Labor; they have certain programs of this kind in a great variety of places. Communities have become aware of this, like was true in the community of Columbus; they turned to the Federal Government for some assistance, guidance, and help, and yet they don't know where to turn, and there is nobody in Federal Government that I have ever found who knew about all the programs going on.

It's extremely complex. It's large. The people in one department don't necessarily know what is going on in another, even when developed, and they don't know about this when this is in the process of formulating. There needs to be some kind of clearing agency so we can refer persons who have problems to those agencies that can best be of assistance to them.

The Special Staff on Aging has tried to do that. In my personal experience, the Special Staff on Aging has done an admirable job. They have tried with limited resources to deal with very broad kinds of problems and, for the most part, have done this successfully. They have, however, been plagued with problems of change in personnel, limited resources that are so limited that make it impossible to pursue their interest. With their recent expansion of staff, they show some promise of being able to carry on more field service, but they themselves cannot perform this coordinating function at the moment because of all the things going on. The Federal Council might have been of assistance if they were more closely tied to the Federal staff. Some device has to be found for the development of what you call in this bill an Advisory Council tied to the operating group. This Advisory Council can be the medium for accumulating the understandings of all of the participating departments, and then have the operating agency itself carry out the interests of these various departments.

In general, I would guess that there would be a great danger in overorganizing at the Federal level as would be true at any level. This is partly because of this notion that I suggested at the outset that the problems of older persons come to them as a virtue of the community setting in which they find themselves. The more we emphasize the problem aspect, the more likely it is that we will continue to segregate the aged. Some way we have to devise a method for bringing to the attention of those who want to work in the field, in the community; those opportunities that are available through Federal organizations, and, at the same time, permit the local instrumentality to continue to function in an intelligent way so we don't segregate further those older persons we have already segregated.

I recognize in many communities in South Bend it is necessary to have public housing for older persons; yet what we have learned in public housing, it is relatively undesirable to set them apart, and this we continue to do. The thing that distresses me even more than the setting apart of older persons in public housing is the extent to which, in private planned communities like Park Forest, Ill., New Whitland, Ind., we are carrying out this program of segregation even further than we are in public housing. New Whitland, Ind., has less than 1 percent of its population over 65. One wonders then what conception of older persons can a young person have when he grows up in this; the social pressures are such to shape their understandings this way, to shape the understandings of older people themselves. The Federal assistance that might bring this to the attention of the planner is available, but uncoordinated. Because it is uncoordinated, it frequently cannot be found.

This, I submit, is a very general statement, but one which is concerned with the opportunities that exist today in the Federal Government, the coordination of these activities and the implementation of these in such a way as to incorporate the older person into the life of the community rather than separate him from it.

Mr. BRADEMAS. Thank you very much. Mr. O'Hara?

Mr. O'HARA. Dr. Breen, several proposals have been made to the Congress with regard to amendments of the Vocational Educational Act, and amendments to the program dealing with university extension services to provide opportunities for older persons to partici-

pate more fully in training and educational matters that may not be directly related to full-time employment. I would gather from your testimony that you feel that greater effort and better coordinated effort in this regard could be helpful.

Dr. BREEN. I must say, I am inbenevolent about that. I don't see in the long run how our economy can benefit by the inclusion of a large number of older persons in the work force. We are now losing approximately a million and a quarter jobs a year through automation. At the same time, fortunately, through expansion, we are increasing almost that same amount, about a million and a quarter jobs a year, but this is at a time when our labor force is growing. The one thing we know is that our labor force is going to continue to grow. I think it's unfortunate that we stressed so heavily the contribution that a person can make only through remunerative employment. It seems to me there are a great many places where this might be possibly done in other ways. For instance, I understand in the Senior Citizens Act of 1962 which is currently being considered, there is an opportunity created within which older persons can contribute to communities in a variety of ways without being involved in a situation of remunerative employment. It seems to me this is the kind of thing that the Federal Government is uniquely able to do.

For instance, we have a great program of national parks, we have a great many natural resources in our society that have lain dormant. Our Spring Mill State Park here in Indiana is one example of this. At Spring Mill, we have an active mill which tries to recreate a time of the past. When I visited there last, I thought to myself wouldn't it have been wonderful if we could have right in this place created a community of older persons who have been involved in recounting of the past in such a way as to bring to the attention of young people who had come there the heritage of the past.

Now, there is no reason why this couldn't be done throughout our national park system and many other places in our national monuments as well where the heritage is what we are trying to preserve. Older persons represent the human heritage. What more obvious thing to do than to try to tie the human heritage to the physical heritage and, in this way, make a place for these older persons. By the same token, I think there are many persons who are not yet 65 but thought as being older who need to go on working. A man of 45 today who loses his job is in tough shape. This man ought to have the opportunity to be retrained to carry on in the society which he has contributed so much already, to carry on effectively. He can do this by this kind of vocational rehabilitation program.

Another way this might be done is through one of the programs established in this 1014 bill, namely through the instrument of direct grants to States, and I must say I would like very much to see this implemented by not having the grants made to existing health and welfare agencies as is so often the case, but organized directly through the Governor's offices, through the organized committees or commissions of the States.

Mr. O'HARA. Dr. Breen, I perhaps didn't make myself too clear. The proposals to which I was referring had to do with broadening the Vocational Education Act so that we permitted vocational training of older persons when it didn't lead to remunerative employment but led

to some other activity that would make his life more meaningful. And to the same point, the broadening of the provisions with regard to the State University's extension services to permit older persons to participate more fully, not necessarily with the objective of obtaining a full-time job of some sort, but to give them some sort of an extension of their growth as individuals and permit them to participate in things perhaps they have never done.

Dr. BREEN. Yes. I am sorry. I misunderstood your question then. This is the kind of thing we ought to be doing. We need to help develop those skills which will make it possible for the older person to function more effectively in the community. One of the real problems we are faced with is a direct conflict of interests in many areas between younger and older persons. This is something you can't avoid. Persons of different generations grow up with different values. Older persons find they are suddenly tossed to the doorstep of a society they have not grown up with.

To the extent we can provide those educational opportunities to help them adapt to this changing society, to implement change in the community, I think this is one of the important things that American colleges and universities can do, to get out into the community and work with these people.

Mr. O'HARA. I thank you for the help you have given me in understanding some of these problems. I agree with you that often we place too much emphasis on the tangible aspects of these problems, such as income, what is the average income and what should it be, and medical care, and we don't look at the situation enough probably as an overall social problem. I think you have helped with your contribution today.

Mr. BRADEMAs. I have just one question, Dr. Breen.

Obviously there has grown up in the last few years in the United States this intense interest in the problems of aged and aging. Do we have enough people, I take it that's a rhetorical question, how do we get more trained personnel in the field of gerontology and related fields? That hasn't anything to do with any legislation, particularly, but you are an expert in this field and I wondered what your feeling is.

Dr. BREEN. I think it has a great deal to do with the legislation, as a matter of fact. I think it has a great deal to do with every phase of it. We have wrestled with this for a very long time. Some have tried to do it by developing institutes of gerontology. Purdue University has tried to do this by developing a program within our own department of sociology in the training of persons with a special skill in sociology, but with an understanding in the course in the problems of aging. As an example, one of our good students received a Ph. D. in sociology, went on to the Harvard Medical School, is this June going to get his masters in public health degree, and is going on to be an important component in the Cornell system of their study of occupational retirement, studying the relationship between the social aspects of society and the health aspect. This man will be trained to do this. It's unfortunate I have to point out this one person and say this is an unusual case. We try to develop persons who are able to do these kind of things, who can work with older people.

We have at Purdue a health fellowship program where we train only about three a year. Now, this is much less than a drop in the

bucket. We have under consideration now, and this was announced by Secretary Ribicoff last week, a program in training persons to administer congregate housing facilities. Purdue University in cooperation with the Department of Health, Education, and Welfare, is in the process of developing that curriculum which will be a 2-year masters program. One of our problems is that we don't find enough people because of the competition with all other disciplines going on now. The reason we don't find enough is we aren't apt to attract them. In our department right now we have, I believe, something like sixteen awards for graduate students coming into the department this next year. Of these 16, I am only going to be able to capture 2 or 3 with any kind of interest in aging simply because the funds are not there. We need to provide somewhere a concern with other than the problems and provide training funds to do this. We ought to have a fund for students on a fellowship basis to attract them into such things as the social sciences, social work, psychology, and so on.

MR. BRADEMAS. Thank you very much indeed for having come all the way up to be with us, Dr. Breen.

DR. BREEN. My pleasure.

MR. BRADEMAS. I might take this occasion to announce to everyone attending our hearing what our general schedule will try to be the rest of the day. We will continue here for 1 more hour. Then we shall break for 1 hour for lunch, come back again at quarter of 2, and it is our hope, we have witnesses scheduled for the rest of the morning, and also for the first couple of hours or so in the afternoon; we have several physicians coming in this afternoon, and after we have heard testimony there, it is our hope to throw the meeting open, throw the hearing open for any comments anyone may make, and we are scheduled to adjourn about 4:30.

Our next witness here this morning is Mr. Lewis F. Nicolini.

STATEMENT OF LEWIS F. NICOLINI, DIRECTOR, INDIANA STATE EMPLOYMENT SECURITY DIVISION

MR. NICOLINI. My name is Lewis F. Nicolini. I am the director of the Indiana State Employment Security Division.

MR. BRADEMAS. And a resident of this county.

MR. NICOLINI. Resident of this county. I might say, the employment security division has a twofold function, that of operating the Indiana branch of the U.S. Employment Service, and also of paying unemployment insurance benefits to individuals who are legally qualified.

I have a brief statement, Congressman.

The economic, employment, and unemployment conditions in Indiana in recent years are, I think, fairly typical of the overall national experience. This has been a period when most of our people were reasonably prosperous. Production of goods and services has been high. Employment has been high, but in spite of all the favorable factors, our average unemployment rate has been above 5 percent in Indiana for each of the past 4 years.

I think what we are witnessing are the growth pains of an industrial revolution. Machines are becoming more and more automated. There are fewer and fewer jobs for unskilled and semiskilled workers. This has created a buyers' market for the employer who needs to hire in

those categories. As a natural consequence, employers have become very choosy, and they can afford to be. Consequently, some people who know they can perform the work to be done are turned down. They feel they have been discriminated against.

Now, we know that some of the hiring restrictions practiced by employers are unrealistic and, therefore, we might rightfully call them discriminatory. However, not all of these restrictions are as unrealistic as they seem to be on the surface. Many times the employer is hiring for the future. He knows what he wants in a worker tomorrow and he feels the worker hired today should be qualified for tomorrow's job. Now, whether this constitutes discrimination or not may be a matter of viewpoint.

Speaking from the Indiana State Employment Service side of our division, I would say that we do observe instances where unrealistic age restrictions are specified by employers. However, based on past experience, I believe this problem will disappear when the overall unemployment problem is solved.

As an agency, we do have a program of service for older workers and we do try to give them some special attention. We maintain a statistical count of the services provided for two older age groups, those 45 through 64, and 65 years and older. In the table I should like to distribute, Mr. Congressman, we have statistically presented the service record rendered by the service for the calendar year 1961 for these older workers. Looking at it from the standpoint of the statistics, those in the 45 to 64 age group have as good or a little better than average chance for placement, but the picture is not quite so good for the applicant past 65 years of age, and this is particularly true of the male worker.

The females in this age group are less of a problem for us because most of them are more realistic about accepting jobs available to them. On the other hand, the average male has a longer attachment to the labor force and doesn't want to be downgraded. Another problem we encounter in this age group is the desire for part-time work; the ability to earn some money but not enough to interfere with social security payments.

We sincerely believe that we can do and should do more for the older workers. However, when we analyze what we are doing, what we have done, we always arrive at the same conclusion, and that is the problem goes deeper than serving any one group. What we must do is build up a strong economy so that our employment service can encourage all employers to place job openings with the agency, and we believe we will be moving in that direction once we devise ways in our economy of absorbing those individuals in the labor force who want to work. And this, Mr. Congressman, would conclude my remarks.

Mr. BRADEMAS. Thank you, Mr. Nicolini. Mr. O'Hara?

Mr. O'HARA. Mr. Nicolini, I know this isn't really too pertinent to the problems of the aged although, as you have noted in your testimony, it's pertinent to problems of the aging, those persons over 40 or 45 who might find themselves unemployed. Very recently, as a Member of the U.S. Congress and working with the chairman today, Mr. Brademas, we were privileged to play a part in the passage by the Congress of the manpower development and training bill which was signed into law by President Kennedy about a month ago. Under

the retraining provision of the Area Redevelopment program, which was a much more limited program, it is my understanding that a very large percentage of those successfully retrained for employment were persons over 40 years of age. I wondered if you might give us the benefit of some of your thoughts on what, specifically, we might be trying to do for the older worker who has many years yet ahead of him of productive expectancy, who find himself unemployed because of automation or technological changes or any other reason.

Mr. NICOLINI. Based on three training programs in Indiana, under the ARA program, we have noted this—that the older worker, I say the older worker, the individual past 40, is more amenable, more willing to undergo training than the younger individual. The reason is that he is more apprehensive about the future than the younger individual. Of course, in addition, these are groups, although this is an isolated instance, I would like to spend just a little time citing a situation that occurred in Lake County just recently in the petroleum refining industry. Because of the increase in technological change, we have had some 1,200 people displaced in recent months. These people's seniority dates back to 1946. These were the youngsters, the high school graduates, the cream of the community there that were hired. Now, some 16 years later when they find themselves in the late thirties, early forties, in the bracket where they should be most productive, they find themselves out of jobs, and this, of course, concerns them much more today than it would have 10 years ago. I think this brings out the point I was trying to establish where the individual 40, 45, and even 50 years of age is much more agreeable to undergoing training than his younger components or younger counterpart in the labor market.

Mr. O'HARA. Well, I am interested to hear that, because you fairly often hear what I regard to be mistaken comment to the effect that when you have a middle-aged worker who has been working on a specific trade for X number of years, he isn't going to be willing to take up a new trade even if he can't find a job in his old one. I think that is wrong, and I think your experience and testimony demonstrates it is wrong. I appreciate the help you have given us.

Mr. BRADEMAS. Mr. Nicolini, I just have two or three questions. Do you, in the division of which you are the chief executive, employ an older worker specialist or not?

Mr. NICOLINI. Yes, we do. We do have a small unit within the State Employment Service that deals specifically with the problem of the older worker.

Mr. BRADEMAS. Do any States have the policy in their Employment Security Division, or whatever is their similar type of State agency that deals with employment problems, do any States that you know about have a policy under which that department would refuse to process a work order if that work order specified restrictions on account of age that did not really seem essential to carrying out the job?

Mr. NICOLINI. I cannot answer that, Congressman. I do know there are agencies such as that in Indiana which would refuse to process job orders where other items of discrimination appear, particularly with respect to color, race, origin, but I cannot answer whether this would be applicable to an age factor.

Mr. BRADEMAS. Just one other question: Do you have any feeling about legislation that would bar discrimination in employment on the grounds of age? I understand that many States have such laws.

Mr. NICOLINI. Yes. I would, of course, after having spent some 21 years in this field and, of course, our philosophy always is that an individual should be considered on his ability and his ability alone, and his chronological age should have nothing to do with whether he should be qualified for employment, and because of this I would favor it, some legislation that would encourage the employment of older workers. I dislike the idea of prohibitions of any type, but if the system of education, our promotional efforts, and others don't succeed, perhaps legislation is needed to accelerate the idea that people should be hired on their ability and nothing else.

