YOUNG AT ANY AGE

NEW YORK STATE JOINT LEGISLATIVE COMMITTEE
ON PROBLEMS OF THE AGING

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* On June 21, 1950, Assemblyman Farbstein the Committee.

Introduction

By Senator Thomas C. Desmond

Chairman, New York State Joint Legislative Committee on Problems of the Aging

IF YOUTH must be served, age merits its own rewards. For it **has served.** And is eager to **continue serving.**

Our Committee, in its studies of the aging, has found that our older persons do not ask to be served; they plead only to be allowed to serve. They ask for a chance to serve in industry, civic work and charitable efforts.

And yet, society shunts the older person out of productive, useful life. Somehow in our national race for expansion and wealth, we have overlooked not only some fundamental human values but also some productive values. For with all the tremendous talent and energy that bless our wonderful American youngsters, we can ill afford in terms of dollars and cents to lose the "know-how" and productive power of our 45-plus, 55-plus, and 65-plus groups.

Too, we can ill afford, if we wish to expand the purchasing power of our economy, to keep our older persons in a financial ghetto of dependency. It doesn't make sense. It doesn't make us strong. It doesn't make for justice.

The Hidden Disaster

We human beings move quickly and usually effectively when disaster strikes. An explosion, an earthquake, or a train accident will throw governmental machinery, community agencies and neighbors into high gear to care for the unfortunate victims whose agony is laid bare before our very eyes.

But when millions of older persons face the slow death of forced retirement, when millions of persons face the hidden disaster of old age on relief rolls, when thousands of oldsters are thrust into mental hospitals although all they may need is love and understanding, when millions of oldsters are consigned to a lonely old age, we move at a painfully slow rate.

That is why a grey-haired man, his head buried in his arms, cries out, "Nobody cares." He might be in your community and probably is. Maybe he needs only companionship. Maybe he needs a job. Perhaps, a doctor. It may be that all he needs is renewed confidence. But whatever his problem, we in our neighborhoods, our communities, states and Nation have the wealth, the energy, the technical skill to see to it that our older persons have a chance to make their later years happy years.

Does nobody care? Our Committee recognizes an increasing will to do. As the needs of the elderly become better understood, communities are here and there rising to the challenge. Industry itself, confused as it is about its relationship to the elderly, arbitrarily banning the hiring of older persons, spends nearly a billion dollars a year for pensions, and grants generous privileges to its senior workers. The problems of the aged are complex. Some of the solutions will be inexpensive; others will be costly. But we can, under our free enterprise system, meet this challenge. Our productivity, combined with our humanity, will surmount obstacles.

In this report, the third of our Committee, a wide range of armament is recommended to combat the trend of the past fifty years toward squeezing more and more of our older population out of productive and useful life.

But there are many of our aging who look forward to retirement. There are others who cannot work. For these, improved nursing homes, better hospital facilities for the chronically ill, adequate housing to meet the special needs of older persons, widespread community recreational facilities, a social security system that really makes oldsters secure, and other such aids, discussed in this report, are urgently needed.

The Individual's Responsibility

There is no doubt that government has a large role to play in this field. And yet, while our Committee's endeavors are necessarily and primarily geared to governmental action, we must emphasize that the individual must help by developing his own resources.

All of us have within ourselves the capacity to enrich our own lives to the very end. We all have the responsibility for doing our own planning for ourselves, so long as we can.

If you work in a plant that has a compulsory retirement system, for example, it is sheer folly to do nothing to prepare yourself for the day when you will be retired. It is sheer folly, realizing that as you age you are subject to deterioration of physical tissues and to disabling illnesses, not to attempt to prevent chronic ailments by having periodic medical examinations, eating nutritious foods, and, in general, living wisely. Many of the problems you will face in the later years can be anticipated. Some of the problems of later life can be prevented early in life. And

it is rarely that you are too old to begin to overcome them. The best way to plan for a happy old age is to plan for tomorrow's happiness today.

Of course, cooperative action will be needed when individuals cannot cope with their own problems. That is why social agencies, medical groups and government need to wake up to the growing challenge that already confronts us.

Government can, for example, accumulate all available data on the problems of the aging. Government can raise and make available the sums needed to undertake basic research in this field. Government can make available facilities for use of the aging, whether it be housing or sheltered workshops. Government can remove some of the causes of unhappiness among the aged.

And yet, the thought remains: we cannot legislate happiness for young or old. **Happiness is earned.** It is achieved usually by effort, integrity and understanding.

In "Birthday's Don't Count," our Committee presented a wide range of social, economic and medical problems which particularly afflict the elderly, and explored possibilities of certain avenues of state action. In "Never Too Old," the employment difficulties of the aged were emphasized. In this, our third report, particular stress is laid upon the role of local communities in dealing with the aging, and in charting a definite blue-print for state-action. However, even as this report goes to press, our Committee is exploring two hopeful new facets for state activity in the field of housing and sheltered workshops. Plans for the aging, we can readily see, will never be final; they will change as understanding enlarges, as times and conditions change, as problems are altered.

Our Committee is encouraged by the amount of stimulative work it has been able to do in arousing governments on all levels, social agencies, and other groups of various types to an increased awareness of the problems of the aging, and what can be done to meet them. In our State in particular there has been a great awakening of interest.

The "talk-talk stage" is behind us. We are emerging from the planning stage. As the second half of the twentieth century opens before us, we are entering the action stage.

The future for older persons is not black. We shall bulwark it with economic security, strengthen it with true social security, and buttress it with inner security.

Can industry afford to lose productive power of such vigorous older workers as James Currie (above), a pipe still operator for an oil refinery?. (Drawn for *The Lamp*, Standard Oil Co. of N. J., by Charles Goldhamer).

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Our Findings and Recommendations

To the Governor and Legislature of the State of New York:

"FORSAKE us not in our old age."

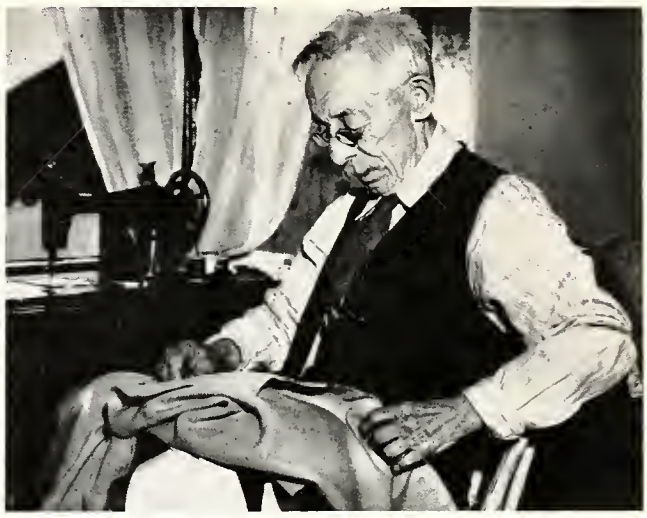
From millions of the elderly in this country comes this plea. An appeal as ancient as the beginning of family and tribal living, it is today no less demanding, no less urgent, that it has echoed through the centuries in all civilizations that neglected the old.

Sometimes spoken midst tears. Sometimes written in a pathetic shaken scrawl. Often-times expressed only in the dark shadow of fear and anguish that flits across a wrinkled face pondering the present and the future.

Poverty. Sickness. Loneliness. Humiliation. Uselessness. These are too often the rewards of survival until old age.

Yet it need not be!

A society that has reached into the atom itself for power, that has erected huge skyscrapers of steel, that has flown armies across the far seas, that has given man a higher standard of living than ever before, that has shown man can live in dignity as a free human being in a free, popularly governed order, can certainly ease the plight of our elderly.



Self-employment keeps many oldsters self-supporting, useful and happy.

Talent knows no age barriers.

The problems of our aging are not insurmountable.

Some there are who have conquered the obstacles of old age by themselves. We often see those who, though they may not have much worldly goods, face old age with courage and confidence that the last is the best yet to be, with the serenity of humans who have found comfort and hope in devotion to God, or in philosophic adjustment to life, or even with zest for yet another adventure, another accomplishment if it be only another endeavor to understand life itself, or to render another service to others less fortunate.

Others need the help of their fellow man, whether by individuals or by cooperative associations known as governments, to fight the ills that plague our oldsters.

Our Committee is convinced that society can reclaim to usefulness many of our oldsters who are now disabled, economically or physically. Our Committee is convinced that limited only by human intelligence we can change man's Last Years to creative Golden Years.

We believe that here lies one of the great challenges of the 20th century. For if we in this century can remove the fear of destitution in old age, if we can restore to our older persons the dignity of status which comes through usefulness and through mutual understanding, we shall indeed be solving one of the most complex problems that has plagued mankind.

And the heartening conclusion reached by our Committee is that it can be done!

Not with any panacea. Not with any "one-shot" pill that cures the disease but kills the patient. Nor can it be achieved over-night. Nor by yielding to pressures of sly promoters of economic artifices seeking political or personal advantage by capitalizing on the fears and needs of our elderly.

It is to the economist, the social worker, the industrial manager, the labor leader, the psychiatrist, the geriatrician, and the adult educator that we must turn for guidance.

In our Committee's efforts to approach the problem scientifically, we have done just that.

Social and Economic Changes

Our Committee in its two previous reports, "Birthdays Don't Count," and "Never Too Old," has presented an accounting of the tremendous upsurge in the numbers of our elderly and of the spectacular social and economic changes of the past century which have altered the status of the older person and produced so many heart-breaking difficulties for our elderly.

We shall not elaborate on these causative factors, except to point out that the number of persons 65 and over in New York State has doubled since 1930, and by 1960 it will have doubled again! Our total population increased 71 per cent in the past 40 years but the increase in older persons has been more than three times as fast, or 258 per cent. In 1850, life expectancy was 40 years; one hundred years later, it is about 68 years.

But it is not alone the impact of numbers that concerns us. The industrial revolution, the change from an agricultural to a factory civilization, and the concomitant movement from farm to city have produced a tremendous change in the living patterns of our older persons.

The small city apartments, the trend to smaller families, the mobility of labor, the modern wage-income patterns, and the emphasis on specialization are pressures which have produced an upheaval in the position of older persons in our society.

Society did not foresee the impact of these developments and scarcely understands that they lie at the root of many of the social and economic difficulties of our elderly today. With the result that society has been picking up the human wreckage and trying to mend it together with the scotch tape of old age assistance and the adhesive of social security.

Areas of Neglect

Before attempting to develop a program for the aging, it is necessary to know the basic needs and wants of the elderly. Our Committee has reported on these in previous reports, so we shall not repeat them here. However, it is abundantly clear to our Committee that there are large areas of neglect in our handling of the elderly that need to be brought to the attention of our people and our public officials.

Today, in this country, we are:

1. Providing social security that is noble in concept but petty in the pittance which it allows. Not only does the Social Security Act, as presently in force, not provide any real measure of security but in such provisions as that which bans payments to those earning more than $14.99 a month in covered employment, it is anti-social.
2. Spending millions for old age assistance, but hardly a dime, except for work recently undertaken by this Committee, to find out how we can prevent oldsters from needing to apply for assistance.
3. Dumping our oldsters into mental hospitals in many cases because we do not know what to do with them.

4. Kicking men and women out of our shops, factories and governments at age 65 though they are still able to work, need work and want to work.
5. Refusing to hire men over 45 and women over 35, though our Nation needs more production to increase our standards of living.
6. Forcing older persons to retire, though retirement is often a death sentence.
7. Setting up huge public housing projects but barring our older persons.

8. Establishing recreation programs for youngsters but ignoring the recreational needs of our oldsters.
9. Devising miracle treatments of the aged and wonderful new diagnostic aids, while providing few facilities for the oldsters who are chronically ill.
10. Shoving oldsters into nursing homes, boarding homes and old age homes, but failing in many instances to prevent such homes from being turned into dismal death depots for persons waiting release from life, or from being turned into money rackets.

11. Thrusting oldsters into county homes which are in some cases scandalously inadequate, firetraps, dreary dungeons filled with despair.
12. Attempting to plug up the flood of human problems with which the oldsters are faced by concentrating solely on economic security and totally ignoring the emotional security needs of the aged, their need to be wanted, loved, useful, their psychological needs.

The conditions which have been highlighted here are present throughout our country. They are not characteristic solely of our State, or of our own communities. Nor is our 12-point indictment directed against the Federal Government. Our governments can move no faster than the people permit. And our people, let us frankly state, have not demanded action. The public has not had the facts. Facts often have been unavailable in the infant science of gerontology, which deals with the aged. Or where the facts have been available, they have not been dramatically brought to the public's attention.

Here in the State of New York, virtually until our Committee was created, there was little awareness of these problems, except by a few private agencies, a handful of social workers, and a few medical men, whose warnings went unheeded year after year.

Our Committee has stimulated in virtually every city in this State not only a greater awareness of the urgency of the problems of the elderly on the part of civic leaders, not only a better understanding of the needs of the elderly, but also an active willingness to root out these evils, which we believe will be of tremendous long-range benefit.

Our Committee is the first such agency set up by

A study in intense concentration by aging minds that are still young.

any state. As such we felt we had a definite responsibility to handle our obligation in a mature, nonpartisan manner.

We soon found we had to assume some functions not legislative in a narrow sense, such as educating of responsible community leaders, encouraging, prodding and stimulating State and local officials, and while these activities may not produce legislation, undoubtedly they will bear fruit in better service to our old folks.

This Committee has excluded from its official inquiries (a) the field being covered by the Ostertag Committee on Interstate Cooperation, whose sub-committees are considering the problems of social welfare administration and financing, including adult institutional care; and (b) the field covered by the Mailler Health Preparedness Commission, the Hospital Study Committee, and Joint Hospital Survey and Planning Commission, which agencies have considered the problems of medical care, hospitalization and chronic illness of the elderly.

Our Committee has concentrated its attention largely though not entirely in six main fields: (a) employment problems of the elderly; (b) recreational needs of the elderly; (c) health needs of the oldsters; (d) community services to the elderly; (e) integration of State programs for the elderly and (f) development of an informed group of medical, labor, industrial, social work, and religious leaders in this State who will be informed in this field and who will be able to provide a continuing medium for advancement of the interests of the elderly apart from any governmental agency.

Basic Principles Guiding Our Committee

We come to you with no panacea or legislative cure-all for the problems of our oldsters. We carry no elixir of youth in our files.

Our Committee is guided by five basic principles:

1. *Activity is a biologic duty.*
2. *Oldsters must feel wanted and useful.*
3. *Aging is a personal and local phenomenon.*
4. *Until we know far more about the aging than we do, seek a diversity and fluidity of approaches and services and institutions rather than attempt now to freeze into law a single line of attack or encourage a single kind of institutional care.*
5. *The seeds for a happy old age are best planted early.*

We shall not elaborate in detail on these largely self-explanatory guide-posts. The late Dr. Alexis Carrel pointed out that "to those whose forces are declining appropriate work should be given, but not rest." We urge Grandpa to get out of the rocking chair; we want to encourage activity, whether it be work, social activity, recreation or any other kind of activity for older persons. The psychiatrists speak of the "lethal cessation" of activity, and Dr. Edward J. Steiglitz, renowned geriatrician, emphasizes to our committee that inactivity speeds up the degenerative processes. The phantasy of retirement and old age as a period of the Grand Loaf must be erased, for nature eliminates those who have relinquished their functional usefulness.

Activity is not enough. It must, in part, at least be purposeful. The older person must, like all of us, feel that he is doing something that is useful. This feeling of utility becomes especially vital in old age because oldsters very commonly feel rejected, because they are rejected.

We all age differently. The aged have no monopoly on aging; nor youth on youthfulness. Some at 65 are young; some at 35 are old. We age differently mentally and physiologically; and different parts of our body age at different rates. Beyond that, the needs of the aged differ greatly. Thus we must avoid, as much as possible, a broad sweeping treatment of the aging and attempt, *as far as possible*, the individualized, personalized, local approach of the case-worker or the modern group techniques of therapy. The closer we can bring service agencies to the aged, the more effective they will be.

Gerontology is in its infancy. We know little about our old folks. We know little about how to care for them. We aren't sure, for example, whether we need regional hospitals for the chronically ill in a few centers in the State, or many wards or cottages set up in connection with our local general hospitals. We aren't certain as yet whether we should set up settlements of old folks or bring them into neighborhoods with younger people. Our Committee believes that at this stage in our evolution toward services for older people it would be unwise to freeze into law any one type of approach or service to older persons. We are only in the planning and experimental phase of our development to a more mature handling of our oldsters.

Finally, we are convinced that those of us who are thinking about the elderly of the future would do well to be concerned about child welfare today, for the patterns of adjustment of the individual to his environment are determined early in life. The crabby, crotchety oldster of 76 was probably a miserable man in his 40s, an irritable youth, and a sniveling, brat in knee-pants. The well-adjusted, happy oldster of today was probably full of life and pep and ambition in his younger days.

A New Era for Our Elderly

Despite the tragic situation in which many of our elders find themselves, we believe we are on the brink of a new era of tremendous progress insofar as our oldsters are concerned.

Our Committee senses an awakening of society not merely to the statistical facts of life, that more of us are living longer and that the number of our elderly is booming, but also to the fact that we have been wasting one of our great human resources, our elderly. Too, society is gradually learning about old age, its limitations and its possibilities.

We are coming to understand that the Brotherhood of Man does not merely encompass a Brotherhood of Young Men.

Moreover, we are witnessing before our very eyes, though our people little realize it, the development of a new "breed" of oldsters. It is not only the Bernard Baruchs, the Herbert Hoovers, the Grandma Moses, the Connie Macks, the Arturo Toscaninis, who are contributing their talents to our country though past three score and ten, but also the oldsters who live on your block and ours, our elderly neighbors. Newspapers daily herald the exploits of septuagenarians, octogenarians and nonagenarians. A 77-year old great-grandmother is still an active barber in a small Vermont community. A 101-year old man in New Hampshire takes a 25-mile hike. A Massachusetts man, age 95, plays golf. Mr. Joseph Merrit of Goshen, N. Y., is an active lawyer at age 94. Adolph J. Cohn, of New York City, delivered an oration on his 96th birthday, and exulted, "I'm so doggone old, the insurance company is going to have to pay me off. I was supposed to die first. But I'm alive. And I feel fine, considering my youth, of course." A retired cotton broker of New York City swims happily on his 93d birthday, and goes up for a plane ride with a "young" pilot of 62 years of age.

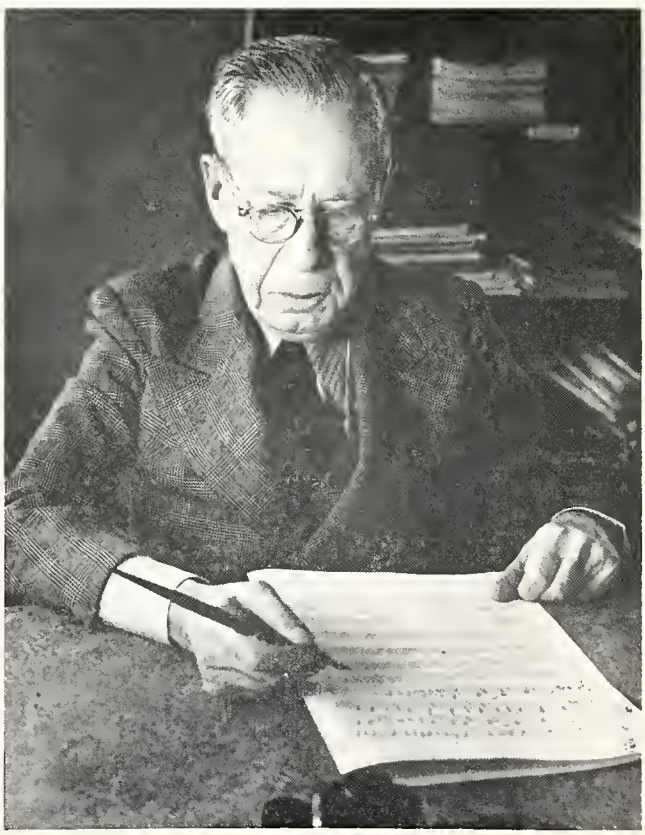
Dramatic new discoveries in medicine are bringing relief to our oldsters. The synthetic adrenal gland hormone, cortisone, and an adrenal cortex stimulating hormone from the pituitary gland, called ACTH, is effecting amazing benefits to sufferers from painful rheumatoid arthritis, and they show promise of combating certain aging processes.

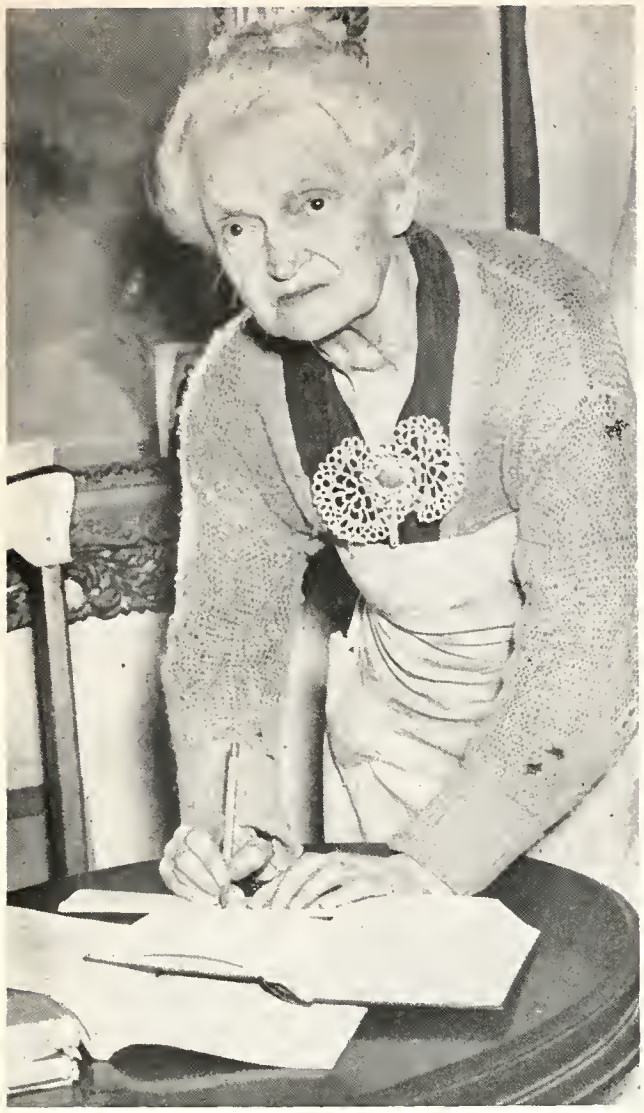
New findings in preoperative and postoperative management, anesthesia, operative techniques and early ambulation are combining to lower surgical mortality in middle age and old age, and are helping to restore older persons to vigor and activity where just a short time ago they would have been bed- or chair-bound invalids, racked with pain.

New drugs have been found of help in combating muscular tremors which often plague older persons. And a new compound, called reticulo-endothelial immune sera, is believed to give physicians a powerful weapon in combating degeneration of connective tissues.

Old and young enjoy adventure of air-flight.

Our Committee is understandably excited by the awe-inspiring results being achieved by Dr. Howard A. Rusk and his associates in rehabilitating old persons, and by the home care experiments in New York City.





A young oldster who went back to school bones up for exam.

(Courtesy Peabody Home for the Aged.)

Dressing up is morale booster at any age.

The current move to elevate standards in nursing homes and old age homes, the establishment of foster homes for the elderly, the growth of non-resident aid by old age homes, all these are but a portion of the many recent developments which argur well for our older persons.

Plans for the creation of a National Committee on the Aging under the temporary sponsorship of the National Social Welfare Assembly, along the lines our Committee has proposed for a State-Wide Committee on the Aging, mentioned later in this report, are also noteworthy. In New York City, the Mayor has appointed an Advisory Committee on the Aged.

A survey undertaken by our Committee indicates that schools of social work slowly but surely are taking the first painful steps to altering their curricula to make a place for study of the aged and training of personnel specially qualified to care for the elderly. Reports to our Committee from medical schools, long resistant to the idea of teaching geriatrics, show that the ranks of those preparing to be specialists in medical treatment of the aged are growing. Psychologists and psychiatrists are turning their attention for the first time to mental and emotional problems of our elderly. Family welfare agencies, religious and non-denominational welfare groups are devoting increasing attention to the aged. The creation of a State affiliation of councils of social agencies in New York State, with a special committee on the aged, will mean stimulation of more local activity in behalf of the aged. Recreation clubs for the elderly are springing up throughout the State and country. Employers, pressed by demands for private pension funds, are supporting an expansion of social security protection for the aged.

The drive by unions for pensions has focussed attention of the entire country on the need for improving the economic cushion provided by the Social Security Act.

All these developments, when seen in proper historical perspective, indicate that the second half of the 20th century will yield more than mere promises and hope for our oldsters.

The State's Stake

The State already has a heavy financial stake in the problems of our older persons.

It embraces an annual $29,613,023 State tax load to meet old age assistance payments for nearly 120,000 persons.

It covers custodial and medical care for 22,500 oldsters in our State mental hospitals, at a cost of over $20,000,000 a year.

It includes a substantial portion of State aid for cancer and tumor clinics, which serve primarily our older age groups.

If we add to these costs the payroll tax on employers and employees for the Federal Old Age and Survivors Insurance, or the $44,445,538 a year Federal contribution to old age assistance in this State, or local costs for old age assistance and old age homes, or the burden assumed by private groups in this State for supporting old age homes and nursing homes, chronic disease hospital wards mainly for the elderly, visiting nurse service for the aged, and many other such programs, or if we were to include the extra-long payments to elderly on unemployment insurance rolls because they cannot obtain work, we gain some appreciation of the staggering burden already assumed by citizens of this State for aid of our elderly.

State Activity

But this summary of some of the State's financial obligations in alleviating the plight of the elderly does not present a full picture of the extent to which the State of New York aids its oldsters.

There are a myriad of State activities directly affecting the aging, and we are happy to report that coincidentally with the creation of our Committee, various State departments have stepped up their services to the elderly, have re-examined their programs, or have increased the tempo of their researches into the needs of the elderly.

A 64-year old man, disabled by a fracture of both legs, was guided by the vocational rehabilitation unit of the State Education Department. This agency guided the man into a profitable rooming house venture. A 72-year old man, suffering from an affliction of the legs that barred his return to his former job, was placed through this agency's help as a landscape gardener.

The State Education Department, through its Adult Education Bureau, is promoting a variety of courses especially for older persons, in old age homes, day centers, and factories, as well as in schools.

Pension funds of various charitable and teachers groups are supervised by the Insurance Department, which also exercises general supervision over the various insurance companies which sell group retirement and welfare policies. The State Bank Department similarly supervises banks which are often named as trustees of various industrial pension funds.

The Social Welfare Department has appointed supervisors to check on nursing and old age homes and is developing standards for these institutions. This department also supervises the grants of old age assistance by local welfare departments. And when Mr. B., an old age assistance recipient, deems his grant is inadequate, he can appeal to the State Social Welfare Department for a hearing. This department is setting up in-service training for local welfare workers. It has encouraged improved medical care for the destitute aged. Too, it operates at Oxford, N. Y., the only State operated home.

The State Labor Department, through its Bureau of Research and Statistics, is beginning to compile case histories of successful employment of older persons, and has initiated a series of studies dealing with older workers. The State Employment Service, under the State Labor Department, has set up an experimental unit in Manhattan to place older persons seeking clerical jobs, and is slowly expanding this valuable type of work to other areas and other types of positions.

The State Mental Hygiene Department cares for 22,000 persons who are over 65 in its mental hospitals. Last year it launched an experiment at Willard State Hospital in which naval barracks at nearly Sampson are being used to determine the practicability of cottage care of the harmlessly senile. This department has placed 827 persons over 60 years of age in foster homes and is developing its family care program.

The State Housing Division has set aside some 53 apartments at the Fort Greene Housing Project for older persons, and of course, when older persons live at the site where slums are demolished for new state-aid public housing projects, they are given priority in renting the new apartments. This division is undertaking an analysis of its research data to sift out all available facts relating to the living conditions of the elderly.

State Health Commissioner Herman E. Hilleboe recently informed the American Public Health Association that his No. 1 health goal was better care for the chronically ill and aged. This represents a major shift in emphasis in the thinking of this department along lines urged by our Committee. Many of the services rendered by the Health Department from its cancer work to its tuberculosis program directly aid the elderly.

The State Retirement Fund in the State Department of Audit and Control directly affects former State and local employees as well as older workers now employed by the State or local governments.

There are a host of other State services to the elderly ranging from free fishing licenses granted by the Conservation Department to oldsters, to bath treatments by the Saratoga Springs Authority especially popular with older persons, and which are free in some instances to persons on old age assistance needing the therapeutic aid of the baths there.

Our purpose in recording these activities is to underscore the diverse relationships between a modern state and its older people. It also may help the reader to understand why our Committee believes there is need for coordinating State activities.

ANNUAL PARTIAL COST TO THE PEOPLE OF NEW YORK STATE OF CARE FOR OLDSTERS

Old Age and Survivors Insurance payroll deduction	$322,800,000[1]
Private industrial pension payments	135,000,000[2]
Old age assistance, Federal, state and local payments	87,600,000
Care of elderly in State mental hospitals	20,100,000[3]
Homes for the aged, public expenditures for	5,000,000[4]
Elderly in State prisons, cost of care for	1,500,000[5]
Assistance to elderly blind	1,000,000[6]
Benefits to elderly veterans and veterans dependents	28,000,000[7]
	$601,000,000

[1] Fiscal year 1948–49.

[2] No accurate data available for state or Nation on private industrial pension payments. This figure is 10 per cent of the *estimated* national figure for employer-employee contributions to industrial pensions.

[3] Fiscal year 1948–49 maintenance cost; does not include construction or depreciation costs of buildings.

[4] Data relates to 1946, from New York State Department of Social Welfare.

[5] Estimate based on ratio of 65-and-over age group in prisons to total prison population as of January 1, 1948; cost estimates based on per capita costs in 1946.

[6] Based on ratio of persons 65 and over in upstate caseload, for calendar year 1947.

[7] Based on ratio of persons 65 and over receiving disability pensions and survivor death claims from World War I and previous wars and estimated cost in maintenance in veterans hospitals and homes.

Community Programs

One of the most stirring advances being made in the State toward alleviating the plight of our elderly is being made by local private agencies, which are taking the lead in their communities in awakening the people to the need for aiding the oldsters and often in actually operating new services for the aged.

A state-wide survey made this past year by our Committee shows that old folks are getting more attention than ever before from their home towns. Local activity in the field of the aging is beginning to boom.

Our Committee has attempted to stimulate this development, provide a source of information for the local agencies, and channel their efforts into the most productive avenues.

Recreation centers for oldsters are being set up in many communities. Old age homes slowly but steadily are improving their standards of service. Health, welfare and industrial organizations are joining to plan community-wide welfare programs for the elderly. A variety of research is being initiated, and new ways for dealing with ailing oldsters are being developed.

We find that New York City and Rochester are foremost in advancing the interests of the elderly in our State. Rochester, by virtue of a gift from the local Women's Educational and Industrial Union to the Rochester Council of Social Agencies, has appointed a Community Consultant on the Aged to spur on services of oldsters and coordinate work dealing with them.

Rochester's social agencies are outstanding in their advanced planning for the elderly. This city has what our Committee believes to be the only geriatric clinic in the State, operated by the Baden Street Settlement House. Rochester's Planning Commission has assigned a staff member to report on housing for the elderly. The local Welfare Department has made studies of oldsters on old age assistance rolls. Old age homes for the first time are being encouraged to lift their standards. Recreational projects have already been set up for oldsters. Rochester knows what it needs to do for the elderly, and is prepared to do it, limited only by available funds.

New York City, through the leadership of the Welfare Council of New York and the Community Service Society of New York, is bringing together public and private institutions, agencies and individuals dealing with the elderly for a unified attack on old age problems. Miss Ollie A. Randall, Consultant on the Aged for the latter organization, is an unofficial New York City ambassador to its elderly people.

New York City's Hospital and Health Departments are taking a world-wide lead in studies of degenerative diseases which afflict the elderly. The city is also pioneering in providing housekeeping services and home care for sick oldsters who often respond best to help in their homes rather than in hospitals. New York City has the first geriatric unit set up by any local health department in the country. The Hospital Department, guided by the able medical counsel of Dr. Howard A. Rusk, is doing miraculous work in rehabilitating the elderly for work.

New York City's Welfare Department is providing staff personnel for the world renowned Hodson Recreation Center for oldsters in cooperation with private agencies.

Social welfare organizations in various communities are setting up special committees for the aged. In the long run these will prove to be major steps forward, for they will provide the necessary leadership and planning needed for total community programs.