Mr. BRADEMAS. Thank you for being with us this morning.

Mr. John M. Fewkes of Chicago. Would you identify yourself, please, sir.

**STATEMENT OF JOHN M. FEWKES, PRESIDENT, CHICAGO
TEACHERS UNION, CHICAGO, ILL.**

Mr. FEWKES. I am John M. Fewkes, president of the Chicago Teachers Union, Chicago, Ill. Our organization is composed of 12,043 paid-up members who are regularly certificated teachers employed by the board of education in the city of Chicago.

We have great concern over the problem of retired teachers, particularly. Also, of course, we have also been concerned about the problems of aged and aging in all walks of life. Because of our deep concern, in the last session of our Illinois State Legislature, we introduced and looked for passage of a bill which would provide supplemental payments for teachers who retired some years ago and are now receiving \$1,000 or less per year in pension, who are not qualified for social security, and who are independent enough to refuse public aid or assistance in any form. These supplemental pension payments would only have increased salaries by contributions of certain small amounts on the part of these teachers and to a maximum of \$2,250 a year, which is certainly not too much for any individual to have who has performed public service for 25, 30, 40, 45 years in the public schools of the State of Illinois.

After securing passage of the bills and their being signed by the Governor, a suit has been instituted against Pension Systems, the pressures of the State and of the city of Chicago, and the pension funds involved enjoining these pension funds from paying these supplementary payments to these retired teachers. This matter is now in the courts. We cannot conceive of any individual citizen instigating such a suit, but it has been done. We are tremendously interested in seeing that these aged and aging teachers receive hospitalization, medical care, housing, and all of the things that a grateful nation should supply to them. So the Teachers Union is presently in the process of setting up a housing project, a nonprofit organization that will rent to aged and aging teachers, good housing at a minimum of cost. We are hopeful that we are going to have this financed by Federal aid. We are deeply grateful that the Government is presently offering this type of service to such organizations.

Now, we feel that the area of health, hospitalization and medical care is certainly one place where all of the citizens of all of the States in the United States of America should receive adequate care. We are certain that this only can be done through the Federal Government

because certain areas of the Nation are less prosperous than others. We are sure that the Federal income tax is the only way in which we can tax equitably wealth where it is and then use it where it is needed, and therefore we certainly subscribe to the proposition that some coordinating agency should be set up in Government that will attempt to coordinate all of the present efforts to do something for the aged and the aging citizens in all of the States of the Union.

The suggestion has been made that because of the great shortage of teachers, that there probably should be greater mobility amongst teachers and that possibly some sort of reciprocity in pension systems should be set up between States. There are grave problems concerning this idea which we think need a great deal of study and careful thinking before this type of thing is accepted or put into effect in any degree. I am sure that States are going to feel that if they have been paying a teacher's salary for a number of years and that that teacher has attained a certain amount of pension, that State would not like to see that teacher move to another State because of better climate or for some other reason, and that the State from which they had moved would still be responsible for paying that pension which the individual had acquired within the State.

There are other grave concerns about that proposition. I don't think they necessarily have to be insurmountable, but there are a lot of questions involved which we think need careful consideration before being put into effect. We subscribe to the idea that the Vocational Education Act should be broadened in order to offer some training and other activities for the aged or aging. All of these things we feel should, of course, be regardless of race, creed, or color, and that every citizen of the United States should be provided equal benefits and when it comes to hospitalization, medical care, and housing, we particularly feel that this is desirable from every standpoint, moral, legal, and economic. I believe that ends my testimony.

Mr. BRADEMAS. Thank you, Mr. Fewkes. Mr. O'Hara?

Mr. O'HARA. Mr. Fewkes, with regard to the position of the older teacher, Mr. Brademas, the chairman of this subcommittee, has in particular taken a great deal of interest in problems of education, and the proper Federal role in education, and we together have heard much testimony with regard to the teacher shortage. I wondered if you might have some observations you would like to make on ways in which the services of the older teacher might be more effectively utilized than they are today.

Mr. FEWKES. Yes. I would be very happy to. The Chicago Board of Education has established an emeritus teaching position, and any teacher who reaches the age of 65 and who is at that age automatically retired, then by taking a physical examination receives a temporary teaching certificate, and they can continue teaching until 70 years of age at their regular salary rate, receiving any additional increases that other teachers may obtain, and also providing that their pension may be increased by such service because we have a pension formula that's multiplied by $1\frac{2}{3}$ percent the salary for the best 5 years of the last 10, and usually the last 5 years of service are the best 5 years of service insofar as salary is concerned; so the Chicago Board of Education has moved forward in this way, and we feel this to be a very fine, reasonable, equitable provision that has made available to the

city of Chicago as many teachers as desire to continue employment until the age of 70. This we think to be remarkably fine.

Now, the Federal Government we feel does have a tremendous responsibility insofar as education is concerned in spite of the fact that the States do have the primary responsibility of education. We are very certain that our very first arm of defense is the education of our people, and that the United States should be spending a great deal more on this arm of defense than it presently is. And that here again, in seeing that equal educational opportunity is offered to all of the citizens wherever they may be. The Federal Government is the only agency that can really do the job. We are very certain that in order to equalize educational opportunity, that we must have Federal aid to education and that that Federal aid should take a form that goes through State government, of course, and is not federally controlled, other than to see that certain minimum requirements are met. This, I think, the Federal Government has a right to do before it does put out aid anywhere, as it does in housing, as it does in roads, et cetera, but we do not need to worry about Federal control on education.

There has been Federal aid to education going on for many long years without any overt Federal control, so we are very hopeful that before very long the Congress of the United States will provide Federal aid to education and it could take a number of forms without there being any danger of control, and that should be acceptable to all citizens in view of the great good that would eventually come to all of the people of the United States.

Mr. BRADEMAs. Thank you very much, Mr. Fewkes. We appreciate very much your coming.

Is Mr. Noel in the room?

Then I will call on Mr. Murray Dolan who will be our last witness before we adjourn for lunch. While Mr. Dolan is taking his seat, I will ask unanimous consent to read into the record the following telegram:

Thank you for your invitation but illness prevents attending hearing. Heartily endorse S. 2779 and H.R. 1014 to establish separate Federal agency for problems of the aged and aging. The many, many important problems of this great group of our population deserve more attention than can be given under present and various departments and agencies.

LINDSAY L. CRISSWELL,

Field Vice President, National Association of Retired Civil Employees from Evansville, Ind.

Mr. Dolan, we are pleased to have you with us.

STATEMENT OF MURRAY DOLAN, STUDEBAKER LOCAL 5 RETIREES

Mr. DOLAN. My name is Murray Dolan, connected with Studebaker Local 5 Retirees, and my report will be more of a local report.

About 11 years ago, an agreement was reached by the Studebaker Corp. and union whereby all dayworkers would be pensioned off upon attaining age of 68 years, which a lot of them didn't like. They knocked their livelihood off. Willing to work some more, they were granted a small pension plus social security. At this time, there were about 400 pensioners and since then increased to over 2,200, 2,200 retirees. Local 5 Club was formed at that time. The object of the

club was to improve the welfare, social and other activities, plus indulgence of civic projects. Since that time, there have been small increases in the pension and social security, but the cost of living has greatly increased and these increases do not cover the expenses entailed and do not allow the elderly people to live up to the American standard of living. The insurance policy covers about half of the medical cost and hospitalization. Up until recently, the widow of a deceased member was left nearly destitute with a small amount of social security to exist on. The majority of the retirees own their own homes, and the widow of a member on a small income is unable to pay the high taxes. They have to depend on the welfare. We were able to have a bill passed in the State of Indiana that would allow the owner, if he were 65 years or older, \$1,000 exemption, providing his income does not exceed \$2,225 a year, and I wish to thank Mr. Dyke for putting that through.

We have an agreement with some druggists who will allow a certain discount on drugs. We are now endeavoring to induce the bus lines to reduce the bus fares for elderly people. We also proposed a bill at the last session of the Indiana Legislature to eliminate personal tax on household goods of elderly people which did not go through. We have also had our members send hundreds of letters and petitions to the Congressmen for the passage of the King-Anderson bill and other medical bills. Many people are required to spend sums of their meager income on medical supplies. I have been in the welfare business for a long while, and the main complaint I think is the hospitalization and medical care which is very expensive, we all know. That is the end of my report.

Mr. BRADEMAs. Thank you very much.

Mr. O'HARA. Mr. Dolan, I don't think I will have to ask you any questions about this because I want to commend you on the direct and forceful way in which you expressed yourself on these problems. I also would like to commend you personally and the organization of which you are a member for the continued interest they have shown in their members after their working years were ended, during the retirement years, and for those persons within that organization who have especially devoted themselves to these problems as you have. I think it's a very fine example of the sort of initiative and activity that nongovernmental groups can undertake and the sort of thing that ought to be encouraged by the Government.

Mr. DOLAN. Thank you very much.

Mr. BRADEMAs. I might also express my appreciation to Mr. Dolan. I know there are few people in this community who, for so many years, have shown themselves to be deeply concerned about these problems and to write weekly columns about them as you do in the Studebaker News. We appreciate your coming.

The hearing is adjourned until quarter of 2, at which time we shall hear several other witnesses, following which we shall invite any of you who may wish to testify to do so. May I say if you have an opportunity to do so, would you please advise Mr. Ellsworth, the gentleman seated at my right, and who is the special consultant to our subcommittee, that you would like to do so.

The meeting is adjourned.

(Whereupon, at 12:20 p.m., the hearing in the above-entitled matter was recessed until 1:45 p.m., same day.)

AFTERNOON SESSION

Mr. BRADEMAS. Will the committee please come to order. We will resume our hearing.

May I say for the benefit of those of you who were not able to be with us this morning that this meeting today is a hearing of the General Subcommittee on Education of the Committee on Education and Labor of the House of Representatives.

The particular legislation that we have been giving primary attention to today proposes the establishment of a Federal commission to deal with problems of the aged and aging. We have had a number of comments on both sides of this particular bill. We have also had comments on other problems in the field of the aged and aging. We have a number of witnesses scheduled this afternoon as I indicated earlier. We shall hear these witnesses and then if there is time and we do believe there will be time, we shall try to have any comments that anyone in the room would like to make.

Our first witness this afternoon is Dr. Frank C. Toepp, if I pronounce that name correctly; is that correct, sir?

Dr. TOEPP. Yes, sir, it is.

Mr. BRADEMAS. Who is from South Bend and is the president of the Indiana State Podiatry Association. I might also say for the benefit of those of you who were not here with us this morning that my colleague on the left here is Congressman James G. O'Hara, of the Seventh District of Michigan, and the gentleman on my right is Mr. Ted Ellsworth, who is a consultant on special problems of the aging.

Dr. Toepp, we are pleased to have you with us, and you may proceed.

**STATEMENT OF DR. FRANK C. TOEPP, PRESIDENT, INDIANA STATE
PODIATRY ASSOCIATION**

Dr. TOEPP. Mr. Brademas, Mr. O'Hara. I am Frank C. Toepp, a practicing podiatrist from South Bend, Ind., and president of the Indiana State Podiatry Association.

My purpose in appearing before this subcommittee is to provide information which I hope will help you in your determination of how effective present programs are in meeting the needs of the aging and aged, especially as concerns the foot health problems peculiar to these groups.

As you know, there are now upward to 15 million persons over 65 years of age. By 1975, this number is expected to reach 21 million. The biggest health problems facing these people are foot disorders. This fact has been brought out at the White House Conference on Aging held from January 9 through 12, 1962, when it was estimated that 85 percent of the people aged 65 or over have foot disorders. The over-65 age group comprises over 40 percent of the patients seen in private podiatry practices, while in the podiatry school affiliated clinics, from one-half to two-thirds of the patients seen fall into this age bracket.

In those homes for the aged where a podiatry department has been established, the patient volume is generally greater than that of any of the other health departments. Podiatrists are in constant contact with the aged and have come to know their problems well. We are constantly reminded not only of their foot health problems, but also

their general health, financial, sociologic, and housing problems and the efforts made by private organizations and the different levels of government to find solutions or at least improve on the situation.

Podiatry as a profession within the medical sciences is responsible for that segment of medical health related to the care of the feet. This was substantiated over 20 years ago when the Judiciary Committee of the American Medical Association concluded that the field of foot health too often is neglected. General opinion seems to be that podiatry satisfies a gap in medical care that the medical profession has failed to fill. Dr. S. L. Andelman, commissioner of the Chicago Board of Health, has stated that podiatry is, "not just filling a gap; actually it is a vacuum."

Podiatry, then, has been accepted as the guardian of the Nation's foot health. It is in this position that I present testimony today on behalf of the podiatry profession in Indiana.

We podiatrists in Indiana are concerned with the apparent confusion which exists at the local and State levels where problems relating to the aging and aged are concerned. Local community agencies, private as well as governmental, have examined the problems and made some efforts to meet them. However, the approach seems to be piecemeal at best. Some efforts have been made in South Bend to deal with the sociologic problems and have resulted in a community social center and a few outing activities. This is of some value to those who are ambulatory and in good general health, but little has been done in this regard for those not in this health category. The housing situation has been approached in a generally unsatisfactory manner as indicated by public and even official dissatisfaction and resultant inaction. In the State of Indiana, old age assistance at the county level is at best confusing. Some of the services which are offered differ from county to county, leaving the impression that the basic needs of the aged are not the same in all counties. It is difficult to understand how this can be, especially as it relates to the health of the individual.

The medical advances of this century have provided all of us with a much longer span of life. The social and economic aspects of our society have not as yet caught up with the results of these medical advances which, in turn, have produced new challenges to adequate medical, social, and economic well-being of the aged. One of the challenges within the field of medicine is foot care. Older people must be able to move about. If poor foot health confines them to their bed or home, significant medical, social, economic, and psychological disadvantages result. They become family and/or public charges, but more important, they are unable to utilize their skills and interests, and find social contacts which will make the added years of their life a period of reward and happiness and avoid unnecessary social costs due to premature deterioration and disability.

The feet of the aged are prone to infection and ulceration due to weight-bearing trauma complicated by insufficient circulation and neurologic impairment. Often an aged person is unaware of the presence of an affliction involving his feet until it has developed into a serious and complicated condition, frequently necessitating partial or complete amputation. This can usually be averted if proper foot care is provided as has been proven in many large hospitals and peripheral vascular centers throughout the country. In every in-

stance, these centers report a considerable reduction in the number of amputations as a result of podiatry services having been instituted.

Another feature of far less importance but still worthy of consideration is the cost of operating homes for the aged. Podiatry care in these institutions can and does reduce operating costs, thereby effecting a savings for the taxpayers who pay for the care of public charges and for private individuals and insurance companies who also pay for these services.

Walter Alvarez, M.D., in an editorial in the May 1961 issue of *Geriatrics* brought this out very pointedly by stating that—

With good foot care, patients who might otherwise become or remain bedridden are kept ambulatory. And this is important because in 1950 the cost of a bedridden patient in a home for the aged was \$4.03 a day, while that of an ambulatory patient was only \$1.78 a day.