Syracuse recently established such a committee under the leadership of the Onondaga Health Association. The Committee is headed by Dr. Raymond G. Kuhlen, nationally known Syracuse University psychologist specializing in problems of the aged, who

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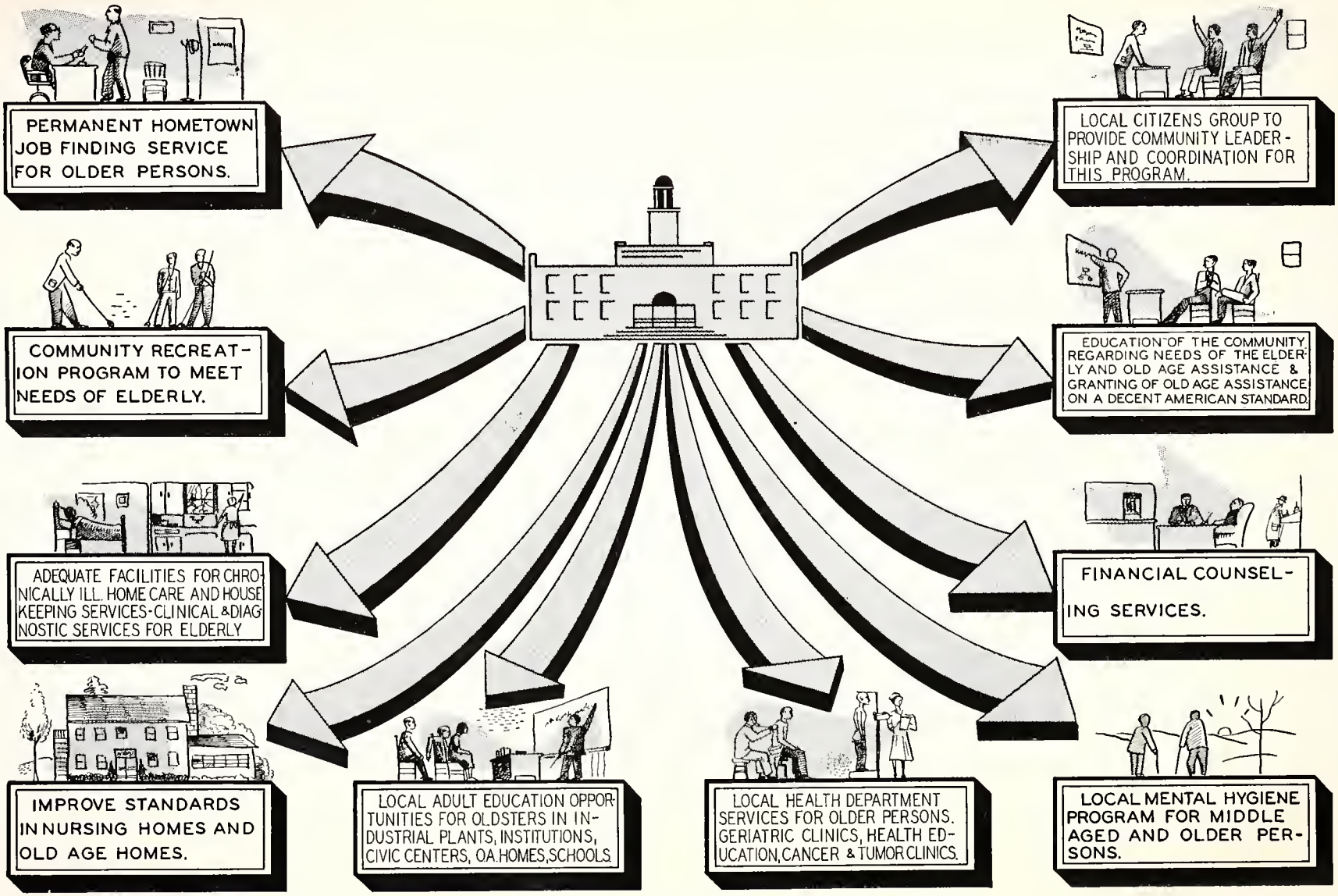


already has a large number of research projects under way and is starting to mobilize community support for recreation and adult education programs for the elderly. A presentation of the Syracuse program is detailed elsewhere in this report.

Buffalo has set up a special committee on the aged under its Council of Social Agencies, and it is working toward educating trustees and administrators of old age homes toward modern concepts in handling institutionalized elderly. The Committee is also developing craft and recreational programs for oldsters. The Buffalo Fire and Welfare Departments recently joined in surveying old age nursing and boarding homes. The Forty Plus Club of Western New York, with its headquarters in Buffalo, has helped many top notch executives obtain jobs though they were in upper age brackets.

In New Rochelle, Port Chester, White Plains, Ossining, Tarrytown, Yonkers, Mt. Vernon and Tuckahoe, "senior canteens" have been set up largely through the support of the National Council of Jewish Women. Local recreation commissions in Westchester County are being stimulated to think in terms of old people as well as young people.

Troy and Yonkers are now considering setting up committees on the aged through their local social welfare agencies. The Community Chest and Planning Council of Utica is launching a study of hospital facilities for the senile in the Utica region.

Jamestown's Recreation Department has organized a "Golden Age Society" to handle recreation for oldsters. At present, it has 341 members, the oldest of whom is 93. The group has picnics, trips, lectures, plays and other entertainment to make life worth living for its members. The club has a special shut-in program for its bedridden members, one of whom has been in bed for 25 years.

These are but some of the developments in our communities. Others are cited in more detail in other parts of this report.

The New York Plan

The heart of our proposed plan for New York State is stress upon a local community approach, an emphasis upon a variety of modes of attack on the problems of the elderly, and a provision for linking private and public agencies in the communities for a united drive to aid our oldsters.

In this, our third report, we present as definite and concrete a program as can reasonably be achieved at the present time.

The program calls for:

1. **Teamwork between Federal, State and local governments, and between government, industry, labor and citizen groups.**
2. **A "home-town" approach to the myriad problems of the aging, recognizing that the strength of our country lies in great measure in vitality of our local communities and in the intelligence and public spiritedness of our local community leaders.**
3. **The *preventive* approach, which seeks to concentrate on preventing our oldsters from needing to fall back on old age assistance, or from needing hospital facilities, or from needing to be institutionalized in old age homes, by providing job opportunities, health services and adequate housing for older persons. Heretofore most thinking in connection with the aged was centered on trying to ease the woes of the elderly rather than aiming to prevent them.**
4. **A diversified, multi-pronged attack on the problems of the elderly, rather than a single approach, characteristic of the Beveridge plan in England and the California approach in this country.**
5. **Integrating services for the aged with general community services for all citizens whenever possible instead of separating old people from the remainder of the community.**

The plan calls for establishing:

1. A permanent home-town job-finding service for older persons, with local citizenry joining with the local employment service offices, to conduct an educational campaign designed to encourage the hiring of older workers, break down artificial age barriers in local plants, furnish counseling service for older persons, and utilize local schools and hospitals for rehabilitation of the elderly job seeker for work.
2. A community recreation program in each locality to meet the needs of the elderly, such recreational facilities, to be sponsored by local fraternal, church, civic and welfare organizations and official agencies; such recreational facilities to be of the day care center type or the club type depending on the size and needs of each community, but in all cases emphasizing not merely recreation in a limited play sense, but also opportunity for creative, purposeful activities. The program should not be limited to a particular building or facility, but should spread out to embrace old age homes and nursing homes.
3. Adequate facilities for the chronically ill in each community, as may be recommended by the Joint Hospital Survey and Planning Commission, more liberal admission policies of the elderly who are chronically ill by local hos-

pitals, provision of home care and housekeeping services for those who often do not need expensive hospital service, and adequate clinical and diagnostic service for the elderly.

4. Improved standards of institutional care, in nursing homes and old age homes, by licensing, education and supervision, as may be recommended by the Ostertag Joint Legislative Committee on Interstate Cooperation and the State Social Welfare Department.
5. Local adult education opportunities for oldsters, embracing a wide range of courses suitable for oldsters, such as hobbies and crafts, and also courses dealing with health care after 60, how to adjust to retirement, etc. Such courses should be given not only in schools, but wherever convenient for the elderly, in plants, old age homes, private homes, and civic centers.
6. A new concept in local health departments geared to adjusting services to an aging population, with development of health education programs, geriatric clinics wherever possible, and a shift in emphasis by local voluntary health agencies from the communicable diseases to the degenerative diseases.
7. Local mental hygiene program designed not only for younger persons but also for the middle aged and oldsters, to block the impact of senility.
8. Financial counselling service by the community's bankers, businessmen and social workers, to low and moderate income groups so that the best use may be made of available income by our elderly and near elderly and so that some may be prevented from needing old age assistance.
9. A program to inform the public regarding the needs of the elderly on old age assistance, the extent to which local welfare departments are meeting these needs, and the granting of old age assistance to the needy according to their needs, based not on a meagre subsistence or sustenance level, but on a decent, adequate American standard of living.
10. A local agency in each community composed of private and public groups to coordinate the local old age program, inventory and develop local resources for the aged, and educate the community to the needs of the older people. The local councils of social agencies, already in existence, provide a ready-made organizational pattern capable of providing the leadership urgently needed in urban areas. In non-urban areas, perhaps existing committees of the State Tuberculosis and Public Health Association, of the State Charities Aid Association, and various farm groups, such as the Grange, Farm Bureau, Home Bureau, and the Extension Service, can provide the central direction and leadership needed.

This is a local program that calls for social engineering that can be launched by our communities without waiting for a beneficent State or Federal Government to prod, finance, or supervise local efforts.

Some communities are already taking action along these lines as we have indicated in another part of this report. This multi-purpose drive is practical, because individual segments of it have already been tested in various communities.

The State's Role

But our Committee believes the State must bear its share of the responsibility. Our communities are already heavily burdened with debt and tax levies. Our Committee believes that the State has these primary obligations in this field:

A. Provide financial assistance wherever justified.

B. Provide the technical assistance and standards needed to assure uniform, high-level administration.

C. Spark its own agencies to a wider appreciation of the needs of the elderly.

D. Provide a central coordinating agency of various departments to give the State program leadership, direction and coordination.

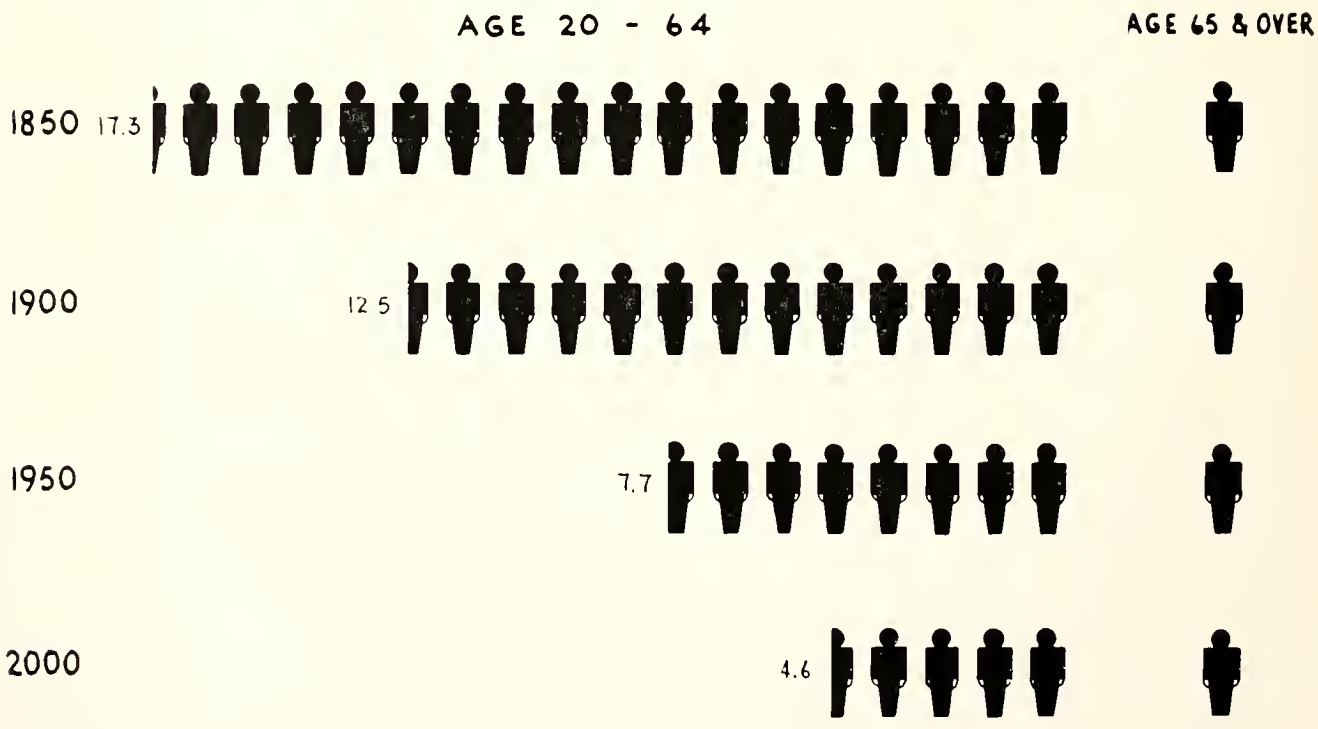
Specifically, our Committee recommends:

1. Creation of a special counselling and placement service in the State Employment Service, to aid older persons obtain jobs. Our Committee believes every local office of the State Employment Service should have one or more placement experts, depending on the size of the community, who is familiar with the emotional, medical and economic problems of the older persons, who is familiar with local job opportunities for older persons, who is trained in "selling" older persons to industry, and who has the special zeal and ability to counsel older workers so that they will have renewed confidence in their abilities.
2. Creation of a permanent, full-time agency in the State Labor Department to promote the employment of the aging through education and research designed to break down age barriers in industry through development of job analysis studies, case histories, etc., publicity aimed at breaking down the several myths which retard the hiring of older persons, and to collect data on employment of the elderly which will aid

the employer and employees alike, such as information on pre-retirement counselling policies, private pension plans, etc.

3. Provision of state-aid for recreation centers for the elderly in the same manner it has authorized state-aid for recreation centers for youths. We recommend that the Legislature appropriate 10c. of State-aid for each person 60 years of age or over to each community matching this aid dime-for-dime. We believe the State will be buying itself a bargain through such aid, that it will decrease the ratio of increase of our elderly in our mental hospitals, and that it will help restore vitality to our elderly.
4. Creation of Division of Adult Hygiene and Geriatrics aimed at shifting emphasis in the State Health Department from communicable diseases to the degenerative diseases which are now the leading causes of death.
5. The Legislature should provide the Adult Education Bureau of the State Education Department with the funds necessary to establish a state-wide adult education program aimed at our older persons, by encouraging localities, industries and labor organizations to organize courses, by training teachers for the special techniques needed in motivating older persons and by providing leadership to carry out plans already well formulated by this bureau.
6. In all state-aided public housing projects, a small percentage of apartments be set aside for older people at least in proportion to the number of elderly in the community as a whole.
7. A permanent State council on the elderly designed to provide the central coordinating machinery needed to provide official leadership in the field of the aged for the various State departments.
8. Adoption of a law banning discrimination against older persons seeking any State or local

NUMBER OF PERSONS AGE 20 TO 64 FOR EACH PERSON AGE 65 AND OVER



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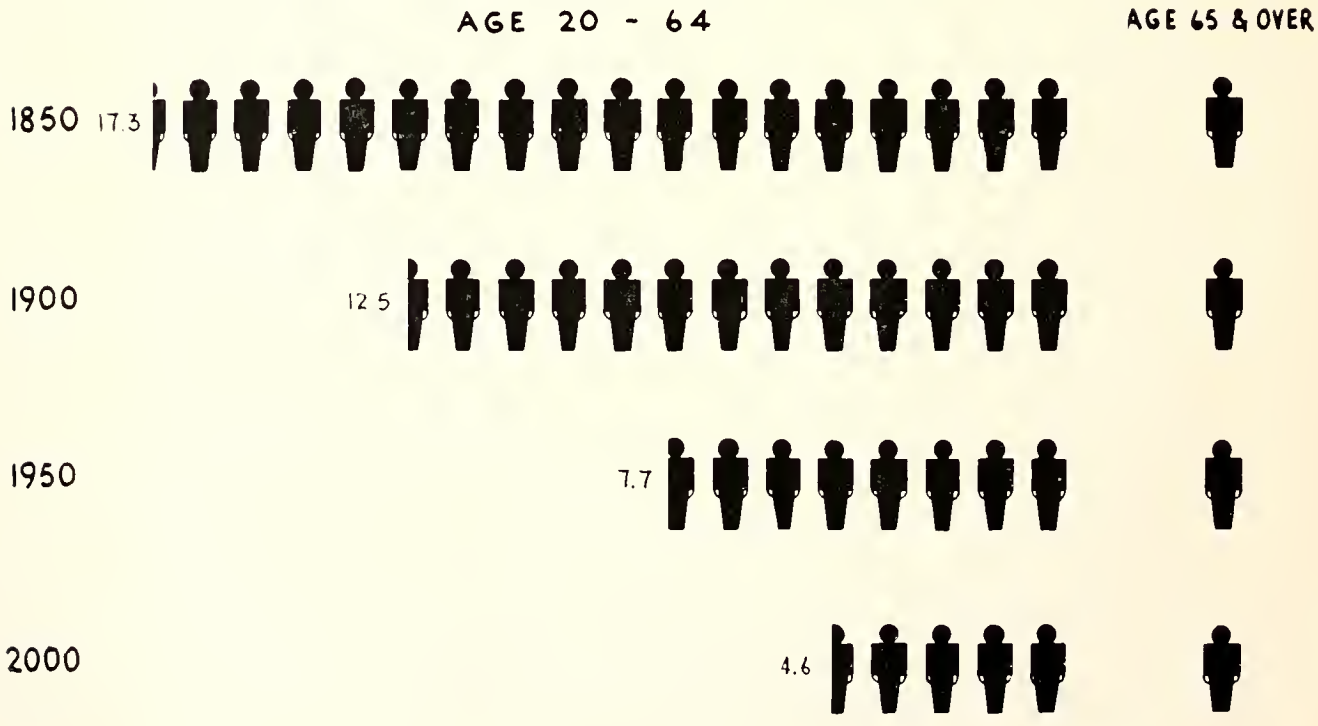

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(Courtesy National Industrial Conference Board.)

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OF

NEW YORK STATE PLAN

FOR

THE AGING

Guide Public Officials—Aid in Developing Public-Private Agency Teamwork

LABOR

Specialized Counselling and Placement of Older Workers

Research

Education of Industry

Stimulate Home Work for Elderly

State Aid for Non-Profit Sheltered Work Shops

DIVISION OF SAFETY

Development of Safety Program for Aged

SOCIAL WELFARE

Supervise Adequate Old Age Assistance Grants

Supervise Old Age Homes, Nursing Homes, Infirmaries

Improve Casework Techniques With the Elderly, and Operate Oxford Old Age Home as Demonstration Center

HEALTH

EDUCATION

State Aid for Adult Education, Hobbies, Crafts, Etc., for Oldsters

State Aid for Recreation for Oldsters

Retraining of Older Workers for New Jobs

Vocational Rehabilitation of Aged

Revamp Grade and Secondary School Curricula for Better Appreciation of Aged

CONSERVATION

Recreational Facilities for Aged in State Parks

Expansion of Cancer and Tumor Clinics

Geriatric Laboratory and Hospital; and Physical Rehabilitation Program

Create Bureau of Adult Hygiene and Geriatrics

Multiphasic Screening of Older Population

COMMERCE

Aid to Oldsters Seeking Self Employment

Pre-Retirement Counselling Aid to Industry

Aid to Communities Planning for Aging Population

CIVIL SERVICE

End Age Barriers to State and Local Employment; and Pre-Retirement Counselling

MENTAL HYGIENE

Research on Care of Senile Psychotics

Adult Hygiene Clinics

Adult Mental Hygiene Education Program

Psychiatric Service in Hospitals

HOUSING

Set-Aside of Apts. for Aged in Public Housing Projects

State Loans for Non-Profit Old Age Homes, Nursing Homes, Infirmaries, Apartment House and Cottage Housing for Aged

Research on Housing Needs of Elderly

COMMUNITY PROGRAM FOR THE AGING

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license, permit, or certificate, or admission to any state-financed, administered or approved course. While our State is admirably free of any such discrimination, we have found that applicants for vocational-industrial teacher training courses set up by the State Education Department are barred if they are over 40 years of age, a policy that blocks able, skilled middle-aged and elderly mechanics, for example, from serving as teachers.

State-wide Citizens Committee on the Elderly

Our Committee recommends that there be established in this State a State-wide Citizens Committee on the Elderly.

We have already initiated moves leading to the creation of such a group and believe that perhaps one of our most worthy long-range accomplishments will be the impetus given to the establishment of such a group.

Such a private committee, representing the thinking of labor, industry, and farm organizations, and religious, medical, and social welfare groups, can bring to bear upon the old age problems in our State, sound, mature intelligence.

Such a non-official group is needed to review legislation introduced affecting the elderly, mobilize public opinion for sound legislative or administrative actions affecting the elderly, prod public officials to greater efforts in behalf of the aged, act as an unofficial auditor of the State's activities for the elderly, stand as a bulwark against "panacea" pressures which might throw the State into bankruptcy, and serve as a vital link with any national committee set up in this field, and aid local councils of social agencies in their efforts to alleviate the plight of the elderly.

This, then, is the New York Plan. It is not a complete, final and definitive plan. But it is believed to be the best plan that our Committee can propose at this stage in our social evolution, and with the present limitations on the scope of our Committee's activities.

Man's Quest for Security

There is a disposition among some publicists and officials to view the current drive for security for the aged as a new trend that stems from a weakening of the moral fibre of our people.

This line of reasoning totally ignores the physiological and psychological drives and the socio-economic factors which underlie the search for security.

Man has always sought security.

He sought it in the caves. He sought it in nomadic tribes which travelled far to find food in abundance. He sought it under the protection of lord-subject relationship and under master-slave relationship, and when he found no real security in any of these, he sought security in freedom.

The baby who wails when it does not receive its milk on time is crying out not only with the pangs of hunger but with fear of loss of its security. The baby grown to manhood searches for security through his own labors, through religion, through family relationships, through participation in a free society.

Speak to the psychiatrist and he will say: "The man who loses his sense of security is lost. Today mental institutions are jammed because so many people have, for a variety of reasons, lost their sense of security."

And so the quest of our aged for a modicum of security in their old age lies deep rooted in the physiology and mentality of man. And if it erupts in modern man as a drive for pensions, or old age insurance, should it not be viewed as stemming in large measure, at least, from the change from a rural economy to an urban economy, from an agricultural economy to an industrial economy, from a society where families lived in large homes ample for three generation units to one of small apartments where two generation units are often cramped, from conditions which often bring our people to later maturity shunned by an industrial society and haunted by fears of destitution and a pauper's grave.

The financial needs of the elderly are real and urgent. Of 6.3 million nonfarm families with incomes below $2,000 in 1948, more than one-fourth, or 1.7 million, were headed by persons over 65.

Half of the families headed by persons over 65 had incomes below $2,000 a year.

A study of old age and survivors insurance recipients indicated that 69 per cent of the nonmarried persons and couples living alone and drawing OASI checks received a total annual income from all sources of less than $1,000, and practically all of them were below the $2,000 level.

The problem is not should we provide a measure of security for our aged, but rather:

(a) how much security can our industrial economy afford to provide now and in the foreseeable future; and

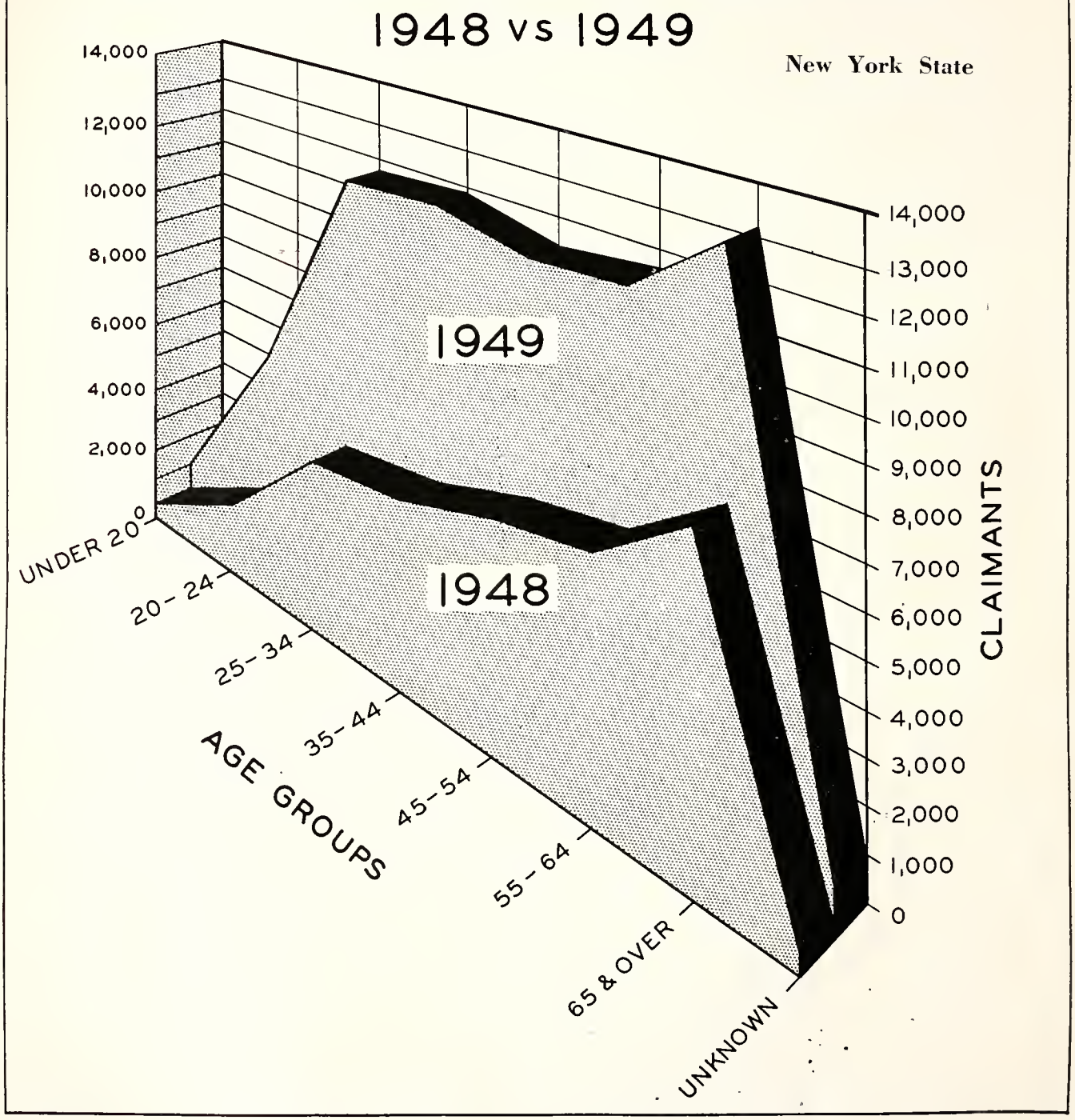
(b) how can we channel the drive for security into proper avenues.

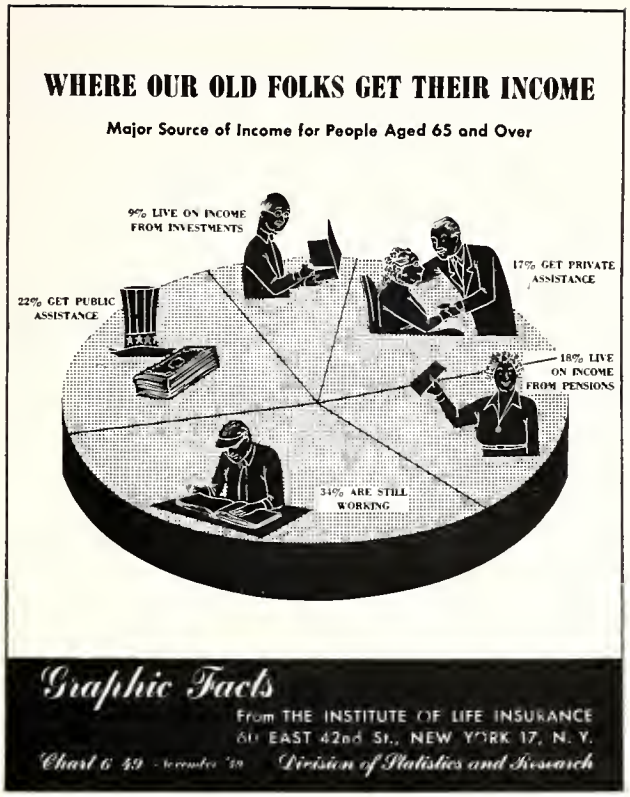
We have today a 250-billion dollar economy. Some economists, more optimistic perhaps than others of their colleagues, believe we shall have a national production in 1975 of 500 billion dollars.

How much of this production can we siphon off for protection of the aged? This is a problem national, rather than state-wide in scope, and requires a degree of study that has not been given as yet by anyone in this country.

UNEMPLOYMENT INSURANCE

COMPARISON OF CLAIMANTS EXHAUSTING BENEFITS DURING FIRST TWO POSSIBLE WEEKS IN BENEFIT YEAR





To cushion the economic blows which strike our people in old age, our country has developed three basic types of financial aid:

1. Contributory old age and survivors insurance;
2. Old age assistance;
3. Industrial pensions.

What Security Costs

Our Committee estimates that the annual cost of providing old age security in its three major forms in this country is approximately 4.7 billion dollars, or 2 per cent of the country's national production.

Cost of Old Age Security in the U. S. A.

(1950 est.)

Cost to taxpayers of old age assistance	$1,380,000,000
Cost to employers and employees of old age and survivors insurance	$2,000,000,000
Cost to employers and employees of private pension systems	$1,350,000,000
	$4,730,000,000

And are our oldsters obtaining financial security from this nearly five-billion-dollar-a-year outlay by taxpayers, employers, employees and consumers?

The answer is no!

How Much Security

Both old age insurance and old age assistance benefits are below a decent living standard. And until recently, the average industrial pension paid little more than the monthly grant to a recipient of old age assistance.

There can be little security on $26 a month. Yet that is the average benefit under the old age and survivors insurance system to single workers.

And the average benefit to couples under OASI is $41 at a time when the Federal Government itself concedes that a minimum food bill alone for a retired couple costs $45 a month!

Old age assistance payments average $45 a month per recipient in this country. And until the recent drive for $100-a-month pensions by unions, private retirement systems paid an average of about $50 a month retirement benefits.

Moreover, the OASI system, which is supposed to provide for "social security" actually provides insurance benefits for only 1,900,000 elderly, whereas our relief system of old age assistance provides welfare grants to 2,735,000. And probably less than 500,000 ex-workers are receiving industrial pensions.

Thus 50 per cent more persons are receiving old age assistance than are receiving old age insurance!

And oldsters on old age assistance are receiving 70 per cent more in average monthly benefits than are those on the OASI rolls!

The chaotic condition of our security provisions for the aged are apparent. The OASI was intended to do away with the need for most of the oldsters applying for old age assistance. Yet, as Miss Jane Hoey, Director of the Bureau of Public Assistance of the Federal Security Agency, informed our Committee, due to the inadequacies of the old age insurance program, old age assistance has grown beyond its intended scope and responsibilities.

The failure of the old age insurance system led to the recent $100-a-month pension drive by unions, adding another complication to the already sadly entangled old age security system in this country.

Oldsters and Economic Protection*

	Oldsters Receiving Benefits	Citizens "Covered"
Old age assistance	2,735,000	2,735,000
OASI	1,900,000	35,500,000
Private pensions	500,000	11,500,000

* There is considerable duplication in these figures, which are suggestive rather than definitive.

OASI

The OASI program fails to cover 23,000,000 workers, the self-employed, the household workers, government employees, employees of non-profit organizations and farmers.

Basic flaws in the old age insurance program, in addition to inadequate coverage and inadequate benefits, are:

1. The ban on any recipient of old age insurance earning more than $14.99 a month from any employer covered by the Social Security Law.
2. Unduly restrictive eligibility requirements for older workers. Special allowances should be made in establishing eligibility requirements for those who were already at the higher ages when the system began.
3. Failure to encourage oldsters to continue to work by not allowing pension payments to accumulate during period of employment past retirement age.
4. Failure to grant dependency benefits to women who have accumulated primary benefits and failure to start benefits for women at age 60 instead of 65. Today more than half of the married men at 65 have wives who are 60, only one in 50 have wives who are 65. This means that most married oldsters must support their wives on a single pension. Moreover, women of 60 find it practically impossible to obtain jobs.
5. Failure to recognize the change in wage levels since 1939, by requiring contributions be paid only up to $3,000 of salary, thereby keeping receipts and benefits below proper levels.

Fortunately, as this is written, there is a drive on in Congress, to extend the Social Security provisions affecting the aged. Our Committee hopes that the old age and survivors insurance system is developed into a real old age security system or is fundamentally recast so that the goal of universal coverage is attained and an adequate benefit obtained.

Our Committee urges, however, that the entire problem of integrating old age insurance, old age assistance, and industrial pensions be thoroughly explored by national authorities.

Our Committee will gladly cooperate with national authorities to the end that a decent old age security system is established. Our present system has failed, and merely to patch it up here and there is to store up troubles for the years that lie ahead.

Old Age Assistance

Old age assistance is bread, butter and bed money. It affects the elderly quickly, directly and basically. It provides the means of obtaining a bag of coal for a cold flat, a pair of eye-glasses for a near-sighted old man, or a woolen nightgown for a frail, impoverished widow. It may help pay for a cancer operation, for a needed sedative, or for nursing home care.

Across the nation, one out of four oldsters is on old age assistance rolls. In New York State, one out of ten is on OAA.

Today, the staggering sum of approximately $87,000,000 a year is being spent by Federal, State and local governments within New York State for old age assistance.

The Cost of Old Age Assistance in New York State, 1949

	Total	%
Federal Aid	$40,445,538.32*	46
State Aid	$29,613,023.18*	34
Local Spending	$17,524,640.81**	20
	$87,583,202.31	100

* Includes aid for local administrative purposes.
** Approximate.

Federal and State aid represents 80 per cent of the total cost, with localities contributing the remaining 20 per cent.

The number of persons on old age assistance in this State hit a peak in 1941, when 121,578 persons received this welfare grant. During World War II, the numbers on OAA declined, as industry opened its gates to the elderly. In the post-war period, the trend has been upward once more, although the number on OAA in this State has not yet reached the pre-war peak. In November, 1949, OAA recipients in New York State totalled 119,113.

As pointed out earlier, our Committee has not had the responsibility of studying old age assistance, for it is being reviewed by the Ostertag Joint Legislative Committee on Interstate Cooperation.