This represents considerable savings at the 1950 economic level. In 1950, a home for the aged in San Francisco reported that a bed patient ran \$8.50 a day; the semiambulatory ran \$6.12 a day, and ambulatory patient ran \$3.58 a day. I am sorry this is not in the report you have, but I will include it later.

The aged are in need of and deserving of foot care, but in many instances are not receiving it. In St. Joseph County in Indiana, the county welfare board has turned down the offer of podiatrists to treat welfare cases which includes old-age recipients. This is true of almost every other county in Indiana. A few, such as neighboring Elkhart County, do include podiatry services in their schedules. This same confusion exists in regard to foot health programs in private and public homes for the aged. Throughout Indiana, a few of these institutions do provide podiatry services along with other health services. The State has recognized the need and has provided for podiatry care in State financed institutions. However, on the county level, this service is generally absent although general medical and dental services are provided. The conclusion one might draw from this is either that the need for proper foot care exists in some areas and not in others, or that some areas are unwilling to recognize or accept the need.

Last year at the White House Conference on Aging, the general feeling was that foot diseases comprise a major health problem to the aging and aged. This being so, it was recommended that podiatry services be included as an essential part of the general health program of these persons, and that a program of foot health education among the aged is important.

In accordance with this, the Public Education Committee of the Indiana State Podiatry Association is in the process of setting up a program to contact all groups interested in the field of geriatrics as well as senior citizen groups to offer information on this important health aspect. Our speakers bureau will soon be in a position to fill requests of such groups for talks on foot health and prevention of foot disabilities.

Through our constant association with aged persons, we have concluded that present programs are not meeting the needs of these persons. Concern seems to be the principle form of decision. It is our feeling that some form of coordination is necessary to determine first of all what the needs are and then what can be done to fill them. The need is for a program rather than a great number of disassociated,

often overlapping and insufficient programs. To date in Indiana, some attention has been focused on the indigent. As I have stated previously, however, the programs are piecemeal, confusing, and often inadequate. A large segment of the aged are of low-income background but above the minimum to receive welfare assistance. Some help must be made available to them.

It is our feeling that there should be one well-planned, organized program consisting of various phases to deal with the various aspects of the dilemma faced by the aged. The States are primarily responsible for meeting and resolving the problems. But investigation into the problems peculiar to the aged can best be carried out by a Federal commission which can then aid the States in an advisory capacity and financially, if necessary, and act to coordinate the different phases of the program. Such action should serve to avoid further confusion and inadequacies which seem to be primarily due to lack of research and coordination.

If there are any questions you would care to ask, I will try to answer them. If not, I will send the answers to you at a later date, and I have other copies of these, if anybody is interested in having them, I will be glad to pass them out.

Mr. BRADEMAs. Thank you, Dr. Toepp.

Congressman O'Hara, have you any questions?

Mr. O'HARA. I want to thank Dr. Toepp for bringing the is problem to our attention. I am sure that it's true and that it's a disabling factor that older persons are inclined to have more foot difficulty than our younger citizens, just as they are inclined to have more difficulty in certain other health problems. I think that if we are going to look into this whole question of the welfare of the older citizen, we cannot neglect the importance of them being able to get around.

In what way do you operate with the physician and surgeon; in other words, what sort of working relationship exists between podiatrists and physicians and surgeons?

Dr. TOEPP. Generally, the physician, if he has a patient that has a foot disability which he feels could best be cared for by a podiatrist, he will refer that patient to a podiatrist. In some instances, this is done freely; in other instances, there is not quite as much cooperation as would be liked.

Mr. O'HARA. With regard to the podiatrist, if they see a condition they feel they are unable to cope with, I assume they refer it—

Dr. TOEPP. This is referred to the physician, the family physician, if there is one. If there isn't a family physician, then we suggest the patient pick one and then we will refer them to that physician.

Mr. O'HARA. Thank you very much.

Mr. BRADEMAs. I would like to ask you this question, sir. You say in your statement that in this county, the county welfare board has turned down the offer of podiatrists to treat welfare cases which includes old-age recipients.

I confess this is a field in which I don't have any great experience, and that is news to me. Why is that?

Dr. TOEPP. Well, we were not given an answer. We were just told no. We appeared in about 1953, I believe, and again we have felt them out on several occasions, the commissioners on several occasions since then, but the answer has always been that the answer will probably be "No." There is no sense in trying to get something that

you are not going to get, so don't waste your time. So we have been in a position where we can do nothing ourselves. We treat welfare patients in our offices and do not charge them; however, we do feel that since there is money set aside for this purpose and since the physician and the dentist is being paid a small sum for his services in the treatment of these patients, that the podiatrist should, in turn, be recompensed.

Mr. BRADEMAS. I notice in the December-January, 1962, issue of the journal, *Mature Living*, which is the newsletter of the Indiana State Commission on the Aging and Aged, there is to be found a report by Dr. George E. Davis, the distinguished chairman of the Indiana State Commission of the Aged, who appeared before us this morning, on a tour he made of facilities in Scandinavia for the elderly. Dr. Davis says in his report that apparently considerable emphasis is placed on the importance of the care of the feet in all of the Scandinavian countries.

Is the problem that you have been discussing here today one that is, you feel, neglected in the United States as a whole?

Dr. TOEPP. Yes; very definitely neglected in the United States. Now, I can speak better for Indiana than the whole United States, but in speaking with podiatrists and officials from State associations throughout the country, the general consensus of opinion is that foot care is about the last thing that anybody thinks about. Perhaps that is our fault, to some extent; perhaps we haven't been as informative to the public as we should be, I don't know, but nevertheless the situation does exist and we are at least now going to try and straighten it out.

Mr. BRADEMAS. Are podiatrists paid in most States for the welfare work they do; or do you know?

Dr. TOEPP. I couldn't say for most States. I know in Indiana there are very, very few counties that have accepted podiatry service on their schedule.

Mr. BRADEMAS. Thank you very much, Dr. Toepp, for coming today. We appreciate very much your testimony.

Dr. TOEPP. Thank you.

Mr. BRADEMAS. Mr. Raymond W. Pasnick. Mr. Pasnick, would you be good enough to proceed.

STATEMENT OF RAYMOND W. PASNICK, MIDWEST DIRECTOR OF PUBLIC RELATIONS AND EDUCATION, UNITED STEELWORKERS OF AMERICA, AND PUBLIC MEMBER, BOARD OF EDUCATION, CITY OF CHICAGO

Mr. PASNICK. Mr. Chairman, members of the committee, my name is Raymond W. Pasnick. I am Midwest director of public relations and education for the United Steelworkers of America and a public member of the Board of Education, city of Chicago.

As a representative of my organization, in charge of labor education for the Midwest region, I have participated in several training programs for the aged and aging, primarily in preparing our members for retirement.

In conjunction with the University of Chicago, my organization was instrumental in outlining course material designed to help those

who are about to retire with problems they might anticipate in making the change from an active to an inactive life after reaching retirement age. These materials, once developed, were later used in a series of pilot education programs in which our members and their wives participated. They embraced the entire gamut of foreseeable problems of the aged, including health, income, housing, leisure time activities, psychological effects, and so forth. The object was to assist these prospective pensioners to make a smoother adjustment when the inevitable day of retirement arrived.

As one who has served on the Chicago Board of Education for almost 6 years, I have been deeply concerned about the lack of programs for the aged and aging in our public school system. While our school system in Chicago, like those in many other urban centers, does attempt to meet the needs of many adult groups, we at present have little, if anything, that could help the growing number of citizens who are in desperate need of guidance, training, and education which is geared specifically to the problems of the aged and aging. This void, in my judgment, can be traced primarily to the lack of funds which such programs would require. Naturally, we, as a board of education, must give first priority in the expenditure of available school funds to the operation of our schools for children. Auxiliary programs for adults must, of necessity, be subsidized either through special State aid or Federal subsidy.

It is out of this experience that I have acquired a deep interest in the problems of the aged and aging. For this reason, I wish to discuss with this subcommittee the question of what the Federal Government might do in an effort to enact legislation which would be of direct benefit to a large and growing segment of our population which is in desperate need of assistance.

Our organization, the United Steelworkers of America, has long been on record in favor of two principal pieces of legislation which will do much to alleviate the plight of the aged and aging. These two proposed laws concern, No. 1, the need for health care for retirees under social security; and No. 2, the need for more public housing, especially of the type that would accommodate those older citizens whose income is limited.

Our reasons for a health and medical care program under social security have been given before other committees of the Congress, but let me restate them in brief: The only reasonable method to obtain universal coverage of aged retirees and to spread the risk over the greatest number of people at the lowest possible cost is through social security.

Under the program we advocate, all aged retired persons should be eligible for benefits under the program; benefits for those not previously covered by social security should be financed out of general revenues. Eligibility for benefits should not be based on means or income tests and should not be subject to deductible clauses or annual fees after retirement. Our people should have the opportunity to prepay their medical costs prior to retirement.

With respect to the housing needs for the aged, it should be noted that Steelworker pensioners are better off financially than many of the Nation's retired population because of their combined private pensions and social security benefits. Yet, many Steelworker retirees

cannot afford to live in rental units which are available through the private housing builders. Obviously, if private building cannot supply the demands for housing our aged people at reasonable rates they can afford, more public housing is needed.

Additionally, there is urgent need for the proposed legislation that would establish a Federal agency to coordinate, encourage, and stimulate programs for the aged and aging. It's my feeling that creation of such an agency is long overdue. A larger and larger proportion of our citizens are joining the age 65 and over group. Three out of every five of these people, according to figures I have seen, have less than \$1,000 per year to live on. How we care for this important segment of our senior citizens represents a frightening challenge that only the Federal Government can begin to meet. Certainly it is clear that private enterprise, public charity, and the combined efforts of our social agencies have not been able to handle this growing challenge.

A Federal agency that can concentrate on the problems and needs of the aged and aging could do much to give our senior citizens new hope. Besides easing the problems of the older worker in our industrial society, it could be of great service to see that all who have need of help can enjoy their declining years as relatively happy, well-adjusted, well-housed people.

More importantly, such an agency could do much to initiate educational programs for retired persons and fill a gap that is sorely needed for this category of citizen. Many retirees would welcome an opportunity to participate in meaningful part-time work in their communities, but there is presently little chance of this. A Federal program of recruitment, training, and placement of elderly Americans in community service activities would give them the opportunity to utilize their time, talents, and energy.

The public school systems of our Nation are logical starting points for this type of adult educational programs. But they cannot undertake this step without specific leadership, guidance, and financial assistance of the kind that the proposed Federal agency could offer.

Over and beyond that, with appropriate help from the Federal Government, our public schools could undertake a comprehensive effort to prepare the aging for the necessary adjustments to retirement. Thus, a person 4 or 5 years away from retirement could properly equip himself and his family for all the new problems he must inevitably face, including reduced income maintenance, utilization of free time, health and medical needs, housing requirements, and the development of fresh interests in life itself.

Looking beyond the immediate needs of our aged groups, a Federal agency in this field could explore solutions to problems that may develop 10 years hence when the number of retirees increases and when the challenges are likely to become even more intense.

These are broad reasons, I realize, for wanting a Federal agency for the aged and aging. Only time prevents me from going into specific detail on the many ways that such a governmental function would prove to be invaluable in the best interests of our entire Nation. In summary, let me just say that the need is definite and the cost, in terms of what it would do to improve our society, is insignificant. Can we afford not to do it?

Thank you for permitting me to make this statement.

Mr. BRADEMAs. Thank you, Mr. Pasnick. Mr. O'Hara?

Mr. O'HARA. Mr. Pasnick, your testimony with regard to the creation of a Federal agency that would have certain responsibilities with regard to the aged and programs of the Federal Government dealing with the aged does not go into the question of just how this Federal office should be set up structurally, whether as a part of the Department of Health, Education, and Welfare, independent agency, or independent commission; would it be safe for me to assume that your attitude is somewhat the same as mine, and that is that you just want it set up so that it's effective, and you aren't sold on either having it done in one way or another?

Mr. PASNICK. This is essentially correct. I think the structure is less important than the effectiveness of the operation.

Mr. O'HARA. As you know, a number of the proposals involved, such as the Fogarty-McNamara proposal, has a system of grants to local, public, and private nonprofit groups for research, personnel training, and demonstration projects. Do you feel that this part of these proposals would assist many different groups that are involved with the aged in improving their activities?

Mr. PASNICK. I think they very likely would, but over and beyond that, I would suggest that if some central governmental agency would do more in the way of coordinating and stimulating the kind of need that is—the kind of aid that is needed to solve these problems, it would be a much more effective way of operating.

Mr. BRADEMAs. I notice in your statement, Mr. Pasnick, that you say although you specify you are making a statement with respect to the housing needs for the aged, that it should be noted that steelworker pensioners are better off financially than many of the Nation's retired population because of their combined private pensions and social security benefits. In your statement, however, you say elsewhere that you support the provision of health insurance through the social security program. Are not the steelworkers who are on pension able, because of this combined private pension and social security system, are they not able to pay for this medical care, their own medical care needs?

Mr. PASNICK. No, they are not. The problem in that respect is the same as it is for the housing. In spite of the fact they have the company pension and social security benefit, they are unable to meet the average going prices for rental units that are available on the market today. This is true very much to the extent of medical assistance that is needed by the aged, including our own members who also receive both a company pension and a social security benefit, retirement benefit. They are still, whenever confronted with either long-term illnesses or catastrophic illness of some kind or even normal sickness of various kinds, are in real desperate circumstances to overcome those particular problems, so we, the Steelworkers, feel very definitely that both the housing problem and medical problem have got to be—some more attention has got to be paid to both these problems.

Mr. BRADEMAs. Is there any kind of provision in your Steelworker private pension or company pension program for health insurance?

Mr. PASNICK. Yes, there is, but it is limited. The life insurance, for example, is reduced to a bare minimum. It continues on indefinitely after the person is retired, but it's a very small amount. As far as the health insurance and hospitalization benefits are concerned,

those who once leave the employ of their particular company who have been previously covered may continue that particular program, but at private expense and in many cases this is an extreme hardship for the individual.

MR. BRADEMÁS. Thank you very much, Mr. Pasnick. We appreciate your coming over here to testify.

Is Dr. Fred Whisler here?

STATEMENT OF DR. FREDERICK M. WHISLER, WABASH, IND.

DR. WHISLER. I am Dr. Whisler from Wabash, Ind. I hope I speak loudly enough that all of you may hear. My message will be brief. I bring you greetings from Congressman Roush of the Fifth District—

MR. BRADEMÁS. Thank you, sir.

DR. WHISLER (continuing). Who I have tremendous respect for, and he has given me a heck of a job as being chairman for the aged for our district, and, if I may, I would talk principally from that standpoint.

I am just an overgrown boy practicing medicine out in a very small town about 10,000 or 12,000 people. It's unfortunate that there are considerable number of young doctors who all that they can think about at the present time is to make money so they can pay for their new pool or their new boat or whatever it is that they have purchased at, well, maybe through the finance company, I don't know, but it occurs to me that the younger doctors are not viewing this situation of the aged and aging in the proper fashion. I believe that I am correct in saying that this bill has not any provision in it at all for the payment of a doctor. Maybe that is the reason they don't like the bill, but for we who have been through it when times were very, very rough and they have been on several occasions during my practice, we managed to get by somehow. I can remember the time when I would go out on a baby case and if I got \$5 I was lucky. And a lot of times I didn't even get that. I had to take it out in produce or something else, so it occurs to me, as I said before, that the organization against this care of the aged and aging is a problem of the young people as well as the older ones.

Now the younger ones are busy taking care of their obligations and their growing families and, consequently, they have no time or no money to lavish on their parents or grandparents, but I was in Indianapolis last Saturday and Sunday at a Blue Cross-Blue Shield meeting, and a gentleman from Detroit associated with management and labor expressed himself in almost these words, that the social security approach was the proper approach and probably would end up in that fashion. He was firmly convinced that the social security approach for payment of this care would end up in that fashion.

I was much surprised to hear him say that in view of the fact he was a guest of Blue Cross and Blue Shield, so I came today not prepared because I did not realize what the subject matter actually was except over the long distance telephone, and I did not have time to sit down and write it up, for which I am very sorry. If I have overlooked anything, I would be glad to try to answer any questions.

MR. BRADEMÁS. Thank you very much, Dr. Whisler.

Mr. O'Hara?

Mr. O'HARA. Dr. Whisler, it seems to me when we talk about financing medical care and when the proposal which you mentioned involves financing of certain hospital and diagnostic nursing home expenses through the social security system under the terms of which a person during his working years pays in and then he receives the benefits after he retires, when you compare that approach to a general welfare type of approach where the public is taxed through the usual tax system and then benefits are doled out to those in dire need, that probably the social security approach involves more self-reliance, more individual dignity and less of the so-called welfare state than does the competing approach.

What would be your thoughts on that?

Dr. WHISLER. Well, it occurs to me, sir, that individuals definitely can maintain their dignity through social security while they can't through the welfare channels. And they are also helping to pay their own way.

Mr. O'HARA. Doctor, would you feel that your ability to prescribe the course of treatment or the course of medication for your patients that you felt in your own private judgment was best for them would be, in any way, limited or circumscribed if we had a program under the social security system which assisted social security beneficiaries in paying the expenses of their illnesses?

Dr. WHISLER. I don't believe it would influence my pocketbook too much, sir. I am of the opinion that most everybody has a little money, but they don't have a lot of money to pay exorbitant hospital bills and care. I am also of the opinion that the bill, worded the way that it is, would help to keep doctors from filling up the hospitals unnecessarily because they wouldn't be getting paid for it. I think it would be a great boon to the ability to find beds in the hospital when you really needed them.

Mr. O'HARA. Would the fact that a person's hospital bill was being taken care of in part by the Social Security Administration through a program of the type that would be set up through the King-Anderson bill prevent you, in any way, from giving your patients the best treatment you know how to give them?

Dr. WHISLER. I don't see how it could influence me. If I am capable and competent to do it, I am sure that we will get along fine.

Mr. O'HARA. Doctor, I know that you know that we are not just interested in medical problems here today. I would gather that you have a very wide range of contact with older citizens in your practice.

Dr. WHISLER. I think so.

Mr. O'HARA. To briefly recapitulate some of the testimony we heard here today, we were told that there are a number of areas of life in which the aged perhaps have the greatest problems. Leading among these areas was the problem of medical care and financing medical care, but there was also considerable discussion of the housing needs of older persons, of their income needs generally, of their need to take effective part in community services and community action, and a number of other fields.

I wonder if now, quite apart from your professional status and your knowledge of the medical aspects, if you might want to give us some of the viewpoint you have acquired over your years of experience in your own community with regard to the sort of matters in which we are deficient with regard to our handling of the problems of the aged.

Dr. WHISLER. Well, if I get what you are saying clearly, you know there are people that would rather live in a hovel than in a mansion, and I don't think we are going to influence either one of those particularly at all. I grant that there are many places that are definitely uninhabitable or unfit for human habitation, but they are still being used.

I had the pleasure of having five homes in Wabash declared unfit for human habitation, and it didn't take long for them to start tearing them down, so I believe that if the right approach is given as to housing, everybody should be adequately housed and comfortable, and that is my complete thought, housed and comfortable, not all the niceties perhaps, but then who does have them all.

Mr. BRADEMAs. Doctor, am I correct in my understanding that you are in the private practice of medicine?

Dr. WHISLER. Yes, sir.

Mr. BRADEMAs. The reason I ask that question is that I am sure that we are going to hear another point of view from other persons engaged in the private practice of medicine this afternoon. I hope so, since we want to get everybody's views on the record here today. That is one of the purposes of this congressional hearing; but judging from your statement, I take it that it can fairly be said that all physicians in the United States are not opposed to the provision of hospitalization and nursing home insurance through the social security system?

Dr. WHISLER. Well, I am sure that there are quite a few that are.

Mr. BRADEMAs. I am sure of that, too.

Dr. WHISLER. Yes, sir, but I will swear I don't know why. I can't understand why.

Mr. BRADEMAs. I know that many physicians feel very deeply that the passage of this legislation would mean we would have socialized medicine in this country. What is your reaction to that?

Dr. WHISLER. My opinion is we already have it.

Mr. BRADEMAs. In what respect?

Dr. WHISLER. It's been growing on us ever since I graduated from medical school, and every year I hear more and more and more about it. And I hear more from the American Medical Association every time I write them a letter and want to find out something, they send me reams of paper like this, but not a darned answer in it.

Mr. BRADEMAs. Why do you feel that private insurance plans, I take it you do feel this way, or you would not be supporting the King-Anderson bill, why do you feel private insurance plans are inadequate to do the job?

Dr. WHISLER. Well, I wouldn't say they are inadequate; in a fashion, yes, that is true. The average person that reaches the age of 60 or 65 or 70, whatever it may be, about all they have to live on is their social security. I mean the ones we are talking about.

Mr. BRADEMAs. Yes, sir.

Dr. WHISLER. There are others who have other sources of income and we are not interested in those people. We are interested in that low bracket group that the man and wife together barely can make \$1,800, \$2,000. Well, I don't see how they can pay very much of a hospital bill if they would happen to fall and break their leg or thigh or arm or whatever it might be. I don't see how they could afford to pay it, and if it were paid, it would have to come through the welfare

or through the trustee and neither one of which seem too anxious to want to pay those bills. You would have to fight like the devil with them to get an adjudication of it.

Mr. BRADEMAS. Thank you very much, Dr. Whisler, for having come today. We are very grateful to you for having taken the time.

Our next witness is Dr. Milton Bankoff.

STATEMENT OF DR. MILTON BANKOFF, MICHIGAN CITY, IND.

Dr. BANKOFF. Permit me to identify myself. My name is Milton Lewis Bankoff. I am a physician, residing at 307 Kenwood Place, Michigan City, Ind., and have been practicing in Michigan City, La Porte County, Ind., for the past 18 years. I received my medical training at New York University College of Medicine and had internships at Bellevue Hospital and U.S. Marine Hospital in New York. I am in general practice with special interest in anesthesia and geriatrics.

I have been president of the La Porte County Medical Society in 1959, 1960, and at present am a member of the board of censors of the La Porte County Medical Society. At the present time, and for the past 5 years, I have been a member of the Michigan City Board of Health. I am also a member of the Indiana State Medical Association, the American Medical Association, the New York Academy of Science, the American Society of Anesthesiologists, the American Geriatrics Society, and other medical groups.

My practice is with an eight-man private medical group, Clinic Associates, with offices at Doctors Hospital in Michigan City.

I am happy to present my views today on the bill H.R. 10014 for the establishment of a U.S. Commission on Aging and to recommend that the committee cast a favorable vote for bringing it to the floor of the House.

Speaking as a citizen and as a physician, I believe there is a real need both in our State and in our community for an adequate coordinating organization which would stimulate the development of groups interested in the problems of the aged. I have studied the bill and feel that it is designed to fill a very definite void which now exists in the field of care of the aging. Although I recommend the entire bill, I will confine my remarks to those aspects of H.R. 10014 concerning the areas of mental and physical health in which I am particularly interested.

Here in Indiana, such a law, if properly implemented, would provide a tremendous boost in official interest in the problems of the aged and stimulate coordinating efforts on a local level. To become more specific, in our Michigan City area, I feel that at the present time we have many agencies interested in various aspects of the problem. They could benefit greatly by an overall coordinating approach.

For example, at the present time we are working on an urban renewal program which will completely reshape much of our downtown community. At the same time, there are efforts being made to procure adequate low cost rental housing for the aged, including work by non-profit organizations, community groups, and church organizations. There is an active program designed to stimulate expansion of recreational facilities, specifically earmarked for the aged. We urgently need increased and improved skilled nursing home facilities. All

these facilities at the present time are almost completely lacking in our area.

If the State of Indiana were to set up a coordinating commission as authorized by the bill, such a commission could very properly provide for consultations with various State and local agencies to set up a master program and fit each aspect of the needs of the aged into the development of such a program. It is easy to see how increased efficiency and better utilization of tax dollars would be obtained by such an approach.

Those people in Michigan City with whom I have discussed the concept of a commission for the aging are heartily in accord with the idea and applaud the nature, purpose, and scope of the bill.

In conjunction with hearings on the bill for the establishment of a commission on aging, I feel it is appropriate for me to ask the indulgence of the subcommittee so that I may make a few remarks concerning a related subject, House bill 4222—the King-Anderson bill.

This bill, or some modification of it, represents, in my opinion, the best way to take care of the hospital needs for care of the aged. I would earnestly recommend its approval and passage. Medically speaking, mine is a minority voice, however. The vast majority of physicians in the Third Congressional District are completely in accord with the position already taken by the American Medical Association in opposition to this bill. However, only a small proportion of physicians have ever read the bill or know exactly what its provisions contain. Even a smaller proportion have read the testimony before the House Ways and Means Committee which has appeared in the Congressional Record in recent months. If they were to analyze carefully the statements made as expressed in the Congressional Record, I feel that they would be obliged to agree with me.

A long list of progressive legislative steps over the past 25 years have been denounced and blocked wherever possible by organized medicine—all with the most honorable and idealistic of motives, that of preserving our freedom and our liberty. Such steps include Blue Cross, unemployment insurance, and the Red Cross blood bank, and other similar programs. All were opposed originally by the ranks of organized medicine.

I hasten to add that the American Medical Association is not a bureaucratic lobby which pushes its will on the doctor. It truly represents the opinion of the average physician, at least as far as I know it after 20 years in the profession. The average doctor is dedicated, sincere, hard working, but unalterably conservative in his political approach.

Most physicians ignore the fact that only hospital and not medical care is included in H.R. 4222. They also ignore the fact that the vast majority of their patients want and need better protection for the illnesses and infirmities of old age than is now available by any private agency, even including the excellent Blue Cross-Blue Shield coverage. They ignore the fact that, all through the King-Anderson bill, strictest care has been taken to insure the highest quality of hospital and nursing home care by using the standards of accreditation set up by the doctors themselves through their membership in the Joint Commission on Accreditation.

Therefore, I feel that the King-Anderson bill offers the best hope for comprehensive health coverage. Social security offers the most equitable way to finance health insurance for the aged despite many attractive alternatives now being offered. High standards of health and hospital practice will be required to participate in benefits. The physician would not lose control of the patient. There would be no disturbance of the doctor-patient relationship. A permanent program is essential to the solution of the problem of financing the health care of the aged. Voluntary health insurance, private efforts, and present-day laws will not do the job that needs doing. The bill would not in any way hamper the efforts of the medical profession or private agencies. Rather, it would implement and supplement their fine job.

There are many other bills and alternatives that have been or will be offered for medical care for the aged. The Commission on Aging would have, I presume, as one of its responsibilities the purpose of developing national policy concerning the health care of our senior citizens. I sincerely believe that objective study of all alternatives by such a commission would lead to the conclusion mentioned above, that the King-Anderson bill offers the most efficient, effective health coverage for the greatest number of our aged at the lowest cost to the Government and to the patient.

Mr. BRADEMAS. Thank you very much, Dr. Bankoff.

Mr. O'Hara?

Mr. O'HARA. Dr. Bankoff, I wish to commend you for a very thoughtful and, I believe, very fair statement. I can't find a word of an inflammatory nature in here, and I wish that all the discussion of the problems of the aged, and particularly the medical problems of the aged, were in the same tone that yours has been. I am afraid I am inclined to agree with you in your analysis of the sentiment of the vast majority of physicians.

I am somewhat inclined to doubt that the position of the AMA with regard to the question of whether or not medical doctors shall participate themselves in social security, accurately reflects the sentiment among doctors as of the moment, but I think that clearly their position with regard to King-Anderson, whatever the reasons might be, does reflect the sentiment of the majority of doctors.

Dr. BANKOFF. I should add my analogy of physicians is based only on physicians in the Third Congressional District as I know them. I know the doctors in La Porte County very well. I know the doctors in this county only slightly, but in the course of various activities, both medical and nonmedical over the past 18 years, I have gotten to know the political feelings of these men because I have been somewhat interested in politics on a purely amateur and part-time basis, and I have had an opportunity to contact these doctors. I am very certain that in the Third Congressional District that the average doctor is just as I described him here.

Mr. O'HARA. That has been my experience in talking to doctors in my own area of the State of Michigan, and I don't imagine that it's much different in other places.

Well, I am not going to keep you, you have made a very fine statement, and I know that Congressman Brademas who represents the Third District probably has some questions, so rather than take any more of your time, Mr. Chairman?

Mr. BRADEMAS. I, too, want to thank you, Dr. Bankoff, for this very fine statement, and also to express my own appreciation in the same fashion as did Congressman O'Hara for the moderate, reasonable way in which you have set forth your views. I fear that if one could look at some of the mail that some of us in Congress receive on this issue, it would be very distressing indeed, because one would think that some of us, even before we voted on this legislation, are prepared to plunge the Nation into communism or something of that sort, when the Gallup polls in any event seem to indicate that there is very strong support for providing hospital and health insurance, hospital and nursing home insurance through social security.

As I indicated earlier when I think you were not here, Dr. Bankoff, there are many outstanding leaders in our Nation, both Democrats and Republicans, who favor in general the kind of social security approach you have recommended today. One of the charges commonly made against the King-Anderson bill or similar bills is that they would mean socialized medicine. Yet, in my understanding of this legislation, there is no provision at all for the Federal Government to furnish any medical services.

Dr. BANKOFF. No. As a matter of fact, many of the bills that have previously been offered went much further in terms of medical care that was promised. My understanding was the reason this bill left out medical coverage was because the people who proposed the legislation felt this was the least controversial of any bill that could probably do any real good, and this is not the whole answer. I should have added in my statement perhaps that I feel this will not do away with the need for Kerr-Mills, the present law which is on the book but which has not been utilized at all so far as I can tell in Indiana, and it doesn't do away with the need for trustee care, and so forth. This is a bill that will help the middle group which can afford to pay the \$90 deductible for care and which gives care that is greater than any now offered by any of the privately operated actuarial plans. I am sure you heard the statement, the bill for the first illness comes out of savings, the second out of the house, and the third illness they go on the county. This, unfortunately, is the usual course of event, and to me the most important part of this is that it is for the vast majority of self-respecting, hard-working individuals who need the insurance, so that they can get care if they become incapacitated, under a plan that will not require them to claim they are paupers or ask for aid or handouts or anything like that.

Mr. BRADEMAS. Why, in your judgment, cannot private health insurance programs adequately meet the needs of older people for health care?