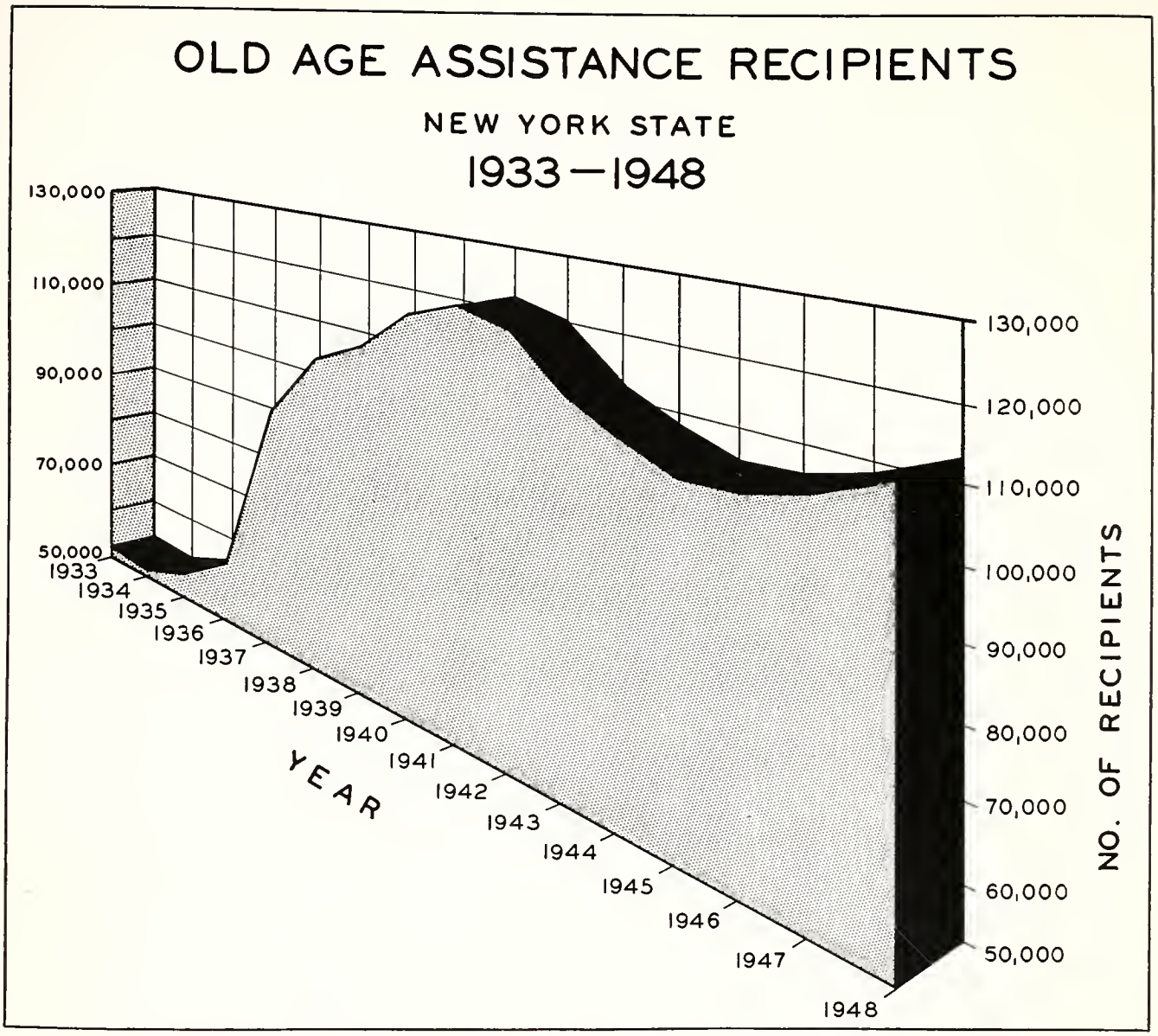
The Social Security Act makes certain requirements mandatory if states are to secure Federal money for the categorical program of OAA, AB and ADC. The act provides states cannot establish conditions limiting residence and citizenship too greatly. Assistance must be provided equitably and must be paid in cash. To this extent these programs have an underlying similarity throughout all the forty-eight states in the country.

However, we should like to note here that the OAA system in this country is in a very jumbled condition. Each State has a virtually different assistance plan, with different eligibility rules and payment standards. The following table indicates to some extent the differences in payments and coverage:

Old Age Assistance in Selected States

State	% of Pop. over 65	% of oldsters receiving OAA	Average Monthly Grant	State Per Capita Income
Colorado	8.6	48	$83.00	$1,482
California	7.6	31	70.70	1,643
Washington	7.4	38	66.87	1,395
New York	8.2	10	52.61	1,781
Louisiana	5.5	82	47.08	892

The need for developing a sound pattern of aid to the elderly was dramatically highlighted this past



year when California was thrown to the brink of bankruptcy by a referendum, subsequently overruled by the people themselves, which put 41,000 additional persons on OAA rolls, removed family responsibility for the elderly, and boosted payments. In the State of Washington, OAA payments constitute 43 per cent of the entire State budget, although a poll conducted there indicated that 81 per cent of the public is in the dark on how much persons on OAA receive.

We believe there is similar lack of information among our own people. In order to protect old age assistance recipients, local welfare departments have gone to extremes in keeping their operations in the dark. Occasionally financial data as to total expenditures or total case loads are released, generally a meaningless jumble of statistics at best. Little mention is made of the needs of the elderly, and of the needs being met and those unmet.

Our people are entitled to know what is being done for their aged neighbors and what their needs are. The local welfare departments will be pleased, our Committee feels, with community reaction, if they pursue a policy of telling the public of the plight of some of the needy aged, what is being done to help them, and what needs to be done. We believe that in many cases there will be an outpouring of public support, financial and service, beyond that provided for by public budgets.

Our Committee suggests that local welfare depart-

ments, while keeping the identity of their OAA recipients confidential, indicate to the press the problems being faced by oldsters in our communities.

Our Committee suggests that leading civic leaders, bankers, labor leaders, medical men, be invited by local welfare departments to see from typical case records what the needs of the elderly are, whether they are being met and what can be done to meet them.

We urge that local welfare departments examine their public relations programs, if they have such programs, and create them if they do not have them. This should be done not to "build up" the department's prestige but to increase public understanding of the needs of our oldsters and what is being done to meet them. We believe that our local welfare departments have much to be proud of in the work being done to ease the plight of our elderly, but our communities simply are unaware of what is being done.

Despite the fact that OAA is costing the Nation $1,380,000,000 a year, little is known about our old age recipients.

Who are they? Are they "every-day" persons, of average intellect and backgrounds, or are they mainly a special "problem" group of persons? What are the long-range and short-range reasons for those unfortunates needing old age assistance? Was it mainly a long history of low-wages, which make it impossible to raise a family and at the same time put aside enough money for old age? Was it perhaps a sudden collapse of one's business or health? Do oldsters rush to get on OAA rolls at age 65 or do they prefer to work? And what can the community do to prevent persons from needing old age assistance? Or—have they just lived too long? These fundamental questions, as our Committee noted in our previous report, "Never Too Old," have not been answered.

Our Committee has undertaken, through a study of a sample of representative OAA cases, to answer these questions. This work is now going on.

To present an idea of the human aspects of the OAA cases being handled by local welfare departments, and to indicate some of the salient features of these cases that should be of interest to our communities, we wish to record here just four cases as prepared by our research staff.

The Case of Miss B.

Miss B., 69-year old spinster, worked for many years as a supervising typist and stenographer for one of the large insurance companies, headquartered in New York City. She helped support her widowed mother for many years. Then, when two years from obtaining a company pension, she was stricken with a heart attack. She had $1,000 in the bank. Her company provided some compensation for a year.

Then, funds exhausted, her heart willing but weak, her hearing diminishing, she had to go on Home Relief. For 10 years she was on HR, until at age 65, she was shifted to OAA.

Miss B. didn't do too well in elementary school, went to business school where she studied typing and stenography.

Today, she lives with her OAA widowed sister in a plain flat. Her sole pleasure seems to be visiting her niece. Case worker reported "these two women live very quiet hum-drum lives, seem to be satisfied with it."

They have to use toilet on second floor jointly with other people, do not have provision for getting hot water in quantity, so have to heat water on stove. Their flat is not very warm. Recently she fell in her kitchen, chipped her shoulder, lay 20 minutes before help came.

During World War II, Miss B. at age 63, anemic, deaf, sought work, together with her virtually sightless sister. "I'll have to be eyes for her while she will have to be ears for me," she said. Wanted job at local hotel because she thought her sister would take the instructions from the supervisor and relay them to her! They went from one factory to another. Their old insurance company turned them down—"there are plenty of women much more alert than they seeking jobs; even though they may not have insurance experience, they are preferable." Social worker thought the sisters could in 1943 not do eight hours hard work, but might do eight hours at something light.

Main Features

1. Indication that overwork caused heart attack that caused her inability to work.
2. Although only two years from pension age from a life insurance company she received an allowance for only one year.
3. This woman tried to get work though anemic, and extremely hard of hearing.
4. Living with her OAA sister has eased each other's burdens, helped fight loneliness, perhaps even helped nutritionally for a person often doesn't like to cook for himself or herself only.
5. Seem to get along satisfactorily without hobby.

Conclusions

1. Overwork was probably due to caring for infirm mother and at same time doing own work, raising question of how far parent-child obligation should be pressed.
2. Failure of the employing insurance company to vest pension rights in employee resulted in this woman going on OAA after receiving one-year's allowance and exhausting $1,000 savings.

3. Health was the factor that led to unemployability.
4. Possibility of referring Miss B. to mail order work or envelope addressing for local firms in her own home might have been explored, as she could have during the war apparently done some light work from time to time and was good typist. Homework possibilities need intensive exploration.
5. Modern retirement plans which permit optional retirement at earlier age than normal will ease plight of some persons in similar situation, who are hit by chronic disabling ailment shortly before reaching retirement age.

The Case of Ed the Stable Hand

This is the story of an old bachelor who lives rather placidly on his old age assistance allotment, in a house owned by his brother. Ed grew up skilled in the care of horses. He finished 8th grade and for the remainder of most of his working days worked as a stable hand. When the depression came, he was thrown out of work for a year before he came on work relief for a short time. Then he got his old job back as stable hand at a country estate. When 1941 came, we see him back at the welfare office, this time for OAA. He wants work but can't get it.

Living with him in his brother's home is his brother and the latter's children, and his sister, to whom he is closely attached. When she becomes ill, having a foot amputated, he stays home day after day taking excellent care of her. She dies not long afterward, and he becomes disconsolate. He is no longer interested in seeking work. He becomes rheumatic, and because he is skilled only with horses, he is deemed officially unemployable. He begins to limp. Meanwhile his brother loses his own store, goes to work in a liquor store, and Ed takes care of him when he is ill. Ed's only fun in life is "going out seeing old cronies on the street."

In 1947, case worker reports he has only 1 shirt, 2 pairs of pants, and 2 pairs of underwear. In 1948, his niece and her husband move into the house which is converted into two apartments, but he doesn't get along well with her husband, so he stays out as much as he can. He helps with the furnace, cuts grass for a woman across the street for 50c. occasionally, and wants a janitor job.

Main Features

1. Lack of training for anything except care of horses handicapped this man in search for position.
2. This man is able even at age 74 to do light work or work that requires no constant standing.
3. This man was narrow visioned throughout his life, perhaps through limited education; range of activities are narrow now.
4. The relative placidity of this case is attributable in part to rather constant, steady living situation with his own family.
5. He never earned enough during his lifetime caring for horses to provide for his old age.

Conclusions

1. Again we see that living with family tended to provide happiness for the oldster.
2. Failure of adjustment with younger generation also is seen.
3. Failure of this man to train for anything expect work with horses handicapped him in later life.
4. Family responsibility, brother-sister, and brother-brother relationships, are demonstrated.
5. Need for social situation, enabling oldsters to get together, is seen.
6. Psychological aspects of work-desire seen in wish to withdraw from labor force on death of sister and re-awakening of desire to work, later.
7. Surely, society could have found a place for a man skilled with horses; surely someone needed this man but the two were not brought together.
8. Need for more than one occupational skill indicated.
9. Few of present OAA cases are eligible either for primary or dependency benefits of OASI.

The Case of Mrs. G.

Mrs. G., a widow of some 22 years, managed to get along by herself, as a domestic, and probably with some accumulated savings, until her physician told her that her health was too poor to continue working any longer. She was 66 when she gave up her part time work which paid $10 a week and two meals a day. The knowledge that her working days were over and she would have to go on OAA came as quite a shock.

Mrs. G's husband had worked for 20 consecutive years for a local gas and light company before his death, but had never qualified for retirement benefits.

This OAA recipient has serious high blood pressure, and needs much rest and medical care. She has been very fortunate in finding accommodations at a boarding home with other older women, some of whom are, like herself, on OAA. She has plenty of opportunity for the peace and quiet she needs, and yet does not lack companionship.

Main Features

1. Mrs. G., who was not prepared for employment at time of widowhood, did not have sufficient

earning capacity to put money aside for the day when she would not longer be able to work.

2. The four children of Mrs. G. were all married and unable to contribute toward her support, although they did give her presents for Christmas, on her birthday, and on Mother's Day, which were apparently sizable enough to help Mrs. G. out some.
3. At 66 Mrs. G. was working and might have continued working until the time of her death if a physician had not told her to stop.
4. Mrs. G. is skilled in needlecraft, such as crocheting, but it has remained only a hobby, and means of providing attractive but inexpensive Christmas presents for her children.

Conclusions

1. Company pension plans, even though they be meagre, might save many couples or the survivor from public assistance. OASI will help, but it is too recent to benefit most of our present oldsters.
2. Protection against the heavy expenses of chronic illness so prevalent in old age would help oldsters conserve savings they might have from their working years.
3. Opportunities for homework might enable oldsters with skills to turn hobbies into profit.

The Case of Miss A.

Miss A., 83, lives with her 85-year-old sister who is also on OAA.

Miss A. worked for years as a domestic, until she could no longer work. At age 74 (!) she had to quit and go on OAA. Rheumatism and an infected leg caused her to have to quit work.

She lives comfortably with her sister in a three-room apartment in a good section of town. She aids her sister when the latter is ill, and the sister cares for her when she is ill. She is remarkably healthy for her age.

Her landlord likes the cheerfulness of both sisters, allows them considerable freedom to use his own apartment and the sisters regard themselves as sort of members of his family, has kept rent low, aided them on various occasions.

Main Features

1. Here is a woman who worked till age 74 when she was attacked by rheumatism.
2. Her years of low wages as a domestic precluded any possibility of substantial savings.
3. She and her sister live comfortably and happily together, social worker reports, aiding one another when necessary, providing company for each other.
4. Amiability has improved their lot by resulting in having their landlord assist them in various ways.

Conclusions

1. OASI doesn't help domestics any.
2. Case suggests possible need for experiment in attempting to get more OAAers of suitable temperament to live together, to relieve loneliness, to help each other, etc.
3. Good humor aids throughout life, even into the late years.

Industrial Pensions

The problem of industrial pensions has come to the fore, as predicted in previous reports of our Committee.

Today, more than 11,500,000 American workers, or nearly one out of every six, from elevator operators to corporation presidents, are piling up pension credits in retirement funds. We believe that employers and employees are pouring $1,350,000,000 a year into these pension pools.

Our Committee estimated last year that over a quarter of a million men and women are receiving $150,000,000 a year in pension checks from their former employers. It should be noted that this averages about $50 a month per pensioner. This average monthly pension is probably a little higher this year, as the effects of the $100-a-month pension drive by unions go into operation.

Industry is pouring enormous sums into pension plans. Marshall Field & Co. allocates $2,000,000 a year into its retirement trust. Shell Oil Co. spends $9,100,000 a year for pension allocations. When the Gannett Co., Inc. announced early this year it was establishing a pension fund for its employees, the estimates of employer contributions alone for past services of employees came to $6,000,000.

In the current hubbub over industrial pensions, it may be well to note that the New York State Chamber of Commerce has said: "It is good business as well as good morale for management and workers to cooperate in promoting sound insurance plans to protect wage earners against the hazards of old age."

It was industry, interestingly enough, that initiated pensions, which were in the past often deemed to be "pie in the sky" by labor leaders. And industrial pensions have proven to be good business for industry because it steps up morale of employees, helps recruit a higher type of worker, provides for orderly retirement of workers, in addition to providing tax benefits for the company and meeting the company's moral obligations to its faithful workers.

Our Committee's survey of companies having pension plans indicates that business likes pensions because they are a precise business-like way of handling workers.

Organized labor switched from an anti-pension attitude to an aggressive pro-pension stand because Social Security payments proved to be so inadequate, because pay-rises were largely halted in recent months, and because of a rising concern with older workers.

To the worker, industrial pensions have their advantages and disadvantages. Private pension plans tend to restrict the worker's mobility, and tie him down to one company, one community. The plans give him practically no protection if he wishes to quit or is fired even after long service to the company. Furthermore, they generally require such long periods of service to qualify so that as a practical matter only a small percentage of our workers may ever qualify for the pensions.

On the other hand, so long as Social Security payments are so niggardly, our people will seek to supplement them by industrial pensions.

As Governor Thomas E. Dewey pointed out in his 1950 message to the Legislature: "some of these pension plans are contributory; others non-contributory; some are funded on a reserve basis and thus safeguarded to some extent against default; others are completely unfunded and unsafeguarded; some are correlated with the national insurance system while others are not."