Dr. BANKOFF. Well, they can in terms of short-term illness. The best available plans are very good for short-term illness. Blue Cross, Blue Shield is probably the best available, and they have improved their plan a great deal recently. But for long-term illness which is a real problem in the aged, a stroke, for example, is very common in getting old, the long-term hospital and skilled nursing home care can't be paid for through present Blue Cross programs without increasing the overall costs to everyone to an almost impossible height. I believe the basic reason for it is they don't have a wide enough base to work with. With a social security program, actually

it would have the same base as any other part of a social security program, and we would be paying for our old age in our early years, in our working life, you might say. That is why I feel social security offers the best way to handle it on a sound financial basis.

Mr. BRADEMAs. Doctor, another charge commonly brought against this particular approach is that it would be compulsory. Of course as we all know at this time of the year, income taxes are compulsory and so is the social security program for most working Americans. Do I assume then that doctors oppose extending the social security program to cover hospitalization and nursing home insurance on the grounds that to do so would be compulsory? They oppose the social security system itself because it is compulsory.

Dr. BANKOFF. Yes; I think that is a very fair statement. I think the average physician that opposes social security is closer to the economic philosophy of Adam Smith than he cares to realize. He may be up to date on modern conditions, but in terms of economic living and things that go with what makes our country operate, he is going resolutely backward, and he just doesn't realize that our society is not built that way, and is not about to turn around and go backward, and he is being dragged willy-nilly into the 20th century whether he likes it or not. I will venture to make a prediction that this bill, if passed, will be in operation and if in operation, it will work real well, and in 10 years there won't be a person in the medical profession that would want to go back to the way we are now. This is a personal feeling.

Mr. BRADEMAs. I might say I have in front of me a copy of *Time* magazine, a sheet from it dated April 13, 1962, in which there is a story which states that our distinguished colleague, Representative William Miller of New York, who is also the chairman of the Republican National Committee, has just proposed a medical care bill for his party to support in Congress, on the supposition apparently that some such legislation is indeed necessary because there is apparently a need for the program.

Dr. BANKOFF. I read that same article and the other material that appeared in the press. Of course, one of the things in this bill that has been proposed is it goes further than the King-Anderson bill in that this provides for medical care and the King-Anderson does not provide for medical care. The Nixon program offered by the Republican Party prior to the last election also provided for medical care, so in one way the Republicans are trying to do the Democrats one better, you might say, by proposing a more advanced plan in some respects. However, I still feel the basic differences between this plan that I am discussing and the plan proposed, so far as I am able to read it, is that only a plan that offers a social security approach gives you the actual sound basis for really long-term financial assistance to the individuals involved without getting the Government into it. In other words, any of these plans proposed either represents a handout by the Government through lowering taxes or some other way, or provides for a direct grant by the Government, and that is fine for the people that really need it, but I think the vast majority of people can be handled very well through some of the implementation of social security.

Mr. BRADEMAs. I just have one other question, and it may be an awkward one, but I am rather curious. Do physicians who take the

position you do, and obviously there are a number in the United States, a number of them met with President Kennedy a few days ago, find themselves in hot water with their colleagues?

Dr. BANKOFF. That is always a difficult question to answer. Actually, my personal feelings about the practice of medicine and the way in which the care of people in general should be handled have been known to my colleagues in the medical profession for many years, and my first official act when I started in practice and went to my first Federal meeting many years ago back in La Porte, this was the La Porte County Medical Society, there was an organization called the American Association of Physicians & Surgeons, and this was an organization which is still in existence, but the prime purpose of that meeting was the Wagdon-Murray-Dingle bill, if that was passed, I think that was the name of it, the physicians would go on strike. They agreed not to serve, if selected; not to serve, if they were elected. This was going like wildfire through the Midwest during that time.

My first official act when they asked for unanimous vote to support this type of thing, we all agree, of course, and then I was just a little pipsqueak fresh out of the East, and I had to raise my hand and say, sir, I would like to cast a negative vote, so that marked me in big letters, N.G.

It never interfered with my practice. I only point this out that many years ago people knew how I felt. I have since been elected president. I am active and have many friends, and I do not feel I have been asked to contribute, and I do contribute, to the Indiana Society for Health Organization Political Education, which is the medical organization, nonpartisan group, to present medicine's point of view, and I contribute to it mainly because I feel there are some good things even though I vociferously disagree with its major premise concerning the King-Anderson bill of the legislation, but in Michigan City, La Porte County, there have never been any retributions, incriminations to make me, although in other communities there have been pressures brought to bear on physicians who feel as I do.

Mr. BRADEMAS. I think it speaks very well for the physicians of La Porte County that in spite of their probably generally disagreeing with you on these various matters, they should have elected you president of the La Porte County Medical Society, and I think it speaks very well indeed for you that you should be willing to come to our committee today and give us the benefit of your thinking even though, as you have indicated, you may be in a minority in your profession. We are most grateful for your coming today.

Dr. BANKOFF. I am glad you asked me. Thank you.

Mr. BRADEMAS. Dr. Alfred Rosenbloom. Dr. Rosenbloom, if you would be kind enough to identify yourself and your distinguished colleague, I would be grateful.

Dr. ROSENBLOOM. I am Dr. Alfred Rosenbloom, dean of the Illinois College of Optometry, and representing the American Optometric Association. It is my pleasure to present Dr. Kane of South Bend, Ind.

Mr. BRADEMAS. I am glad to have you both with us.

STATEMENT OF DR. E. J. KANE, PAST PRESIDENT, INDIANA OPTOMETRIC ASSOCIATION

Dr. KANE. I am Dr. E. J. Kane of South Bend, and I am a past president of the Indiana Optometric Association. I am here to offer the assistance of the Indiana Optometric Association and its members to this committee in their large task for the aged.

We have a committee that has been active for several years both here and, I think, it's throughout the country we have the same thing.

Dr. Rosenbloom will make the principal statement, and I want to say just this one thing: no doubt your attention has been called to a book entitled, "Vision of the Aging Patients." This was published by the Chilton Co., and was edited by Monroe Hirsch, Ph. D., who testified before your committee on a previous occasion. Also a collaborator on that book was Ralph E. Wick, who was a former chairman of the Indiana Optometrics Committee on vision care for the aging. He still continues as a member of that committee. Two other contributors of the book appeared before your committee; namely, Meredith Morgan, Ph. D., dean of the College of Optometry, University of California; and Alfred A. Rosenbloom, master of arts, dean of the Illinois College of Optometry, who is here with me this afternoon. And then there were numerous other contributors to that book, including Dr. Henry Hofsteter who is the director of the Optometry School at Indiana University.

The compilation deals with a number of things relating to the vision of the aged, and the corrective means for caring for particularly subnormal vision patients. Dr. Rosenbloom is an authority in that particular field, in the subnormal vision field. This work is one of the newest things in the field, and I think it should be called to the attention of your committee. I want to present, this afternoon, to you, Dr. Alfred A. Rosenbloom of Chicago, who will make the principal statement for optometry. He was a graduate of the Illinois College of Optometry in 1948. Since then he has been on the faculty of that school, and is now the dean of that school, and has been so since 1956. He is currently completing his requirements for his Ph. D. degree at the University of Chicago, in their department of education. For the past 7 years, he has served as optometric consultant to the Chicago Lighthouse for the Blind. His appearance today is on behalf of the Council on Education, American Optometric Association, and I want to present to the committee now, Dr. Alfred Rosenbloom.

STATEMENT OF DR. ALFRED A. ROSENBLOOM, DEAN, ILLINOIS COLLEGE OF OPTOMETRY

Dr. ROSENBLOOM. Thank you, Dr. Kane. Congressman Brademas, Congressman O'Hara, I understand that your committee is undertaking a most important and challenging assignment, namely, to determine the best way for the Federal Government to assist in promoting the welfare of our elder citizens. While I realize that there are various systems through which the National Government functions, such as cabinet post, independent agencies, and the like; it seems to me when it comes to the vision problem of our older citizens, the important thing is to make certain first the services of optometrists

are made available to the beneficiaries of the program who wish to utilize them, and, secondly, that the optometric profession is given a voice in formulating the programs and in supervising their execution.

At the present time, notwithstanding all of the activities of the Department of Health, Education, and Welfare which pertain to vision, there is not a single optometrist on any one of their advisory councils. Moreover, the Department does not have a single optometric consultant, and there is no provision in the Public Health Service or its commissioned corps for the commissioning or employment of optometrists.

To my mind, this is a rather deplorable state of affairs, and, unfortunately, appears to be one which only Congress can correct. The vision programs of the Department are staffed with physicians. When Congress tells them they must cooperate with the optometric profession, they do so for the most part willingly and effectively. This has also been true in the armed services, the Veterans' Administration, and particularly in the aid-to-the-blind program under title 10 of the social security law. It has been my good fortune to play a small part in the aid-to-the-blind program serving as the optometric consultant for the past 7 years to the Chicago Lighthouse for the Blind. We have found that some 75 percent of almost 1,000 patients that we have examined in the past 10 years at this institution have been aided through the use of special types of lens design, telescopic lenses, microscopic lenses, in some cases contact lenses coupled with visual training. They have experienced a marked improvement in vision as a result of the provision of these subnormal vision aids. Many of these patients have not only become more independent, self-reliant, and happier, but, in many cases, economically self-sufficient.

I have brought along a few of these low-vision aids and would like to simply briefly mention them to you. This is a telescopic lens. Patients who can be benefited by these use them primarily for distance vision, watching television, attending a concert, a football game. These cannot be worn by the patient when he is mobile. They must be worn while he is seated.

Some of the aids of more recent design which, shall we say, are cosmetically more attractive, are microscopic lenses of this type. This is a lens that magnifies a thousand percent. It is known as a microscopic lens, and is worn very much like a bifocal. This particular lens is a double microscope. Both lenses mentioned here have been developed by an optometric scientist.

This is also a microscopic lens employing spherical surfaces. This also magnifies a thousand percent and can be worn very much like a conventional optic lens. We have worked with small segment telescopes such as this which can be mounted in the upper portion of a carrier lens and worn again for many various kinds of activities.

We have worked with different designs of contact lenses, and I simply mention this for the record, that it has been during the past decade that optometric scientists have pioneered in the development of many of these aids, and we find a larger number of optometrists incorporating these services as part of their professional practice. An important advantage to the beneficiaries of the aid to the blind program is the fact that there are almost four times as many optometrists as there are orthomologists. By the nature of their geo-

graphic distribution, optometrists are to be found in almost constant ratio with the population from towns of 2,500 to the largest metropolitan areas. This means that the optometrist himself is the key to the availability of vision care services for an aging population. In my own State of Illinois, optometrists are certified by the Illinois Public Aid Commission to render vision care services to indigent older patients. While our population increase effects all age groups, the greatest increase, as you know, is in the group over 50, the vast majority of whom are in need of optometric services to enable them to contribute to our economy, to enjoy the well-earned rewards which should be theirs in their later years, and to enable them to be self-reliable useful citizens.

Optometrists' interests and concern for the older citizen is clearly evident by the recent publication of the Optometric Symposium "Vision of the Aging Patient" referred to by Dr. Kane. This speaker was privileged to serve as a contributing author to this authoritative volume which is regarded as one of optometry's finest textbooks. Our national association has two committees whose responsibilities relate to the problems you have under consideration; namely, the Committee on Vision Aids to the Partially Blind, and the Committee on Vision Aids to the Aging. Virtually every person has a vision problem even though he may not be partially blind. Among the partially blind, there are many under the age which is accepted as dividing the elder citizens from our younger generation.

Earlier this year it was my privilege to testify before the House Committee on Interstate and Foreign Commerce in Washington, D.C., when it held hearings on H.R. 4999 and its companion bills. I have endeavored to avoid duplicating the information which I gave that committee as the hearings have been published, and are readily available to you. If I am correctly informed, the bill was amended by the committee to include some but not all of the recommendations which I submitted. My latest information is that earlier this week, the House Rules Committee held a hearing on this bill, but has not yet made a report. While it is not my intention to discuss this particular piece of legislation, I hope that when it is brought to the floor of the House, you will bear in mind that in order to provide the best possible vision care for all of our citizens, in and out of the golden circle, we must have the best possible facilities for our schools and colleges of optometry. We must have available funds to attract able, well-qualified students to these schools, to expand our faculty with members who can teach and carry on the vital research programs, and we must give financial assistance to these young men and women who desire optometric education in order to dedicate their lives to the visual welfare of their fellow citizens.

For the optometric profession, the issues and challenges posed by our aging population takes several forms, sociological, legal, educational and professional. Sociological in the varied influences contributed by the growing public health movements in America; legal in the necessity for legislation which specifically includes the optometrist as a vital member of the health care team; educational in its personal emphasis on the importance of professional study as an essential means of acquiring the techniques and understandings necessary for the proper care of the visual needs of older patients; and professional

in the recognition of the optometrist as a person uniquely qualified to provide visual care for our aging population.

It is my understanding that the American Optometric Association has not gone on record as favoring either the bill which would put the responsibility for our aging population into the Department of Health, Education, and Welfare, or the one which would provide for an independent commission. My personal view is that the plan set forth in H.R. 10014 is the better one. However, I cannot conclude without emphasizing the fact that any legislation enacted as a result of these hearings should make certain that optometric services are made available to those individuals who desire to use them and that the optometric profession be represented on the Advisory Council and the administrative agency charged with the duty of carrying out the plan formulated by our Congress.

Thank you very much, sir.

Mr. BRADEMAS. Thank you very much, Dr. Rosenbloom and Dr. Kane.

Mr. O'HARA. I might add I was privileged to hear some of the representatives of the optometric groups in earlier hearings on this subject, and I think the American association is to be complimented on the obvious concern and attention that they have given to the vision problems of older citizens.

Dr. ROSENBLROOM. Thank you, sir.

Mr. BRADEMAS. Dr. Rosenbloom, you spoke of the testimony which I believe you said you presented to the House Commerce Committee with respect to the bill that would provide funds for the construction of medical schools; is that correct? Did I understand you correctly?

Dr. ROSENBLROOM. Yes.

Mr. BRADEMAS. Are schools of optometry included in that legislation or are they excluded and that is your complaint?

Dr. ROSENBLROOM. Well, in the original design of the bill, Congressman Brademas, the H.R. 4999 included facility development grants in aid for medical schools, dental schools, schools of osteopathy, and public health. Optometry was not included in the original bill, and it was my purpose in going to Washington to present an amendment to the House Interstate and Foreign Commerce Committee which was presented by Congressman McDonald, of Massachusetts, in our behalf requesting our inclusion in this bill; and subsequent to this presentation, the committee did vote favorably to include the optometric amendment as part of H.R. 4999.

Mr. BRADEMAS. You are obviously very effective and persuasive. I am the author of that bill, also, I may say, and I had not been aware because I do not serve on that committee that your amendment had been adopted. I, too, have been most impressed by the obvious concern that you display about the problems of vision for older people.

I just have one other question. Why is it that optometrists have been excluded from these various advisory councils and staff positions in the Federal Government? I am not an expert on the politics of medicine, so I put the question to you bluntly.

Dr. ROSENBLROOM. Well, Dr. Kane, I would like to call on you for a statement in this connection.

Dr. KANE. Well, I think you have the problem that the overall direction of any medical program in Washington is under some kind of

medical authority. We are economically in competition with medicine in a certain sense, and they do not desire to give us any break whatsoever, and that is the reason we are not included in those originally.

Mr. BRADEMAS. I think that answers my question. I just have one other question. Dr. Rosenbloom, what about older people who do not meet public assistance eligibility requirements but who may need contact lens or may need vision aids because they have subnormal vision? How do they get taken care of? Do you have any suggestions as to how to meet their needs?

Dr. ROSENBLOOM. Well, in referring to the Chicago situation, I can say that our own college, the Illinois College of Optometry, which is the only optometric institution in the State of Illinois, does provide for subnormal vision and contact lens services as part of our clinical services, and we do have a welfare section which considers indigent persons and provides for their needs regardless of their ability to meet these needs financially. At the Chicago Lighthouse for the Blind, which is an independent agency and one of the finest agencies of its kind in this country, we are fortunate again in having a social service department which will provide the needed services, be they optometric or medical or psychiatric or vocational as part of a group health care approach, which I am privileged to be a part of. Now, these services are made available again to indigent persons who cannot afford it.

Mr. BRADEMAS. Thank you very much, Dr. Rosenbloom and Dr. Kane.

Mr. Sage?

Mr. SAGE. I will make this very short.

Mr. BRADEMAS. Would you give us your name and tell us—

STATEMENT OF GEORGE SAGE, STUDEBAKER RETIREE

Mr. SAGE. George Sage is my name, Studebaker retiree. First, I want to say this, everyone of you that possibly can, thank these speakers here today for being here and giving them this information; and the other thing is this, these people are the ones that meet the public and help get public opinion on our side. That is what we need, to get more and more support from the public to put this good program across. Now, I want to say this to the younger people, tell them they will soon be old, years pass quickly, maybe their health may not be good, can't tell about that. I have known people that become diabetics, had 300 relatives and not one diabetic in the whole gang, and that person becomes a diabetic, and anybody may get that. People get asthma, arthritis, all kinds of things like that, and to prepare for their old age, the time to do it is now. Maybe 10 years from now it will be out of the question, but tell these young people to get out and work for it, too. I say this again, tell the young people it may be your father or your mother who needs help and is sick. I know a poor retiree's widow who went to the hospital a few days ago with her foot off and no insurance from Studebaker at all. It will probably take most of her money away from her, and her son will have to help her a great deal. Well, these younger people, if they have this help in social security increased and medical situation taken care of, they pay a very, very small price in comparison to what they have to pay when they pay the bill directly. Some of these things should be

mentioned to the young people, and get the public opinion more and more in our favor.

Here is the last thing, tell these young people that soon maybe the aid will be reduced and if conditions are made better, so they have sufficient social security to live on and the medical situation is taken care of, many, many people may retire at a much earlier age, and, if they do, it means a lot more work there, and it makes jobs for the boys that come out of school. Think these things over carefully, friends, and let's do all we can to put this thing over in a big way.

Again I say thank our good speakers here for the work they have done here today, and for the help they are giving us in selling the program to the public. Thank you very much.

Mr. BRADEMAs. Thank you very much, Mr. Sage. I know from years past of your continuing interest in these problems.

Dr. James Wilson, the president of the St. Joseph County Medical Society. Dr. Wilson.

STATEMENT OF DR. JAMES WILSON, PRESIDENT, ST. JOSEPH COUNTY MEDICAL SOCIETY

Dr. WILSON. I would like to thank you very much for allowing me to appear here today. I think that the county medical society which takes care of the people in this community of ours should speak and should be allowed to answer questions and explain our position. I don't know exactly what percentage of the people in this community are taken care of by members of the county medical society, but as for the M.D.'s practicing in this county, there are only two who are not members, and I suppose that approximately 80 percent of the people here in this county are taken care of by members of the county medical society.

Now, I have not prepared a speech because I wasn't invited to come here, and the members of the medical society have not instructed me what to say, so I am speaking as an individual, but I am speaking as the president of the medical society and that I do know, I think, the feelings of the men in our society.

You hear the statement every once in a while that the physicians are not interested in older people, and that is a statement I think that many individuals that are trying to put physicians on the defensive make. I would like to assure you that the physicians in this county are interested in every person that they take care of. Now, they want them to get a square deal. They want them to get good scientific medical care, and they want to charge reasonable prices for that service.

Now, I can't imagine any group in this county knowing any better the financial plights of older people. There isn't any question about it, and that the cost of the hospitalization and medical care are terrific and they are very serious for some people, and this group of men, the physicians that are taking care of these people would naturally immediately know of these serious problems, and we are interested in those financial problems, and there are avenues for which anyone can get service in this community for nothing, if that is necessary, and the physicians are glad to do so, on the whole.

Now, we have 206 persons in our society, and I think if you took 206 persons in any organization, you might find several people that would

give you a poor deal, but I am certain that the physicians, the majority and vast majority right down to two or three would be considerate in the charges that they make to persons for medical services.

Now, there is a serious problem of hospital charges. The hospital doesn't automatically reduce your hospital bills, and I am very well aware of that, and that is a serious problem and it's a very hard thing on some families.

Now, the fact that we have a serious problem, does that mean that we ought to run to the Federal Government with it? Private industry is taking many steps to improve the availability of insurance for older people, and I know that there are a lot of them that are not able to buy it today. Of course one of the main reasons that a person isn't able to buy it today is the fact that what he has saved in the past and which would ordinarily take care of him is now worth so little that he cannot buy the things that he needs today. The physicians are very well aware of these problems. Well, does that mean, though, that we ought to turn to the Federal Government in order to solve this problem? As I said, there are improvements right along the line where private enterprise is offering people better and better opportunities to solve these problems. The contracts now, for instance labor people are able to continue their insurance after they are retired; the Blue Cross national organization has recently offered a hospital plan for elderly people and it is at a reduced price.

Now, in the future, it seems to me and it might take several years, but in the future, I believe that these problems would be solved and they would be solved by each individual's own individual responsibility, his own planning for the future. I hesitate myself to turn my planning for the future or any segment of it over to the Government, and I think many physicians, there are other independent groups, I admit, but I believe that they feel that an individual's own responsibility and his planning for the future is a preferable method of solving this problem. I think it adds a lot to a person's own initiative to be planning for himself. Now, he may need some help and guidance, and I think the Government might offer some advice and certainly in an educational way it would be a fine thing, but to take the problem over lock, stock and barrel, I personally, and I am not speaking for the medical society, but I personally would rather see the thing solved by a person's own individual responsibility and I very readily admit that there are some people in a position today that cannot solve it themselves, and they need help, and there are avenues at the present time for those people to receive help. There are free clinics in each one of the hospitals and the physicians rotate in taking care of the people there, and they are glad to do it. There isn't any complaint about it at all. The Department of Public Welfare helps individuals not able to meet these high costs. The Portage Township trustee does likewise.

Now, the medical assistance program for the aged in the State has been activated so that a person who doesn't need help for his food and shelter can obtain funds for his medical care. Now, these are applied to only those, and I think it's a few people in this area anyway, I suppose there are other areas in the country in which this is more of a problem than it is here. It is not a large percentage of the people that require absolutely free care here in this community.

I am interested that Dr. Bankoff was asked to come here from La Porte. I think that he does represent about 3 or 4 percent of the physicians in this country. I think that the other 95, 96 or 97 percent of the physicians are against social security approach for health to the aged. I think physicians would rather have the person providing for himself and making his own plans.

Now, is there anything wrong with giving a person the responsibility of making his own plans? I think the Government ought to see that the dollars that a person saves when he is age 40 or 50 still are worth a dollar when he is age 70. That, I think, is the responsibility of the Government, and if they are not able to maintain the value of the dollar, then, of course, there is going to have to be some programs that will help those people who have saved their money and the value of whose money is depreciated.

It is interesting to me that the optometrists and podiatrists were invited to appear here today. We get along very well.

Mr. BRADEMAS. I might interject that I think they asked to testify, and I think, for the record, I ought to make it very clear that an invitation to testify today was sent to Dr. Nathan Salin, who is the chairman of the health committee of the Indiana State Commission on Aging. You may know Dr. Salin's name. He was not apparently able to come, and it was also made clear in the press announcements of this hearing that we would be delighted to hear from anybody who asked to testify. So we are delighted to hear from you, too.

Dr. WILSON. Thank you. That is why I came. I think the optometrists and podiatrists get along very well together. The statement that the optometrists are uniquely qualified to give eye care, of course, he is referring to the fact that they do care for people's eyes; medical men do that also. We feel we are well qualified to do it.

Are there any questions you would like to ask?

Mr. BRADEMAS. Thank you, Dr. Wilson. Mr. O'Hara?

Mr. O'HARA. Doctor, I want to make the same comment to you that I have made to Dr. Bankoff, that I am very pleased by the manner in which you have presented your views, and I can certainly understand your position just as I can understand Dr. Bankoff's position. I would like to suggest just a couple of the problems that we get into in this sort of consideration. A possible approach to this problem is one that you have suggested; that is, that persons be permitted to make their own arrangements for taking care of their own old age, and I am sure that all of us would agree that this is the very best thing, but some of us are simply economically unable to do this, and, in addition, some others of us perhaps through circumstances beyond our control, perhaps more illness than the average person, might soon find that portion of his resources set aside for these purposes to have been exhausted.

Dr. WILSON. Absolutely.

Mr. O'HARA. And I wonder what your proposal would be with regard to those people. Let's take a hypothetical case because it's easier to understand a hypothetical case. Let's take a retired person who owns his own home and an automobile and has a small bank account and perhaps has a private health insurance policy of the more typical limited benefit type, and he becomes ill or he has some other loss of some kind, and he ends up spending what he had in the bank. If he has exhausted the provisions of his health policy, I suppose the

next step for him, as one of the witnesses here suggested, is to sell his house or mortgage his house. I am very much worried about these people, not the ones who are destitute, but the people who have saved for the rainy day, who have taken the normal precautions, but who face a situation where, before they can get any help, they must very nearly completely liquidate their assets, and then when they are back out of the hospital, when they have recovered, they find themselves in a very poor position indeed to face the future, and I am very concerned about that group.

Dr. WILSON. So are we. I would say this, I think that what you say it absolutely true, the person probably has a policy that doesn't really do much for him, and that is the thing which I think people are going to come to realize shortly, is the poor kind of insurance to buy. It's cheaper, for instance, to buy a policy which has a \$300 deductible clause in it, and that policy will pay for all the expenses over \$300, that runs up to \$10,000. Now, that is going to take care of that illness that you speak of, that serious illness, and the cost of that premium is not very large.

Now, that individual is going to have to pay all the costs below \$300, but for that major illness that you speak of, that insurance policy which is not expensive is going to give him excellent protection; but few people have it, and I think that is one of the answers to that real serious problem.

Now, if a person does get down to a position where he has spent what money he thinks he can afford to spend on medical illness, and it's a question of his mortgaging his home; under the Indiana laws, he can get an interest-free loan. It's just a loan, interest free, to borrow to help him pay what bills he needs. It seems to me like that is a fairly reasonable thing for a person to be able to get.

Mr. O'HARA. Well, I just want to ask one more question, and then I am going to yield to Congressman Brademas.

Your feelings with regard to individual initiative and having the individual plan for himself and do so though privately organized systems of insurance and so forth, when you consider that there have been all along very adequate private annuity programs and so forth, would apply with just about equal force to all of the rest of the social security system, wouldn't they?

Dr. WILSON. Yes, I think that is right, with this one exception. You are giving money under the social security system, you are giving money to the individual which he is allowed to spend as he sees fit. When you give money to a person, I think he spends it efficiently, but if you give the service, I think it's overutilized, and there is nothing really the physicians can do about that. It will be overutilized regardless of what stand we take on that, so in that regard, I think this system will be more expensive than the other by far.

Mr. O'HARA. Well, I thank you, Doctor, for your presenting to us your viewpoint which I think does, as I suggested before, represent the majority viewpoint of medical doctors in the United States. I have no further questions.

Mr. BRADEMAS. I, too, want to express the same appreciation, Dr. Wilson, for the way in which you have expressed your views here today.

I have in front of me a copy of the New York Times clipping dated March 18, 1962, which is an article that describes some activities of

physicians in this State and in this congressional district that does not indicate the same sort of moderation which you have represented here today. In fact, I read that an organization called the Indiana Health Organization for Political Education, known as I-Hope, has already marked this program for defeat in Indiana, according to this article.

This is even before the House Ways and Means Committee has even reported a bill in this area out of the House Ways and Means Committee, and it goes ahead to say that thousands of dollars are being raised in this area. I had, myself, been looking forward to sitting down at your invitation, I believe, with physicians in this county to discuss some of this legislation, and I pick up the New York Times, and I say to myself, I wonder if I had the letter straight. This says that this organization, of which I take it most of the doctors in this county are members, has received contributions, averaging \$50 each, from over 1,000 of them. This was in March. I don't know where it stands now, but without objection, I feel this article ought to be inserted in the hearing at this point, and I think you will understand, having read an article of that sort, why I appreciate even more the moderation with which you have expressed yourself today.

(The above mentioned article follows:)

[From the New York Times, Mar. 18, 1962]

WIVES OF DOCTORS BATTLE CARE PLAN—JOIN AMA FIGHT ON SOCIAL SECURITY HELP FOR AGED

(By Donald Janson)

Special to the New York Times

CHICAGO, March 17.—Mrs. Burton Kintner of Elkhart, Ind., is one of hundreds of doctors' wives in Indiana who wrote letters to their Congressmen this week.

The burden of their message was that passage of the administration's King-Anderson bill to provide medical care for the aged with social security financing would be a blow to the private practice of medicine.

Mrs. Kintner did not stop with letterwriting. Yesterday she explained her stand in a speech to an Elkhart labor group. Next month she will begin ringing doorbells to ask friends and neighbors to vote against Congressmen who favor what she and the American Medical Association consider to be a step toward "socialized medicine."

Mrs. Kintner's efforts in Elkhart are being duplicated by physicians and wives throughout the country. The campaign has been organized by the new political-action arm of the AMA—the American Medical Political Action Committee. It plans to pour time and money into a concerted drive to defeat proponents of the King-Anderson bill in 1962.

DEMOCRATS THE TARGET

In Mrs. Kintner's district the target is Representative John Brademas, a Democrat. She will be working with many other members of the women's auxiliary of the Indiana Medical Association. When the time comes she will be holding political "coffees," asking local clubs to sign resolutions, and eventually organizing car pools to get voters to the polling places.

The interest of the women has already become so "intense," she said this week, that their busy doctor-husbands have been stimulated to participate by attending meetings, and, in some cases, by speaking to civic groups.

One who does this regularly is Dr. Guy Owsley of Hartford City, Ind. Dr. Owsley is chairman of the Indiana Health Organization for Political Education, known as I-HOPE. This year-and-a-half-old group of physicians and their wives is dedicated, its brochure says, to "battling the socializers."

"All Indiana Congressmen will be up for election in 1962," I-HOPE's platform states, "and unless I-HOPE and groups allied in the same principles come

to the help of those who vote and practice Americanism, they will surely go down to defeat."

I-HOPE has received contributions averaging \$50 each from more than 1,000 physicians. Beginning in June, Dr. Owsley said in an interview, I-HOPE will make monthly contributions to the candidates whose campaigns it supports.

I-HOPE and similar political-action organizations of doctors and their wives in 35 other States, most of them set up in recent months, are working with the support and guidance of the new national group.