Our Committee is concerned over six main defects of the current retirement systems:

1. The plans fail to take into consideration fluctuations in the cost of living.
2. Inadequate and usually no government supervision to assure adequacy of the pension systems exist.
3. The plans themselves operate as a barrier to the employment of the older worker.
4. The plans foster compulsory retirement on a chronological age basis rather than selective deactivating of older workers based on fitness.
5. The plans fail to provide some retirement protection for employees who work for many years for a concern and then leave or are discharged before retirement age.
6. The plans tend to restrict the mobility of workers and keep them tied down to one employer.

Industrial pensions probably cannot cover the self-employed, the domestics, the farmers, nor can it adequately cover those employed in small stores or marginal firms, thus leaving without protection millions of our people, in the same manner as does our OASI system. Industrial pensions must be viewed as supplementary to the social security system, not as a substitute, and must be integrated with it.

This whole subject needs further study by national and state authorities, as well as by industry and labor. Our Committee will gladly assist in any such deliberations.

Our Committee feels very strongly, however, that while social security is a necessary part of the protection we must afford our older people, it is folly to attack the problems of the elderly as though merely boosting OASI coverage and payments or increasing old age assistance grants or simply giving everybody who reaches 65 a pension of some sort is the whole answer to the problems of our old folks.

Social security for the aged is an important element but only one element in a sound program for the aged.

UN and the Aged

Our country may possibly save itself from making dismal errors made by other countries in dealing with the elderly if we have sufficient information available.

The organization best equipped to roundup the world's experience in dealing with housing for the aged, recreation for the aged, social security, mental care of the aged, and care of the chronically ill, is the United Nations. It has the staff, facilities and status to assemble data on a world-wide scale.

Our Committee urges that the appropriate office of the United Nations be authorized to spearhead a drive to bring about better conditions for the elderly of all nations by acting as a central depository of old age data, by exchanging old age information, by assembling world leaders in geriatrics, housing for the aged and related fields for the exchange of experiences and viewpoints.

Employment Problems of the Elderly

Director Robert C. Goodwin of the U. S. Bureau of Employment Security informed our Committee that a survey made by his agency produced five major findings, all of which, incidentally, are in accord with the findings of our own committee:

1. In labor markets with little unemployment there are substantially fewer jobless among the older workers as compared with the younger workers;
2. As employment increases, employer specifications with respect to age are tightened and the percentage of older workers jobless increases;
3. Older workers, once separated from a job, take longer to find employment, and if not re-employed at their regular work, are usually downgraded in skill and pay;
4. Discrimination against older worker varies not only with conditions of the labor market but also

with occupation, industry and worker characteristics.

5. In all areas surveyed, there were significant restrictions against older workers.

Our Committee has in its prior reports, "Birthdays Don't Count," and "Never Too Old," explored the trends in employment of the elderly, emphasized the need for utilizing the experience of our older persons in our productive forces, warned of the wide-scale prejudice against hiring of workers over 45, and tracked down reasons for discrimination against the elderly. Our Committee set forth a reasonable program that the State should undertake, revolving around two main concepts:

1. Provision of special counselling service for older workers in the State Employment Service, so that more oldsters would be placed in jobs.
2. Establishment of a long-range education and research program in the State Labor Department designed to break down the bias that exists against hiring the aged.

Our first proposal provides that the State Industrial Commissioner shall establish in the State Employment Service a special counselling and placement service for the 45-year and over job applicants.

The placement service will:

1. Appraise the capabilities of older workers seeking employment;
2. Advise, guide and direct oldsters to employment opportunities;
3. Encourage older workers to seek work for which they are best suited;
4. Build up the self-confidence of the unemployed oldsters;
5. Survey local job opportunities for older persons;
6. Educate and encourage industry to hire older workers.

The proposal envisions that a small corps of highly skilled old age placement experts will be set up to train and supervise placement officials in local employment service offices and act as consultants in this field. It contemplates that one or more placement workers in the local offices will be given the special training in placing older workers, in dealing with older persons, and in trying to break down the resistance of employers to hiring older persons. Once trained, these placement workers will act as special task forces assigned to handle the bulk of older applicants for jobs.

The recommendation is based on the successful experience of the Canadian Employment Service, the Forty-Plus Clubs of Western New York and New York City, and the Federation Employment Service in New York City.

In Toronto, 1,400 out of 2,200 applicants in the upper age brackets obtained jobs after special counselling, and now receive salaries ranging from $30 a week to $12,000 a year. The special counselling service for older workers even placed an 83-year old! The Forty Plus Clubs are day after day finding jobs for older executives. The Federation Employment Service increased placements 68 per cent when it launched a special drive to obtain jobs for oldsters.

Our Committee was informed latest available figures indicate that 168,000 persons receiving unemployment insurance in this State are in the 45-year and over age bracket; that 63,900 persons receiving such insurance are 60 and over. Thirty-three per cent of the women and 44.5 per cent of the men receiving unemployment insurance are 45 or more.

A study in the Rochester office of the State Employment Service indicated that applicants 40 years old and over represent 40 per cent of all job seekers, but only 11 per cent of the job opportunities are filled by these older workers. Obviously, a special drive must be made in behalf of the older persons.

When a placement worker, as at present, has to obtain jobs for all age groups, he tends quite understandably to concentrate on the 18–35 age group, where success is most easily obtained. Emphasis on the younger age groups helps build up his ratio of placements to applicants, makes his record look better, and enables him to avoid spending longer periods trying to place older persons.

Mr. William Green, President of the American Federation of Labor, informs us that he favors establishment of counselling and placement services for older workers. And we are certain that the CIO and organized industry likewise will actively join to support such a move.

Unless our State and local communities make a determined, all-out effort to obtain jobs for older persons, costs for old age assistance, pensions and hospital care will soar to dangerous heights. Moreover, our elderly may become easy prey to shrewd promoters seeking to take advantage of their discontent. Today, discrimination against the elderly in industry is plunging many oldsters into mental depression which hastens senility. Our State hospitals are jammed with men and women who became senile before their time.

Our proposal represents a new approach to the old age problem. Up to the present, government, Federal, State, and local, has been concentrating on the wrong end of the old age problem. It has been concerned almost exclusively with keeping oldsters alive through old age assistance or keeping them out of harms way in mental hospitals. We must now make a shift toward a positive approach. We must emphasize efforts that will prevent persons from needing old age

Employers who study the problem know you can't find better, more loyal workers than middle-aged and elderly women like these.

assistance and from needing care in mental hospitals. Jobs are a large part of the answer.

Job Counselling

Director Robert C. Goodwin of the U. S. Bureau of Employment Security informed our Committee that his agency would establish an experimental counselling unit for older workers in a local employment service office in this State in 1950.

The New York State Employment Service is cooperating with the United States Employment Service in a study of the placement of older workers which is now being undertaken in five cities throughout the country. The cities participating in this study are New York City; Houston, Texas; Columbus, Ohio; one city in California and one in Pennsylvania, both unannounced as this report is being written. This study will be made for a six-month period from January through June, 1950, and the purposes of this study are to try to ascertain on a sampling basis in respect to unemployed persons over 45 years of age who are seeking employment through the public Employment Service:

1. The size and characteristics of this group of applicants including the magnitude of this problem in relation to the total unemployed.
2. Employer attitudes and practices in the new hirers of persons in this group.
3. The peculiar employment problems presented by this group of applicants.
4. The effectiveness of existing public employment services facilities in helping this group.

5. New or additional techniques in counselling, classification, employer contacting, publicity, telephone soliciting, etc. which may be effective in helping this group.

In New York City this study will be made in the Queens Industrial Office, the Commercial and Professional Office, the Manhattan Needle Trades Office and the Hotel and Service Office, thus covering a cross-section of all occupations and industries with the exception of domestic and farm placement.

In each of the offices in New York City, and as a matter of fact, in each of the cities participating in the study, the sampling will be small because the number of staff all of the cities can assign to this study is very small.

In New York City it is expected to include a sampling of approximately 3,000 persons over 45 years of age for the experimental group and the same number of similar persons for the control group. In the other cities participating in the study, approximately 750 persons will be included in the experimental group and the same number of similar persons in the control group.

However, for New York City and for the country as a whole it is felt by authorities that this sample is sufficient for the purposes of the study.

It is expected that the study will result in considerably greater knowledge about the employment problems of the unemployed older worker and techniques that can be applied in the Public Employment Service to assist him in securing employment than we now know.

Our Committee notes with pleasure that in the past year there has been a more enlightened attitude in the State Employment Service regarding the need for and desirability of special service for older workers. We hope this will develop into a full-blown, all-out special effort to place our middle aged and elderly workers in jobs.

Our Committee further urges that the State Labor Department, through the State Employment Service, prepare suitable literature aimed at helping our older workers who are seeking jobs. Many of our oldsters who suddenly find themselves out of work have not had the experience of writing for a job, or of being interviewed for a job, perhaps for 20 or more years. They don't know how to proceed on what many of today's youngsters would consider elementary matters. The older worker seeking a job is discouraged; he needs encouragement, direction. Until such time as counselling and placement service is available to our older workers, the State Employment Service should attempt to help the older persons by mass media, pamphlets and brochures, radio and newspapers.

Homework and the Aged

The possibility of directing older persons into homework strikes our Committee as being a definite possibility for meeting the needs of some elderly men and women who cannot travel to factories or work in stores, or who can work only part-time. Social workers are not as yet fully conscious of homework opportunities in their local communities for providing employment for older persons. Too, the historical background of homework, with its tradition of exploitation of workers, has developed a trend toward curtailing homework. This whole subject needs further exploration. Today, 8,379 persons in this State have homework permits. About 824, or 10 per cent of these, are 65 or more. Only 59 of the 824 are males.

Homeworkers with Permits under the General Homeworker Order in New York State Spring, 1949

Age	
Under 20	31
20 and under 30	877
30 and under 40	2,133
40 and under 50	2,179
50 and under 60	1,639
60 and under 70	1,208
70 and over	312

Oldsters Inc.

Our Committee has been thrilled by the Mohawk Development Service Co., Inc., of Schenectady, composed entirely of men who are over 65!

This company, engaged in drafting and new product development, will not employ anyone who has not reached retirement age.

It was organized by men who refused to be shunted aside by industry's compulsory retirement policy. Today you can see 70-year olds in the company handling contracts rolling in from American Locomotive Co., Ludlum Steel Co., General Electric Co., the Atomic Energy Commission, and others. A fuller account on this company of oldsters is contained in another section of this report.

While the Mohawk Development Service Co. does not establish a pattern that will solve the employment problems of oldsters, it does indicate very dramatically that (1) at least some older workers can successfully compete in the industrial market today. (2) that skills of workers do not suddenly rust away when they reach their 65th birthday, and (3) that at least some oldsters in our local communities can organize for production themselves—without government help and without special consideration from industry.

Anti-discrimination Law

Our Committee is alarmed at the persistent, senseless barring of older persons from jobs. The help

wanted advertisements are rife with age qualifications which sicken the spirit of our able elderly and unnecessarily load our old age assistance rolls. The ads say stenographers must be between the ages 18 and 25; salesmen over 45 are not wanted; engineers over 35 need not apply. Such arbitrary age barriers are without economic justification and are cruel to our more mature workers who do not ask preference, only an equal chance based on ability.

Scientists have emphasized to our Committee that chronological age is meaningless, that everyone ages differently. Economists know it is short-sighted of industry indiscriminately to bar older persons from work only to support them through taxes. Our Nation needs the added productivity of our elderly.

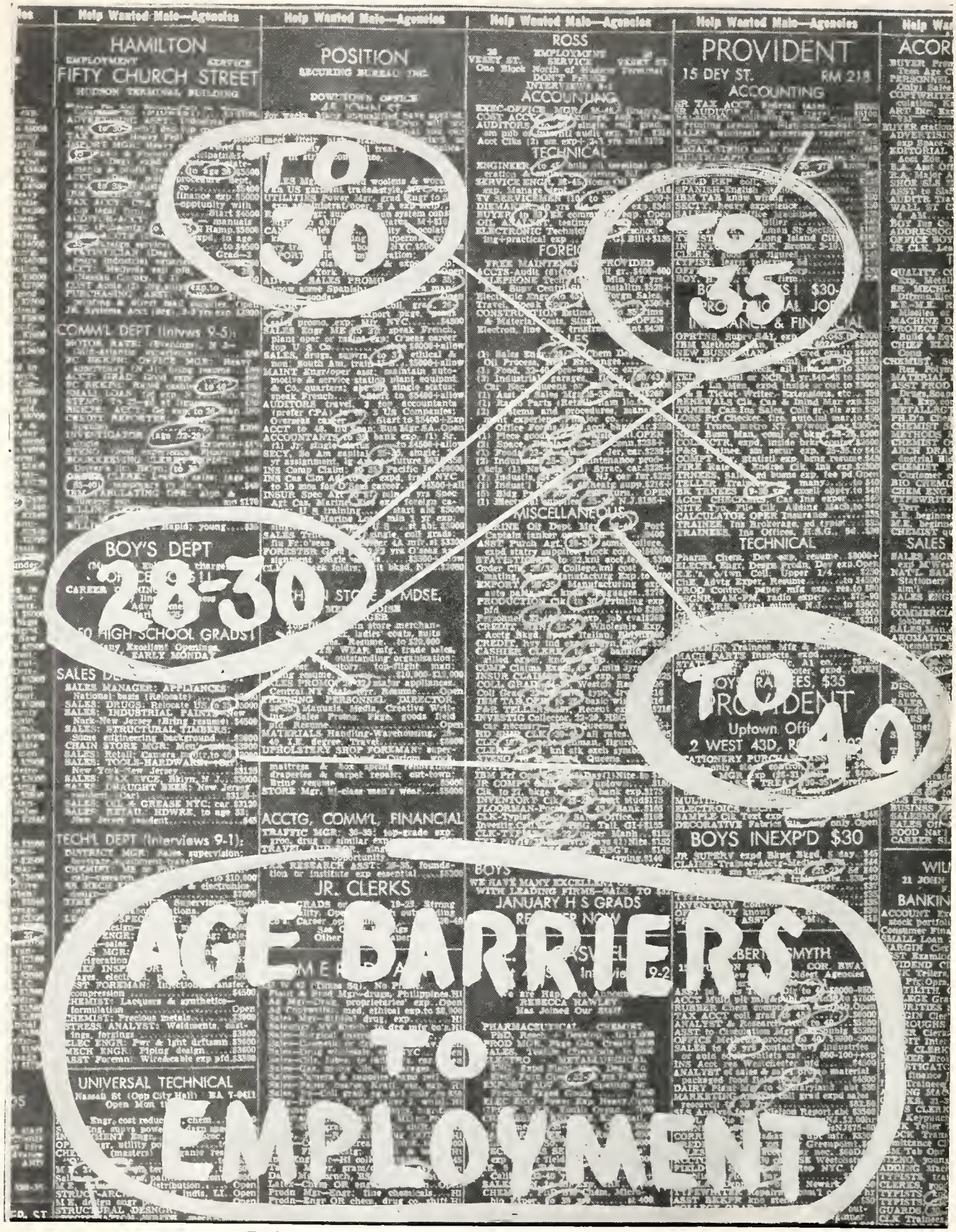
While we are reluctant to sponsor a crack-down on industrial personnel policies by law, there may be little alternative unless management stops making industrial "DPs", displaced persons, out of our older persons. Unless industry curbs arbitrary age discrimination based solely on birthdays, it certainly will face legislation of some type barring age limits for job applicants, just as the State has already banned discrimination against race, color or creed.

Our Committee has studied the Massachusetts law adopted in 1937 to attempt to ban discrimination in the hiring and firing of older workers.

This law declares it to be against public policy to dismiss from employment any person between the ages of 45 and 65, or to refuse to employ him, because of his age.

This statute, which does not apply to domestics or farm laborers, declares null and void any provision of any contract or agreement that shall "prevent or tend

This man keeps young by riding a useful hobby. He's too busy to keep running to doctors with imaginary aches and pains. (*Courtesy Hodson Center of New York.*)



Typical "Help Wanted" Advertisements in Daily Newspapers.

to prevent'' the employment of any person between the ages of 45 and 65 because of his age. The law compels employers to keep age records of their workers.

The law authorizes the State Commissioner of Labor and Industries to summon before him any employer believed not to be complying with the law. After a hearing, if the Commissioner deems the employer has violated the law, he may publicize that fact in any newspaper or newspapers or in any other manner deemed appropriate.

If this law gave any hope of helping our oldsters obtain employment, our Committee would recommend its adoption in this State. However, we have been informed by the counsel of the Massachusetts Department of Labor and Industries that the department's experience ''has been limited to two or three cases, all many years ago, undoubtedly because of the weakness of the law. It was not necessary in any case, to publish the name of an offender.''

From other sources, our Committee learns that the law has been ignored and unenforceable. For example, every company having a pension plan in Massachusetts presumably would be subject to the adverse publicity provided by the law, since pension plans undoubtedly ''tend to prevent'' the employment of older persons.

Even if teeth were put in the law, by providing for fines or imprisonment, or both, or by making offenders ineligible for state contracts or other benefits, it would still be unenforceable since companies can tell an older applicant for a job he is too intelligent for the job, or that the opening has been cancelled or any of a hundred reasons commonly used by personnel managers.