AMPAC, as it is called, was set up by the American Medical Association as an independent operation last September. Its purpose is to organize doctors into an effective political action group.

The job, said Joe D. Miller, the executive director at AM-PAC's modest suite of offices in Chicago this week, means first organizing medical political action groups in every State. To this end, Mr. Miller, formerly research associate for the American Medical Association Council on Medical Services, has been on the road 80 percent of the time since he assumed his task 6 months ago. He says every State will have a unit by election time.

Following organizational chores, the work of both National and State groups will be to make doctors more aware of political issues and to encourage them to support candidates "who favor medicine's point of view."

A "DEADLY CHALLENGE"

The American Medical Association, with a membership of 186,000 of the Nation's 260,000 doctors, has described the King-Anderson bill as the most "deadly challenge ever faced by the medical profession."

"Like it or not," said Dr. Edward A. Annis of the American Medical Association's speakers' bureau, "the physician must acknowledge that his profession has been thrown, willy-nilly, into the political arena."

"He has a story to tell and he must tell it to his patients, to his neighbors, to his friends, to his community."

Doctors and their wives, relatives, and officeworkers are being urged to do this through membership in both the State and National political-action groups. Some of the State units ask for voluntary contributions rather than dues. AMPAC has a four-classification schedule of annual dues ranging from \$5 for students to \$99 "or more" for "sustaining" members.

It will use the money to prepare analysis of the voting records of candidates for national offices for the guidance of members. It will issue pamphlets reviewing a variety of legislative issues and will initiate drives to register voters.

DOCTORS OFFERING HELP

Members are being urged to participate in practical politics from the precinct up. Dr. Owsley said I-HOPE already had some 60 doctors in each political party interested in seeking delegate posts to the forthcoming State political conventions.

"We will encourage doctors and their wives to get into campaigns to the nth degree," Mr. Miller said.

In the current issue of the American Medical Association Journal, Dr. Leonard W. Larson, president of the association, urges all doctors to "do your part by becoming a member of AMPAC."

"AMPAC will support candidates who favor medicine's point of view," he says, "and will oppose those who are known to have a position contrary to the maintenance and continuation of our private, free enterprise system of medical care."

Dr. Larson noted that prior to formation of AMPAC "no comparable activity existed in the business and professional world."

He said that labor had dominated the field through the Committee on Political Education of the American Federation of Labor and Congress of Industrial Organizations.

PRAISES LABOR'S PLAN

Mr. Miller said he considered COPE's book of strategy, "How To Win," to be a masterful compendium. He lists it in a bibliography of source material including in a kit of organizing aids given to each new State unit. He also has a well-thumbed copy on the desk of his Michigan Avenue office.

Mr. Miller said his organization would follow the lead of COPE and devote "off years," beginning in 1963, to political "education" courses for doctors and

their wives. He said the "action course in practical politics" of the U.S. Chamber of Commerce might provide a guide.

AMPAC's first year, however, will be one of participation in specific "marginal" contests in 1962. These battles, the organization believes, will be close enough so that hard work by physicians could tilt the scales.

Decisions on candidates will be made by the board of directors of AMPAC, officials appointed by the board of trustees of the American Medical Association, after consulting State units. Already marked by Dr. Owsley for opposition in Indiana, for example, are Representatives Brademas, J. Edward Roush, and Winfield K. Denton, all Democrats.

Meanwhile, the AMPAC board of nine physicians and one wife, headed by Dr. Gunnar Gundersen of La Crosse, Wis., has been constituting itself as a sort of organizational speakers bureau, Mr. Miller said, to stimulate interest in the new endeavor across the country.

A "VOLUNTARY" GROUP

The American Medical Association formed AMPAC, "a voluntary nonprofit, unincorporated group," because corporations such as the AMA and the Association of American Physicians and Surgeons are forbidden by Federal law to contribute to the campaign of a candidate.

Such political activity at the State level also requires formation of "non-partisan, nonprofit" organizations. About a dozen State units were set up before AMPAC was, including the Empire Medical Political Action Committee in New York City.

Dr. WILSON. I think even Dr. Bankoff stated that he had made a contribution because he believes the work of that committee is good.

Mr. BRADEMAS. I hope that 3 or 4 percent of it might be earmarked for some of us who were on the other side, if that is the way it works out. That is a very large sum of money. This is March, that is \$50,000. I am wondering what it will be like by November of 1962.

Dr. WILSON. Do you mind if I comment on that?

Mr. BRADEMAS. No, I would be glad if you would.

Dr. WILSON. I can tell you exactly how much money has been raised in this county over the period of the last year and a half, which is not just a recent drive, and that amount is \$3,500. Now, I think if we are going to talk about raising money in politics, that you would say that is a moderate amount of money, and we have a right to do that.

Mr. BRADEMAS. You do indeed.

Dr. WILSON. And there will be others on the other side raising equally large amounts of money.

Mr. BRADEMAS. I wouldn't say that. Being in my fifth congressional campaign, I am not unfamiliar with the problems of raising money. It always is my biggest headache, and never have I dreamed of raising—

Dr. WILSON. \$3,500?

Mr. BRADEMAS. No, not in the year before an election. But \$50 from each of over 1,000 people; in any event, I think I will write a letter to the New York Times and scold them for bad reporting.

Well, let's go back to the sum and substance here, Doctor. You have indicated your strong feeling that it is always better for an individual to plan for his own future because this helps stimulate his own initiative. Is that a fair indication of your position?

Dr. WILSON. Yes, I think that is right.

Mr. BRADEMAS. And this is one of the reasons you feel, if not a basic reason, that you feel to tie a health insurance program to the social security would be unwise; is that fair?

Dr. WILSON. One of the reasons, yes.

Mr. BRADEMAs. Is it not fair, and perhaps this follows from the question asked by Mr. O'Hara, is it not fair to conclude then that you would have to oppose the social security system as such on the ground it is certainly not a program which, in your terms, would help an individual to show initiative and to plan for his own future on his own without a government sponsored program?

Dr. WILSON. No, I don't think so.

Mr. BRADEMAs. You see no contradiction in that?

Dr. WILSON. No, I don't.

Mr. BRADEMAs. How do you explain that you can support, as I assume you do, the social security system as such, but that you would oppose social security for medical care on the ground it impairs initiative?

Dr. WILSON. Well, the way in which it is proposed, this program under—and I have read this bill that Dr. Bankoff mentioned, this provides a service and not a cash benefit to a person; is that right?

Mr. BRADEMAs. That is correct.

Dr. WILSON. It provides a service?

Mr. BRADEMAs. That is correct.

Dr. WILSON. We feel that that service is going to be overutilized.

Mr. BRADEMAs. Is there any evidence, in fact, for that proposition other than feeling?

Dr. WILSON. Well, have you ever been in a veterans hospital to see how long it takes a person there to be treated for the same illness that—well, it's going to be a comparable thing to that.

Mr. BRADEMAs. I yield to my colleague.

Mr. O'HARA. Doctor, I didn't really want to get into this because I don't know an awful lot about it, but one thing about the Veterans' Administration hospitals, without going into the question of whether or not they are overutilized, is that the admissions to the Veterans' Administration hospitals are handled differently than the admissions to the ordinary hospital. As I understand it, admissions to a civilian hospital, such as are contemplated under this bill, would be sent to the hospital by their private physician.

Dr. WILSON. Yes, sir.

Mr. O'HARA. And I don't like to believe and, in fact, I don't believe that the doctors of America would be so derelict in their responsibilities to the ethics of this profession that they would be sending people to the hospital who didn't need to be in the hospital, and, therefore, I don't have any great fears about a marked overutilization of hospital services under the King-Anderson bill, if it were to be enacted.

Dr. WILSON. It's not that type of overutilization that I am speaking of. Once a person gets in the hospital, he says he is not ready to get out, and there isn't any way that the doctor can readily determine that that is true, and you can't fight with people about that. If they feel they need to stay a few more days, I think the doctor finds, after a while, that is the thing he has to do, is go along with that person.

Now, an individual who is paying the cost himself, we see this all the time, they are very anxious to get out of the hospital as soon as possible. There is an individual responsibility coming into play and that particular thing.

Mr. BRADEMAs. Doesn't this same thing happen under Blue Cross and Blue Shield, Doctor?

Dr. WILSON. Yes, it does. And it's a problem, and that is one of the reasons that the cost of Blue Cross and Blue Shield has gone up.

Mr. BRADEMAs. Do you oppose these programs, Blue Cross and Blue Shield, for that reason?

Dr. WILSON. No.

Mr. BRADEMAs. I wouldn't think so. Let me ask you this question also: You said, in your statement earlier, that the Federal Government should not be turned to, to resolve these problems, and yet did not the doctors of the country, through the American Medical Association, strongly support the Kerr-Mills bill which is certainly a Federal law?

Dr. WILSON. Yes.

Mr. BRADEMAs. Wasn't that turning to the Federal Government in an effort to solve some of these problems?

Dr. WILSON. Yes, it was, but it was a different method for the solution. I think you must admit that is true.

Mr. BRADEMAs. That is true. The point is, of course, that you said earlier in your statement you did not think we should turn to the Federal Government to solve these problems. Isn't that sort of trying to have it both ways?

Dr. WILSON. No, I don't think it's trying to have it both ways at all. I certainly don't. Under one method you are giving the hospital care to everybody, is that true, under social security? You are taking over, completely, the responsibility for that person's hospitalization regardless of whether he needs the help or not.

Mr. BRADEMAs. I don't think that is a fair statement. I think you said you read the bill, Doctor?

Dr. WILSON. Yes, I have.

Mr. BRADEMAs. I don't think the bill provides complete hospitalization coverage along the lines you have just suggested. There are limitations in the bill.

Dr. WILSON. Well, there are limitations in the bill?

Mr. BRADEMAs. Yes, sir.

Dr. WILSON. I will take that back. But the bill provides hospitalization for everyone; is that true?

Mr. BRADEMAs. No.

Dr. WILSON. Under social security.

Mr. BRADEMAs. Or the Railroad Retirement Act.

Dr. WILSON. Yes. Now, the Kerr-Mills bill provided only for those people who were not able to take care of themselves; is that true?

Mr. BRADEMAs. I think you missed the point of my question. The point of my question was that you are—perhaps I am caviling with you here. I thought you said earlier that you thought the Federal Government should stay out of this whole area, and yet on the one hand you would be supporting Federal legislation, the Kerr-Mills bill. That is a Federal law.

Dr. WILSON. Yes, that is absolutely true. I think that under that plan, it is just helping those people in need and not helping the vast majority of people, so I think they are entirely different.

Mr. BRADEMAs. So that so long as the bill were a response to people in need, as you would define it, you would be willing to support Federal action.

Dr. WILSON. I think, some way, we should help people in need; I agree with that.

Mr. BRADEMAs. I see. I also ought to say, for the record, that I have sat down with representatives of the AMA in Washington, D.C., and consulted with them about legislation in which I thought your organization was interested, and following one conversation, I introduced a bill that was endorsed by the AMA.

Now, that may get me in trouble with a lot of people in this room, but I felt that was necessary.

I have just one other question. I refer to legislation to help build medical schools in the United States which, as you know, the AMA supports. You have read this bill. Do you see any place in the bill where the Federal Government provides for paying doctors?

Dr. WILSON. No.

Mr. BRADEMAs. For their services?

Dr. WILSON. No, but we do feel this, if the provision for hospitalization is taken over by the social security system, that it won't be too long that the payment of doctors would be included likewise, and to have the Government, in effect, hiring doctors, we feel would disturb a relationship at the present time which is pleasant, and under that system we feel it would be unpleasant.

Mr. BRADEMAs. Let me get your reaction, in that regard, to the following statement which is a statement endorsing the extension of health insurance through the social security system. I quote, "to provide this aid need not be socialized medicine as opponents claim, since payments could be made through private channels, and patients select their own doctors and hospitals as before."

Do you think that is an inaccurate statement?

Dr. WILSON. No, I think that is accurate, but who is going to pay the doctors? Who would pay them?

Mr. BRADEMAs. That is another matter to which this bill makes no effort to respond.

Dr. WILSON. That is true, but in the future—

Mr. BRADEMAs. You are not suggesting we should include doctor bills in the legislation?

Dr. WILSON. No, not at all.

Mr. BRADEMAs. I think this is a very interesting editorial, and, without objection, we will put it in the record. It is entitled "Age, Health, and Politics," and it is an endorsement of the social security approach from Life magazine, which is not usually regarded as a leftwing publication.

(The above-mentioned editorial follows:)

[From Life magazine, Apr. 25, 1960, p. 42]

AGE, HEALTH, AND POLITICS

The hottest political potato so far in this election year is this question: Are Americans over 65 entitled to Federal help to meet their hospital and doctor bills?

The Forand bill, which would raise \$1 billion for such care by a one-half percent boost in the social security tax, has produced floods of favorable mail and given the Democrats an unexpected issue. Republicans, while granting the need for aid, are trying to find a more private, voluntary alternative. Since the issue is important, let's try to separate its social realities from its politics and facts from principles.

Unquestionably, many older Americans (15.8 million are over 65) are in real need. The average \$72 a month they drew from social security scarcely provides food and shelter, much less for the medical expenses which increase with age.

Few are in a position to meet the cost of chronic illness from which many suffer. Yet even to get "charity" care—itsself inadequate in quantity and often inferior in quantity—they must suffer the indignity of a pauper's oath.

Can their need for medical aid be provided by private, voluntary Blue Cross-type plans? These are expanding, but can never meet the whole need. Premiums for the aged as a separate group are prohibitively high. The least burdensome method of insurance is for the whole society to spread the costs over the whole working life cycle. The cheapest and most logical way of doing this, whether by the Forand bill or a better one, is by extending the existing system of social security.

To provide this aid need not be "socialized medicine," as opponents claim, since payments could be made through private channels and patients select their own doctors and hospitals as before.

The first question of principle is whether this form of aid will undermine the private duty of providing for one's own old age through old-fashioned virtues like foresight and thrift. Being a floor, not a ceiling, it need not do so. Individuals will still have plenty of incentive to save for the future, though less fear of it.

Another question of principle is whether it is the proper function of a free government to offer special help to its older citizens. That principle was accepted when social security itself became effective in 1937. The presumption against any extension of Federal activity and expenditure, though Jeffersonian in origin, is now championed, though weakly, by the Republicans, who don't want to be tagged as enemies of the aged. But an extension of an established system like social security is not a violation of principle. But there is also an issue of cost.

Not even the Democrats can extend the welfare state without reference to the price tag. Enough spending bills were introduced in Congress last year to add \$50 to \$60 billion to our existing \$78.4 billion budget if passed. Priorities, therefore, have to be determined. Health aid to the aged can be provided, but it may mean fewer schools, highways, or other needs which may also be urgent. A related question is whether aid to the aged can be done without renewed inflation. The aged, on small and fixed incomes, have been the chief sufferers from inflation, and this is a good reason for giving social security a high priority. By the same token, any aid program that feeds inflation would defeat its own purposes and fool its beneficiaries. So the costs of any plan adopted must be carefully limited and controlled.

Doubtless the Forand bill can be improved. Some \$200 million could be saved simply by raising the eligible age from 65 to 68. Moreover, many oldsters able and eager to work could better provide for their own security if the \$1,200 limitation were raised on the income they may earn without forfeiting social security pensions.