The Massachusetts law has failed.

Its adoption in New York State would probably fail also.

Our Committee is exploring other possibilities of legislative action to curtail the brutal age discrimination that flourishes.

Our Committee is not proposing the older workers be legislated into jobs.

We do wish to see unreasonable barriers to their employment eliminated. We do wish to see men and women hired on the basis of ability rather than arbitrary age specifications.

Our Committee believes that the counselling service which it proposed can render enormous effective aid in obtaining jobs for oldsters. Our Committee believes that the State Labor Department can aid by a permanent educational and research campaign.

However, we should like to emphasize that here again, our local communities should not wait for State action or depend on State action alone. Each local community can organize home-town campaigns for older workers. Through councils of social agencies where they exist, through other citizen or official groups in other areas, local factories, stores, and offices can be solicited for jobs for older workers, appraisals can be made of local obstacles in the way of obtaining employment for older workers, and the full force of home town pressure can be brought against offending concerns which refuse to hire our middle aged and elderly workers. Organized local drives for jobs for the elderly can succeed.

Unions and Oldsters

Our Committee has launched a pioneering study of labor unions in relationship to older workers. We have queried every international union, CIO, AFL, and independent, in this country. Returns have come in gratifying numbers, and are now being analyzed.

The survey covers age barriers to union membership, age of union leaders, union pensions, burial provisions, union old age homes, union security rules, compulsory retirement rules, provisions for downgrading super-annuated members, medical service provided, special services and recognition rendered to older workers, and a series of questions about attitudes of older union members.

Obviously, as unions come increasingly to play an important role in the economy, it is essential that we have an understanding of their activities as they relate to the older worker.

The variety of relationships of older workers to unions can be seen from the fact that the United Brotherhood of Carpenters and Joiners of America has maintained an old age home since 1929 at Lakeland, Florida, and that the International Typographical Union has maintained a home for aged and disabled members at Colorado Springs, Col., since 1892.

Of course, one of the basic ways of assuring our oldsters a place in our labor force, without blocking avenues of promotion or job opportunities for younger people, is to make certain that the Nation needs an expanding labor force; then all who can work and want work will have work, regardless of age.

The variety of pension plans involving unions is reflected in the experience of locals of the International Stereotypers and Electrotypers Union of North America. Some locals have no pension protection, others are protected by employer sponsored plans not covered in union contracts, still others are under 100 per cent employer financed pensions. Other locals of this union have joint employee-employer pensions financed on 50–50 basis, and still other locals, we find, have some members ''pensioned off'' by the employers on a handout basis, rather than on an actuarially sound plan or contractual arrangement, with amounts paid solely at the discretion of the employer.

We note in some returns already studied that a few unions report no diffienlty in obtaining jobs for older members. This is true of the Seafarers International Union of North America, which through its own hiring halls controls assignment of seamen to work and sends men to jobs solely on the basis of length of time out of work, regardless of age. It is true also of the International Union of Journeyman Horseshoers of the United States and Canada, which reports that older persons are preferred by race tracks because of their experience.

We note that many unions are giving special recognition to the aged in the form of special dinners, special pins, free lifetime or honorary memberships, etc.

The unions seem to indicate that older workers tend to make better members because of their greater maturity and stability, because they had to work harder to build unions, and because their long experience has taught them the need for organization.

When our survey is completed, a thorough report will be made.

In this connection, it should be noted here that a study by the Division of Research and Statistics of the State Labor Department indicates that when unions have contracts with employers permitting employees to be discharged "for cause", age itself is not deemed to be sufficient cause.

Industry and the Aged

While private enterprise is guilty of erecting unfair age barriers which keep vigorous, able oldsters from working, American businessmen are engaging in an amazing variety of activities to help our oldsters. This bright side of the old age picture in industry is generally unknown not only to the public, but to the rank-and-file of industry itself.

A survey our Committee completed shows that these beneficial activities range from wholly gratuitous allotments by the Standard Oil Co. of New Jersey to its pensioners who receive under $3,000 a year, to a donation of recreation hall facilities by Stroock & Co. of Newburgh, one of the leading woolen mills of this country, for a clubhouse for the oldtimers of the community.

American businessmen are not only pouring $1,350,000,000 a year into retirement funds for workers, but also spend another $1,000,000,000 a year for the Federal old age and survivors social security pool.

The Shell Oil Co. has hired a psychologist to advise their older workers facing retirement on how best to adjust to "retirement shock". Other companies are beginning similar activity. Some concerns have set aside special work for older men and women to suit their capabilities. Companies throughout the country are communicating with our Committee, asking for information and help in dealing with older workers.

A department store makes a special point of employing elderly women as salesladies because they are kind and patient. One company which employs many elderly has no formal retirement system, but grants workers who retire a weekly allowance, and regularly sends its infirm elderly ex-employees hot meals from the plant cafeterias.

The W. and L. E. Gurley Co. of Troy, engineering equipment manufacturers, as reported in "Never Too Old", employs many old-timers successfully. Over 10 per cent of its workers are 70 years old or more; 20 per cent are over 60. It has, for example, successfully taken a blacksmith retired from the U. S. Watervliet Arsenal as being too old and re-trained him in a short time as a lathe operator.

Some firms show amazing consideration for their elderly employees, not only by granting them longer vacations, permitting them to sit at their work, and exempting them from punching the time clock, but also by permitting them to quit earlier each day, be served first and obtain special diets in the factory cafeteria, and to use private or freight elevators banned for other workers.

One company sends its plant cars to the homes of its retired employees to bring them to weekly social gatherings at the factory. Others keep oldsters on the payroll although they can produce little due to chronic illness.

Group life insurance, health and hospitalization policies taken out by companies are proving a tremendous economic aid to oldsters who otherwise would be ineligible for insurance coverage.

American businessmen are giving generously of their money, time and facilities to ease the plight of older workers. Industrial management, unfortunately, hasn't applied to mass employment policies the lessons learned from numerous isolated examples.

It is unfair to condemn industry as a whole for the callous attitude of some companies toward the elderly; many concerns are acting humanely toward older workers. Wild charges and indiscriminate abuse of all industry for the unfair practices of some will not be helpful. Our Committee is campaigning vigorously against arbitrary age barriers to employment; but we believe industry is entitled to just credit for its numerous helpful achievements in the aid of oldtimers.

We shall make progress toward fairer treatment of older workers seeking employment not by recriminations, but by working out various complex problems involved, in a spirit of mutual understanding, trust and faith.

State Civil Service

Our Committee made a study which indicates that civil service now offers proportionately more employment opportunities for the aging than private business does. State and local governments are prohibited by law from erecting unreasonable age barriers and from forcing older workers to retire early.

A study of 5,050 applications made for our Committee by the State Civil Service Department showed that of the applicants, 695, or more than 13 per cent, had passed their 45th birthday. Almost half of these qualified for appointments in jobs ranging all the way from elevator operator to child psychologist.

By contrast with industry's widely prevalent prejudice against employing older workers, the State Civil Service Law declares void any attempt by New York State or its subdivisions to discriminate because of age against any persons physically and mentally qualified to compete in an examination.

The State Civil Service Law states (sec. 25-a):

> "Notwithstanding any provision of law to the contrary, except as herein provided, neither the state civil service commission nor any municipal civil service commission shall hereafter prohibit, prevent, disqualify or discriminate against any person who is physically and mentally qualified from competing, participating or registering for a civil service competitive examination or from qualifying for a position in the classified civil service or be penalized in a final rating by reason of his or her age. Any such rule, requirement, resolution, regulation or penalization of such state or municipal commission shall be void.
>
> "Nothing herein contained, however, shall prevent such state or municipal commission from adopting reasonable minimum or maximum age requirements for positions such as policeman, fireman, prison guard, or other positions which require extraordinary physical effort, except where age limits for such positions are already prescribed by law."

A similar provision bans discrimination in promotion examinations.

The United States Civil Service Commission informed us: "The age of applicants is, of course, not a factor in our examining standards or placement policy in the federal service."

Government has heard the plea of the geriatricians, the specialists in aging, that workers be judged by their health and ability, not by the number of their birthdays.

Oddly enough, the "over 45" group, which has itself suffered humiliation and frustration in finding employment, expressed the greatest interest in a State examination for Employment Interviewer in the Division of Placement and Unemployment Insurance. Of 180 applicants in this classification 71 qualified for appointment. Other examinations popular with the 45-plus group were assistant accountant, senior engineering aide, general clerk, assistant architect, library assistant, social worker and elevator operator.

At the retirement end of the two-way squeeze against the older worker's opportunity for useful employment, civil service is again more liberal in its policies. About two-thirds of private companies having pension plans set the compulsory retirement age at 65. The New York State Employees' Retirement System permits a member to retire at age 60, although he may continue to age 70 if he wishes and is physically qualified. After age 70 he may still be retained at the request of a department head with approval of the State Civil Service and Pension Commissions.

The average age of retirement in the State service in 1948 was approximately 66, six years above the optional minimum. Still contributing members in the State Retirement System are 993 men and women who have reached or passed their 70th birthday, although this number includes some elected officials.

The Federal Government also sets its compulsory retirement age at 70, but New York City, most liberal of all in this respect, sets the maximum retirement age at 80!

Our Committee notes with approval that the State Retirement Fund has speeded up payments of retirement checks and death awards. It approves of the new system of calling the attention of employees by personal letter two years before they retire and again one year before they retire of the need for preparing themselves for retirement.

Our Committee is glad that the Legislature took the first steps at the 1949 session to remove a legal barrier which blocked State and local pensioners from obtaining part-time jobs with local governments.

Our Committee urges that some form of recognition be given to State and local employees who have served faithfully until retirement. Some token of appreciation for loyal service through the years is merited.

Our Committee again urges that the desperate plight of many State pensioners be eased and is happy that the Legislature passed in 1949 a proposed constitutional amendment which will need to be voted on again at the 1951 session, authorizing the Legislature to provide for an increase in amount of pensions of State and local retirement systems.

Vocational Rehabilitation

The term vocational rehabilitation means far more to our Committee than its customarily restricted ap-

plication only to those who have been disabled. Many of our older persons who are fit, but have for one reason or another lost their old skills, or need to learn new skills due to technological advances, or simply need vocational counselling which will make them employable, need vocational rehabilitation.

Our Committee has recently received a report from the U. S. Office of Vocational Rehabilitation dealing with rehabilitation of persons 45 years old and over during the 1948 fiscal year.

It indicates that 11,438 persons in this age group, or 11 per cent of all age groups, were rehabilitated. The comparable figure for 1947 was 8,600 persons, 19 per cent of all age groups.

In 1948, the number of persons 65 or over at the time rehabilitation started was 882, compared with 654 the previous year.

Men constituted over three-quarters of those rehabilitated in the 45-plus age group. Over a third of the 45 and over persons were dependent on their families or on public or private relief before rehabilitation services were started. About 12 per cent were living on either workmen's compensation or insurance benefits and about 39 per cent were in jobs which they were in danger of losing because of their disabilities.

Disabilities were largely impaired arms, or legs, amputations, visual and hearing defects.

Most of these persons were on the active rolls less than one year before they were placed on jobs.

Services rendered them included medical, surgical and psychiatric treatment, appliances and hospitalization, vocational training, training in use of appliances, self-adjustment training, occupational tools and licenses, counselling and guidance.

This is merely suggestive of what can be done to aid older workers.

The small proportion of oldsters receiving the benefits of vocational rehabilitation is indicated by the following table:

Persons Receiving Vocational Rehabilitation, by Age, New York State, (1948–49 fiscal year)

Total All Ages	3,042
Age 42–47	280
Age 48–59	360
Age 60 and over	67

Our Committee believes that vocational rehabilitation of older persons in this State is subordinated because of a pessimistic outlook that much cannot be done for oldsters. Our Committee recommends that if a comprehensive study is made of State rehabilitation services covering all age groups that it include a determination as to how rehabilitation services can be brought to more of our middle aged and elderly. If no such survey is planned, our Committee proposes to inquire into the rehabilitation of those in upper age groups.

Our Committee recommends that the Federal Security Agency make available funds for a special pilot study of the degree to which vocational rehabilitation service can effectively be rendered to persons on old age assistance and old age insurance rolls. The experts on vocational rehabilitation have given little attention in the past to the needs of the elderly because of a pessimistic outlook regarding their possible employment. However, this antiquated viewpoint needs to be eliminated. We believe that if competent vocational rehabilitation experts were permitted themselves to examine old age assistance records, for example, to determine which persons might be rehabilitated, and then were to attempt rehabilitation of these individuals, they would find a surprising proportion might benefit by their talents. At any rate, such a study would give us the information regarding vocational rehabilitation of the elderly that is not now available.

The Health of Our Elderly

In the field of health, the State has reached a turning point. We must now shift from traditional emphasis upon communicable diseases to degenerative diseases.

The need for such a change has been explored in previous reports of our committee.

Tuberculosis in 1900 was the leading cause of death; today, heart disease is Killer No. 1.

Pneumonia in 1900 was Killer No. 2; today its place has been taken by cancer.

Cerebral hemorrhage was seventh ranking killer in 1900; today it is third.

However, few health departments in this country have geared themselves to the new trend in diseases. Many such departments are still fighting battles won long ago.

Where is the emphasis on heart disease? We do not find it in any public health department!

Examine the public health literature that is available. Booklets, brochures, pamphlets, radio scripts are abundantly available on the feeding of children. But you can find very few leaflets on nutrition of the middle-aged and elderly.[1]

Where is the health department that has set out to campaign for periodic comprehensive health inventories for the middle aged and elderly, so essential to prevention of disease?

Our Committee finds:

1. Few of our elderly are given a chance of obtaining guidance in adult hygiene; emphasis today is on curing diseases, not preventing them.

[1] The Community Service Society of New York, a private welfare organization, recently issued an excellent pamphlet.

Blaze Kills Elderly in Nursing Home

Three elderly persons were burned to death early this year in a blaze that seared a Cobleskill, New York, convalescent home.

Firemen fight blaze which broke out in second-story sleeping quarters of the aged.

Reports indicate oil from a space heater leaked out over the floor and ignited.

This death bed was standing within three feet of the space heater.

A frame building, no sprinkler system or automatic warning device, bedrooms for the elderly on the second floor, space heaters in bedrooms of the oldsters spelled tragedy.

2. We are in need of better diagnostic and clinical facilities for the elderly so that degenerative ailments can be checked before they have advanced too far.
3. We urgently need expansion of our visiting nurse services and housekeeping and home care services.
4. We lack trained medical personnel to deal with the elderly; we lack geriatric clinics; research in geriatrics is woefully inadequate.
5. We need closer check on nursing and convalescent homes.

Our Committee is convinced that there should be set up in the State Health Department a unit on Adult Hygiene and Geriatrics to bring to our middle aged and elderly the benefits of the latest discoveries in science.

Our Committee in "Never Too Old" has outlined 10 specific functions of such a unit. But above all we believe such a unit will provide the working mechanism for our State Health Department to cope with its No. 1 health problem, the health of our aging population.

Our Committee has excluded from its consideration work already covered or being covered by other legislative committees or commissions. It has therefore not inquired into the problems of the chronically ill or into the question of licensing nursing homes.

However, since many persons reading this report will be deeply interested in these two vital phases of the old age problem, our Committee would like to note that the Joint Legislative Committee on Interstate Cooperation, headed by Assemblyman Harold C. Ostertag, has been studying the nursing home situation, and that the State Department of Social Welfare, with the aid of the Interdepartmental Health Committee, recently studied 1,000 nursing homes upstate and is now planning to develop such a set of standards.

Governor Dewey in his 1950 message to the Legislature said: "We shall also have to plan a program for developing more and better facilities, including both nursing and boarding homes and public and private institutions for the aged as well. These efforts will, I am confident, assure to the chronically sick, elderly people, the kind of care, comfort, and safety they should have."

Two recently issued reports by State agencies dealing with the chronically ill were "From Blueprint to Reality," the report of the Joint Hospital Survey and Planning Commission, and "A Pattern for Hospital Care," final report of the New York State Hospital Study, known as the Ginzberg report, made to the Joint Hospital Survey and Planning Commission.

"From Blueprint to Reality" estimated that two million persons in New York are suffering from some chronic disease, and that half of these are 45 or more. The report estimated that 23,000 additional chronic hospital beds are needed, half in New York City and the remainder in upstate New York, and recommended that such facilities be developed only as units of general hospitals. It further urged construction of five 150-bed chronic disease centers upstate and provision for equal facilities in New York City.

The Ginzberg study, however, states: "We do not recommend that general hospitals undertake large-scale expansion of facilities to care for chronic patients, but we do recommend improvement in the quality of services provided for them."

Thus, as our own report is being written, the State policy on this vital and complex problem is apparently in a fluid state, that is, no decision has been made whether or not to create additional beds for the chronically ill.

Both the report of the Joint Hospital Survey and Planning Commission and the Ginzberg report should be carefully studied by all persons interested in the problems of older persons, although their main concern is hospital care regardless of the age of the sick.

We list here, without comment, since it is outside the province of our committee, the recommendations of the Ginzberg study:

"**The State should:**

"1. Subsidize the expansion of services, particularly diagnostic services, to ambulatory patients by making limited grants to hospitals willing to develop adequate programs.