But, in principle, such aid is proper public business. The issue is therefore inevitably and properly a political one. It should be decided according to the Nation's sense of justice, urgency, and choice of priorities in the use of scarce resources—as interpreted by the Nation's elected representatives in Congress.

Mr. BRADEMAs. Another editorial that I think, without objection, that could go in the record at this point is one published in the February 18, 1961, issue of Business Week magazine, which is also an endorsement of this approach.

(The above-mentioned editorial follows:)

[From Business Week, Feb. 18, 1961]

STRESS ON THE WELFARE STATE

Kennedy's vigorous moves on help for the aged and the unemployed—plus aid to education—contrast with his relatively modest economic-fiscal plans.

President Kennedy is hitting Congress with a flow of requests that spell out a welfare program for helping the aged, helping the unemployed, building schools, and granting scholarships to needy students. His entire administration program is shaping up as being generous on the welfare-education side while modest on the economic-fiscal side.

The program fits the picture he is trying to paint of a nation falling behind in meeting its national needs. Speaker Sam Rayburn emerged from a conference

with the President this week to pronounce the economic situation "the most urgent since the great depression" of the early 1930's. Labor Secretary Arthur Goldberg toured five hard hit industrial States and reported economic conditions "as bad or worse" than he expected.

CONGRESSIONAL BRAKES

The biggest obstacle Kennedy faces is the rather widespread conviction in Congress that things are not quite so bleak as the President pictures them.

Disturbed by the sharp reactions his programs for medical aid and education have stirred among Republicans and southern Democrats in Congress, the President has slowed down his barrage of messages. He had intended to ask Congress this week for a sizable program of aid for school construction, teachers' salaries, and Federal scholarships. But legislative leaders put on the brakes; the message is being delayed while administration officials work out some of the details with key Congressmen in advance—and possibly trim down the cost.

"The White House has been shoveling this stuff out too fast," says one congressional leader. A key Senator on the medical-aid bill, Senator Pat McNamara (Democrat, of Michigan) complains that he was scarcely consulted about details although he has led the Senate push for aid to the aged. Now the administration is taking time to make amends.

ON THE AGENDA

Kennedy has sent Congress detailed requests for legislation on unemployment compensation, minimum wages, broader social security benefits, and medical care for the aged.

Next will come an education program, followed by messages on housing, water resource development, agriculture, defense, foreign aid, taxation, and the budget—not necessarily in that order.

Taken all together, administration leaders estimate unofficially that these programs will add up to about \$3.5 billion worth of spending beyond what former President Eisenhower requested in his last budget. More than \$1 billion of that will be increased defense spending.

How far this will put the Government into the red depends, of course, on how much revenues pick up. Officials are running new revenue estimates now that will be made public about the 1st of March in the President's budget message.

Preliminary estimates are that deficits of \$1 billion for the current fiscal year and \$2 billion for fiscal 1962 are likely. If the business upturn hoped for later this year fails to materialize, deficits will be bigger than that.

AID FOR SCHOOLS

The administration is preparing, subject to last-minute revisions, a school bill along these lines: a 5-year schedule of Federal grants to elementary and secondary schools totaling about \$660 million the first year and rising to \$1.6 billion the fourth and fifth years—an average of about \$1 billion a year. States would have the option of spending it for construction or for teachers' salaries. Money would be allocated on a formula favoring the poorer States and the biggest cities. In addition, the program would include a sizable program of 25,000 to 50,000 scholarships averaging \$700 each. Present Federal grants and loans to colleges for construction would also be increased.

WELFARE MEASURES

In the social security and medical program, the President is asking for two separate measures: One lowers the retirement age for men to 62 and increases widows' benefits; the other provides medical care for 14.2 million persons over 65—financed by social security.

The medical program, similar to one rejected by Congress last year, will cause a particularly bitter fight partly because of its estimated cost of \$1.1 billion the first year. Social security taxes already are scheduled to go up from the present 3 percent each for employer and employee to 4½ percent by 1969, when costs begin to peak out under the trust fund arrangement.

The two social security programs proposed by Kennedy would raise the tax to 5 percent each by 1969—or 10 percent of payroll. An employee earning \$5,000 (the maximum proposed tax base) would pay \$250 a year.

Mr. BRADEMAs. The reason, Dr. Wilson, that I call attention to this kind of statement is, as I have said two or three times here today, I think it ought to be very clear that reasonable, rational people, good loyal American citizens, Republicans, Democrats, conservatives and liberals, to use those overworked and not very helpful terms, often both favor and oppose this kind of legislation.

My own feeling is that if we have had any value out of our hearing today, it's been that we have been able to have a good, friendly conversation about these matters with good will on both sides whenever there has been disagreement. I think that your testimony here today is one of the best examples of that, and we thank you very much for coming, sir.

Dr. WILSON. Thank you. I don't know whether Dr. Bixler is here. He had intended to be here, and I believe his name is on the agenda, but I see several other physicians, one of them might take his place, if they wish to.

Mr. BRADEMAs. Fine. Did I understand someone else wanted to testify? We would be pleased to hear from any individual. Would you identify yourself?

STATEMENT OF DR. FRANK SCOTT, SOUTH BEND, IND.

Dr. SCOTT. I am Dr. Frank Scott of South Bend, Ind. I also come as more of a private citizen than as a physician because I am tremendously interested in this bill and tremendously interested in the trend that has developed in the last 30 years toward greater increase in the size of our Government and in the expansion of our public debt and in the increase of our taxes and our tendency toward managing the lives of our individuals. I feel that the King-Anderson bill is another example of this, and for that reason I would like to add my opposition along with Dr. Wilson's opposition to this bill.

Dr. Whisler mentioned earlier this afternoon that he couldn't understand why physicians were opposed to this bill, and I think that there are two chief reasons. One of them is that we would like to see our senior citizens helped when it is necessary. We want all of our citizens, regardless of age, to have the best of medical care, and we are just as interested in our senior citizens as we are in anyone else. We realize their importance to our community, and we realize their problems. We would like to see them helped just as much as we would like to see our young people.

In my own experience, and I take care of a large number of older people in my practice, it so happens that a great deal of my practice is in the hospital because of the fact I am a surgeon, and a number of old people develop surgical conditions, and more and more we are able to manage the surgical conditions in older people which formerly we could not do and, as a result, we have a larger percentage of older people in the hospital. It has been my own experience that by far a higher percentage of these senior citizens have been able to meet the expense of their hospitalization and their medical care than have many of our younger citizens, particularly those in the younger age groups in the first two or three decades of life.

I make every effort, and I am sure that I am not unique in this way as physicians go, to determine the financial ability of this patient and to see that as far as I am personally concerned, I do not work an undue

hardship on that individual, and I think that this is something that each physician in this community does. I believe if it is done in this community, that this is something that is done generally.

To continue on this first reason, we want to see these people get medical care that is right. We want to see those who are unable to obtain medical care for financial reasons to get help, and there are means already established whereby they can get help. It has been mentioned that it interferes with the dignity or the individual to obtain help in the method in which it is necessary to obtain it today. There is nothing that can do more for the dignity of man than to know he is providing for himself before this time comes.

Now, the individual, as I say, who does not have the financial means today, there are methods for doing it. The objection has been raised that it lowers the dignity of the individual to have to do this, but, by the same token, in order to obtain the scholarship for one's child in college today, he must give a financial statement which is just as severe as any required by the Welfare Department or the township trustee. This is regardless of whether that scholarship is offered by the Government or by the college or by private enterprise. There are a few scholarships that are given on the basis of the person's intelligence or his ability alone, without regard for his finances, but by and large, the majority of scholarships have to be obtained in the same method, the same way.

I know that in many of the cases of the needy, not just medically needy but needy in other respects, of union men who obtained help from their unions, which have vast amounts of money, large resources; these people are also required to show a need for this money and this help, and I feel that it is no more different, that it is no less necessary for our Government. The taxpayers should see that people need this before they are forced to pay for it.

Social security is a tax. The law is written as a social security tax. It's been advertised that this is a prepaid medical insurance. This is a tax—social security tax.

Mr. BRADEMAS. Do I assume from what you have said then, Doctor, that you would oppose the social security program as such? I do not now refer to the proposal to extend the social security system to provide for health insurance.

Dr. SCOTT. No, I did not say that.

Mr. BRADEMAS. I asked you that question.

Dr. SCOTT. No, I don't say that.

Mr. BRADEMAS. You support the social security system as it now is?

Dr. SCOTT. Yes. I have no objection to the present social security system.

Mr. BRADEMAS. You made a statement earlier——

Dr. SCOTT. I would like to enlarge upon that.

Mr. BRADEMAS. Yes?

Dr. SCOTT. I have no objection to Social Security. I think we should recognize it for what it is. It's not an annuity. It's not insurance. It is a tax.

Mr. BRADEMAS. I suppose it could be called a form of social insurance; that is the technical term that is used to describe it.

Dr. SCOTT. It's not an insurance, though.

Mr. BRADEMAS. It's not?

Dr. SCOTT. As an example, I have paid social security, too, because of positions that I have had before I went into the private practice of medicine where I was required to pay social security. I have paid social security over a period of years, but I never expect to collect a penny of that social security, and that money is not mine to have unless I go back into a position in which I again pay social security. Just the same as a working man today who starts working when he is 18 years old and paying social security, and he pays social security tax until he is 60 years of age, and then, if he retires, not because of health, but because he wants to quit work, he gets no income from his social security. Is that true?

Mr. BRADEMAS. No; I don't think it is.

Mr. O'HARA. No.

Dr. SCOTT. If he pays, it makes no difference how long he pays—

Mr. O'HARA. He can't collect until he reaches age 62 under the present law.

Dr. SCOTT. If he retires at 55 or 60 or goes into an occupation where he no longer receives social security—

Mr. O'HARA. And was not disabled, depending on how many quarters he had paid, if he had paid a sufficient number of quarters to receive a permanent entitlement, no matter at what age thereafter he quits working or went into another profession where he didn't pay social security, he would be entitled to draw social security retirement benefits at the age of 62, 63, 64, or 65, depending if he elects to go under the provisions that permit him to retire under age 65.

Dr. SCOTT. What are the number of years?

Mr. O'HARA. He has to qualify in 40 quarters.

Dr. SCOTT. Ten years. In other words, if he works 9 years, he gets nothing.

Mr. BRADEMAS. I think we are off on a sort of curious area. Doctor, if you want to continue exploring this route, it's perfectly all right. We have 10 minutes before some of us have to go to Washington.

Dr. SCOTT. No.

Mr. BRADEMAS. The one point you made at the start, I thought was very important, the one in which I recall your saying that physicians in our community, and I take it in the Nation generally, sought to provide services to older persons at a reasonable fee. From everything I know, this is true, and I think that doctors of the United States are certainly to be congratulated for doing this because I know a lot of doctors and I know that they take that responsibility very seriously indeed. As I understand it, it's part of their ethical responsibility as a physician.

But, of course, the bill that we have been discussing here this afternoon doesn't get into that field at all. The problem to which this bill, the King-Anderson bill, or similar bills is addressed is not the fee of the physician or surgeon, but is rather the cost of nursing home and hospitalization care. I wonder what your reaction would be to this kind of proposal which is now before Congress. It's a Government-sponsored health insurance program, and it would provide income tax credits of \$125 annually for everybody over the age of 65, and this money would be used to purchase health insurance for several benefits, including \$12 a day for hospital room and board up to \$1,080 a year, \$120 for other hospital charges a year, \$6 for convalescent rooms, per

day, up to \$186 a year, and \$300 maximum for surgery. What would your reaction be to that kind of Government health proposal?

Dr. SCOTT. Congressman Brademas, I would not be able to give a spur of the moment opinion on this without having an opportunity to study the proposal a little more carefully. The thing I have wondered, speaking about this exemption from income tax, there has been such a tremendous interest by some Congressmen about the difficult time that the senior citizens have with their medical bills and this has been over a period of some 20, 25 years, and still at no time have I ever heard of any of those particular men proposing that any individual, I mean some of these people who have such a difficult time, I don't mean just these over 65, but say some of the older citizens say past 60, that they have their medical expenses exempt from their income tax.

Mr. BRADEMAs. Well, it's an interesting —

Dr. SCOTT. Do you know why there has never been much interest in that?

Mr. BRADEMAs. No, I can't say. The bill I just suggested is introduced by Congressman William Miller, of Buffalo, N.Y., Republican national chairman.

Dr. SCOTT. I am not familiar with that bill.

Mr. BRADEMAs. We have about 5 more minutes, and I saw one more hand go up, Doctor, and I don't want to cut you off, but I think we have time for one more witness, and I appreciate very much, and I know my colleague does, your coming here to appear before us.

Please have a seat and identify yourself.

STATEMENT OF FRANK ROACH, PRECINCT COMMITTEEMAN, MICHIGAN CITY, IND.

Mr. ROACH. My name is Frank Roach. I am a precinct committeeman from Michigan City, and, if I may, will say a few of my views. I have heard a lot of them here this evening, and I had a lot of contact with the elderly people in our precinct and throughout the entire city, and hearing the different pros and cons on it, I find the bill which would be sponsored through social security aid would be the most helpful thing in the world. For this reason I say that: It seems as though when we are in time of need or distress, we always rely on the Government who, other than that, is nothing but the people. They have invented an atomic bomb to preserve our lives—our very lives that you might say the enemy might step in to get us, so therefore if the Government would have control of our health as well as protecting us from harm, I myself really believe that is the only thing that will work.

There is no question in my mind that medical aid through social security is the only fraternity we have for our elders, which they have so dearly earned through their lifetimes, regardless of source or where they spent it or who they paid it to. At the rate it is going, if it's ever going to come to destruction, the wealth they do have or whatever it may be, they will never be able to earn again, and in so doing, by having this law pass, whatever is left, they will still be preserved and will preserve other mankind.

The community we live in, our precinct as well, they have all gone behind me, and we have the honor and the privilege of getting pam-

phlets from our different representatives, Congressmen and Senators, which are very helpful in advising us, and reading our labor paper, and we are well advised, too. It's our children which have supported us in our time of need, so therefore we will be in contact with each other, organized to each other, and put in people that will represent them, which our party is doing now.

I don't believe there is any more I can say. You people write to your Senators and Congressmen in the matter you think. I am sure they will be 100 percent behind you, and advise your neighbors, as well as those of the city and States, write to them and let them know what is to be done. Your word, your thought of it told to them—I am sure these men will represent you.

Mr. BRADEMAS. Thank you very much.

I would like to announce that if any person in this room or any other person who may be interested, wishes to make a statement on this general field of discussion and did not have an opportunity to testify this afternoon, we would be pleased to have your statement, if you will send it to the clerk of the General Education Subcommittee, House Education and Labor Committee, Washington, D.C.

In adjourning this hearing today, I would like to express our appreciation to Indiana University, to Dr. Jack Detzler, the director of the center, for having made it possible for our committee to meet here today. I would like also to express appreciation to all of the persons who expressed their views on any subject, on any side of the subject, and also to express our thanks to those of you who have come and sat in as observers at the hearing today. I think this has been a most fruitful and useful and valuable experience for our subcommittee.

Thank you very much.

The committee is adjourned.

(Whereupon, at 4:30 p.m., the hearing in the above matter was adjourned.)