"2. Act to improve the quality of the care now being provided in nursing homes and in the infirmary sections of public and private homes through the establishment of a comprehensive system of inspections; and to establish minimum standards which must be met if persons on public assistance are to be cared for in these institutions.

"3. Seek to raise the level of care currently being provided for individuals with mental diseases or disorders by expanding the facilities of State mental hospitals sufficiently to meet the estimated increase in the number of patients, to replace beds in obsolete facilities, and to reduce overcrowding. Further, it should raise the salary scale now in effect for psychiatrists and other professional personnel and should expand and improve the training opportunities for all personnel.

"4. Develop a comprehensive program for the sound expansion of mental hygiene clinics now being operated by the State and voluntary groups.

"5. Review the existing rehabilitation pro-

grams now being supervised by the State Departments of Health and Education with the aim of increasing their scope and improving their quality, particularly by integrating the vocational aspects of rehabilitation with more effective employment service and by promoting the specialized training of doctors and other professional personnel in order to exploit fully the potentialities in medical rehabilitation.

"6. Act to raise the rate at which it reimburses local government for its share of the cost of caring for patients with tuberculosis from a maximum of $2.50 a day to $3.75.

"7. Improve the administrative structure through which it discharges its responsibilities for hospital care by establishing a State Hospital Commission to be concerned with raising the quality of care, developing sound methods of determining hospital rates, and insuring that the public interest in hospital operation is furthered.

"8. Devote adequate resources to research in every phase of hospital care, particularly problems connected with the effective care of psychiatric patients and patients suffering from long-term illness.

"9. Promote the expansion of training facilities for all scarce categories of medical personnel, particularly for psychiatric social workers, physical therapists, and occupational therapists.

"Local Government should:

"1. Adopt a more liberal approach toward certifying as public charges older patients who could profit from general hospitalization.

"2. Establish rates of payment to private nursing homes and homes for the aged which would enable them to provide a higher level of service in general and a higher level of medical care in particular.

"3. Agree to pay reasonable fees to voluntary hospitals that provide good diagnostic and therapeutic services to ambulatory patients who are on the public assistance roles.

"4. In New York City, take every possible action to expand and improve the facilities available for the care of patients with tuberculosis, because those presently available are grossly inadequate.

"5. In New York City, act in cooperation with the leaders of voluntary hospitals, Blue Cross, and other groups to increase the numbers enrolled in hospital prepayment plans so as to reduce the pressure for admission for free care in the municipal hospitals.

"Voluntary Groups should:

"1. Improve the quality of hospital care through stricter control over the work of all members of the hospital staff, and reduce the costs of hospital care by effective management, which implies that boards of trustees must grant adequate powers to their hospital administrators and support them in the exercise of these powers.

"2. Recognize their responsibility to make the facilities of voluntary hospitals as available as possible to all competent doctors in the community and not to permit the hospital to be used for the private advantage of a limited group of individuals.

"3. Secure through voluntary efforts some of the requisite funds to experiment in better ways of providing, at the lowest possible cost, a high level of hospital care, such as the expansion of services for patients with long-term illness and for patients who can be treated on an ambulatory basis.

"4. Realize that the continued operation of the voluntary hospital system depends to a very large extent on the expansion of enrollment in hospital prepayment plans that provide adequate coverage for the maximum number of persons. Voluntary groups should therefore act cooperatively to insure the accomplishment of such a result in the shortest possible time.

"5. Multiply their efforts to secure a larger amount of charitable contributions to accomplish essential reforms, such as the replacement of obsolete facilities, and exercise prudence in the expenditure of these funds by avoiding the unnecessary expansion of facilities.

"6. Recognize the fact that no hospital can be self-sufficient, and act therefore to improve mechanisms, such as regional hospital councils, for promoting the coordination and integration of hospitals. The entire hospital system will thus discharge its responsibilities more effectively.

"7. Take cognizance of the significant role of government in the provision of hospital care, and realize that a well-functioning and efficient hospital system for the community at large depends on the cooperation of voluntary and government groups working in the public interest."

Our Committee has been fortunate in having the benefit of the advice and judgment of Dr. Howard A. Rusk, who points out:

> "It is imperative that full advantage of the techniques of rehabilitation must be taken in the management and care of the aged and chronically ill in the State of New York, not only so that they

can be given the dignity, self-satisfaction and independence which comes from ability to care for one's self, but also in order to reduce the increasing overwhelmingly-high costs of custodial and hospital care.

"Much of the acute financial plight of both municipal and voluntary, as well as state hospitals, is caused by the increasing numbers of chronically ill and aged persons who enter the hospitals and stay for long periods. The Department of Hospitals in New York City are occupied by patients with long term illnesses. The percentage in voluntary hospitals is said to be around 20. In a survey in Syracuse, it was found that 84 per cent of 902 successive patients in medical wards were chronically ill.

"It is agreed that a great many of the chronically ill and aged must have general hospital care initially. Many, however, remain in the hospital purely because of the lack of any place to which they can go if they are discharged. Convalescent or nursing homes are totally inadequate to meet the need, and patients discharged to their homes, where there are no facilities for their care, frequently must be readmitted to the hospital.

"One of the great needs is provision for total treatment of the chronically ill and aged in terms of their total problems. Many such persons cannot be rehabilitated to the extent of employability, but a great percentage can be rehabilitated to the point of sufficient self-care so that they are able to live at home, requiring a minimum of aid from other members of the family.

"The Veterans Administration and a few civilian hospitals and agencies have shown that a great many chronically disabled and aged persons can be rehabilitated to the point of self-care and independence in performing the normal activities of everyday living. They have also demonstrated that such programs provide for immense economic savings not only from those patients who are thereby able to live at home, but in nursing care and other costs for patients, who must continue to live in an adult institution. However, in most of our civilian hospitals, the patient does not receive the services he needs to achieve this degree of self-sufficiency. Hospitals complain that the chronically ill and aged are responsible for their crowded conditions, but do little to provide their patients with the necessary retraining opportunities that will permit them to leave the hospital.

"In reviewing the study made in New York State on the medical, social and institutional aspects of chronic illness, you will see that almost 70 per cent of the 139 hospitals surveyed accepted chronic patients, but relatively few had specialized departments for their care. The great majority frankly admitted trying to avoid their admission, and in answer to the question 'Do you have satisfactory arrangements for referring individuals who require further care?', of the 118 hospitals replying, 92 said that they did not. They cited insufficient facilities, poor staffs, reluctance of patients to go to county, city or state institutions, and excessive costs.

"I feel that primary among the needs of our aged citizens is the opportunity to do something purposeful and constructive. The majority have worked steadily and industriously in a society that respects only the productive; the ending of ability to do productive work, even though it need not be for material gain, is, for most, a tragedy. It symbolizes the end of independence and purpose in life. In overlooking purposeful activity, we have neglected to use one of the most valuable tools in the management of the chronically ill and aged. All who have gone through an institution have noted the apathy and hopelessness of the residents. There are always a few, however, who are bright and active. They are the patients who have volunteered or been assigned to tasks within their physical capacities.

"Like work for the homebound, the use of work therapy in adult institutions requires not only imagination but close supervision to prevent exploitation, but it pays tremendous dividends by providing a purpose in life for the individual. The opportunity to work, and if possible to earn, is necessary therapy if patients are to live in dignity rather than desolation.

"Dr. Marcus Kogel, Commissioner of Hospitals in New York City, and I have had several tentative meetings preliminary to establishing an activity program at the Farm Colony in New York, and our medical staff at the Rehabilitation and Physical Medicine Service at Bellevue Hospital has already completed a medical survey prior to the establishment of such a program.

"The problem of providing an integrated service for the chronically ill and aged is a complex one. It affects tremendous numbers of persons, numerous diseases and types of disabilities, varying types of medical and semi-medical institutions, and, particularly, all community service agencies. This has been shown particularly well in the excellent studies on chronic disease conducted by the State Department of Health and the work of the Joint Legislative Committee on the Problems of the Aging. There is one facet of the problem that stands out glaringly at the present time. That is the need in our general

hospitals and adult institutions to provide dynamic training programs which will enable many of the so-called invalids disabled by chronic disease or age to live independently within their own homes."

Commissioner Marcus D. Kogel of the New York City Hospital Department, whose brilliant efforts to increase the number and quality of facilities available to older persons and the chronically ill have made New York City a world leader in this field, has presented to our Committee a basic plan for adapting a general hospital to the increasing number of aged patients. This includes development of a chronic disease wing, small suite of rooms for temporary care of non-custodial psychotics, a dynamic rehabilitation program, an active home care program, and expanded services for ambulatory patients in its outpatient department. His views are presented elsewhere in this report.

Dr. Frederic D. Zeman has informed our Committee that from 75 per cent to 85 per cent of all internal medicine will in the near future deal with care of the elderly. It is therefore vital that the whole problem of establishing geriatric clinics be explored. The pioneer work of Dr. Robert T. Monroe at the Peter Bent Brigham Hospital, described elsewhere in this report, indicates what excellent results can be obtained when skilled technicians deal with diagnosis and rehabilitation of the elderly. We already have a small geriatric clinic in operation by a voluntary agency in Rochester. The full cooperation of the State Health Department should be given this clinic so that it might operate as a controlled experiment in clinical service for the aged.

Mental Hygiene

Approximately 25 per cent of the persons in our mental hospitals in this State are 65 years old or more.

Nearly 21,000 of the 81,500 persons in our State mental hospitals are in this upper age bracket.

The cost of maintaining our older persons in State mental hospitals was $956.27 per capita during the 1948–49 fiscal year, or a total cost of $20,081,670!

In previous reports, we have noted that the percentage of first admissions to our State hospitals of persons in the 60-plus age group has more than doubled in the past 20 years.

The reasons for this increase are many. Since more persons are living longer, more of us are reaching a period when mental disorders due to aging and physiological changes are likely to appear. An upward trend in the rate of psychoses of old age may also be due to improvements in detecting mental maladjustment. Too, the stepped up pace of living and the tendency of present families to accept less responsibility for their elders, the lack of rooms to care for oldsters, all these have tended to increase the number of elderly in our mental institutions.

Many authorities, including our own State Mental Hygiene Commissioner, Frederick MacCurdy, are convinced that a substantial number of elderly are being admitted to mental hospitals who should not be there at all.

The Commissioner has emphasized that our mental institutions were not built to accommodate any large number of elderly incurable patients. Others point out that the harmlessly senile are often channelled to State hospitals simply because no other facilities are available to them. Commissioner MacCurdy has told our Committee that about 93 per cent of the general hospitals in this State will not even keep a patient showing mental symptoms as a hospital patient, although often they need medical and nursing care, not mental care.

Dr. Kenneth Keill, director of the Willard State Hospital, has set up at nearby Sampson Naval Base a program for caring for 1,000 elderly mental patients in the 60–69 age group in cottage type buildings. Classes have been set up in occupational therapy. A recreational program has been developed. The patients eat cafeteria style, just as though they were ordering meals at an ordinary cafeteria. Doors are unlocked, a procedure that in the ordinary mental hospital would be amazing. Patients are virtually free to come and go as they please on the premises. This in itself, Dr. Keill has informed us, serves to minimize the problems; and ability to wander about during the daytime permits a using-up of the energy so that when bedtime comes, the patient is ready to sleep without the need of medication.

Dr. Keill states that the Sampson Division, in charge of Dr. Guy M. Walters, hopes by studying the physical conditions of this largely uniform group, by making studies of behavior, psychological studies, laboratory investigations of blood, urine and other body excretions, as well as the field of nutrition, to arrive at some conclusions as to the causes and treatment of this increasingly large problem.

The large case-load in our mental hospitals is unfortunately shifting emphasis in the Sampson Division from basic, urgently needed research on the care of the elderly mental cases to that of simply providing custodial care.

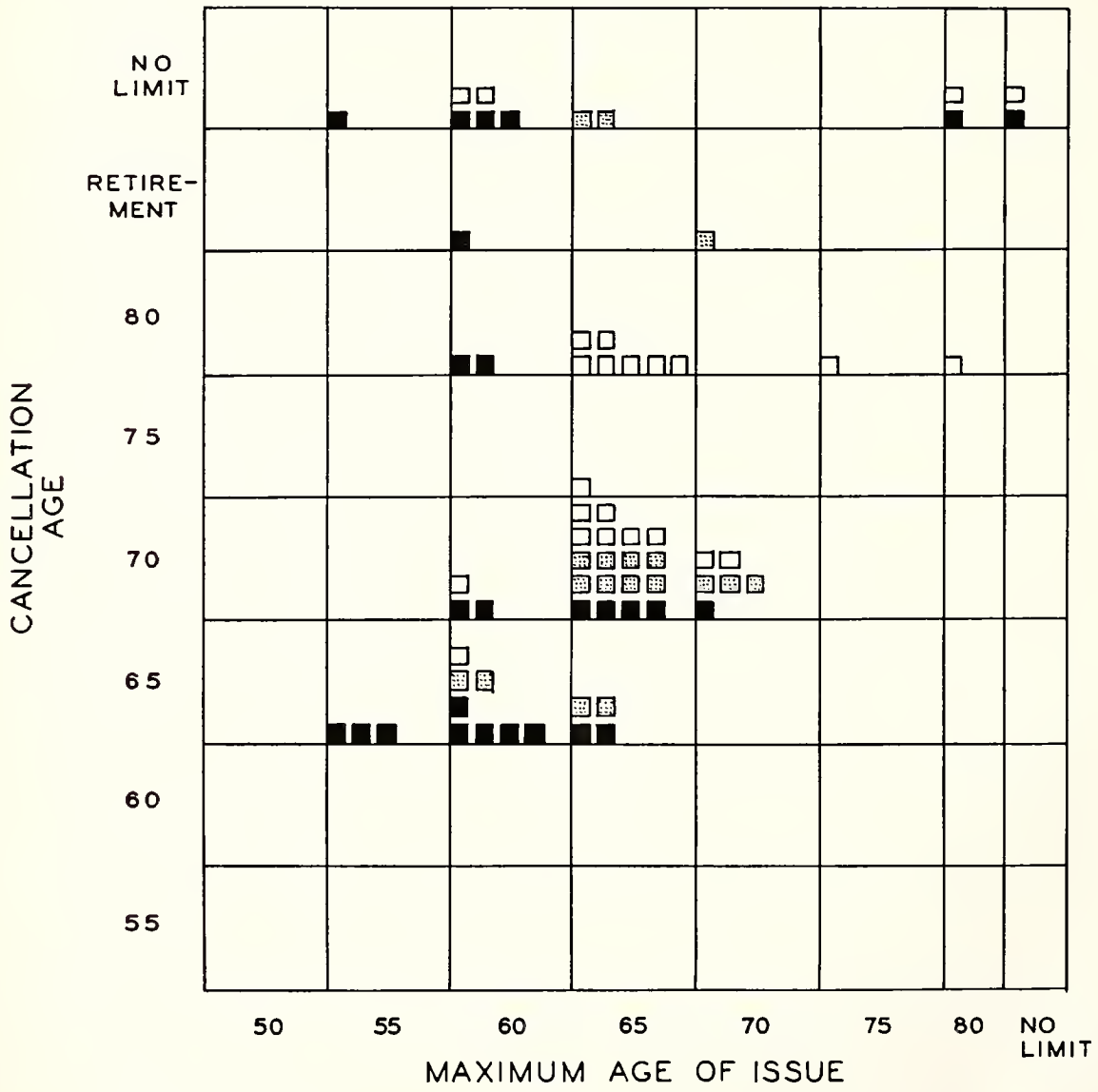
Our Committee urges that full financial support be given by Federal and State governments to the Sampson Division, to the end that there may be developed a sounder, less costly method of caring for the harmlessly senile.

Our Committee is happy to report that the State Department of Mental Hygiene published recently a series of leaflets called "Guideposts to Mental Health," and one of the leaflets dealt with mental hy-

AGE LIMITS FOR ISSUANCE AND CANCELLATION OF ACCIDENT AND HEALTH POLICIES ON MALE RISKS BY INSURANCE COMPANIES LICENSED IN THE STATE OF NEW YORK

FEMALE SAME AS MALE.
FEMALE 5 YEARS LESS.
FEMALE MORE THAN 5 YEARS LESS

ACCIDENT DISABILITY



giene of older persons. This leaflet represents practically the first piece of health literature dealing with the aged issued by the State, except for those published by our own Committee.

Our Committee is convinced that the spread of mental hygiene clinics and a broad-scale educational program directed toward helping persons adjust to life's problems are fundamental. We are convinced that a mental hygiene program that starts with children and adolescents and continues through all the age brackets will be able to keep substantial numbers of persons from ever needing old age assistance.

Our Committee is convinced that when our local communities adopt broad programs for our aging population, covering job campaigns and counselling, better housing, recreational facilities, adult education, home care services, etc., as proposed by our Committee, the proportion of oldsters needing mental hospital care will be substantially reduced.

Our Committee has been very much impressed by the fact that psychiatrists in our State mental hospitals have in many instances actually been "geriatricians" since they have dealt largely with older persons over a long period of years. And it seems to us that in all the thinking that has been going on with regard to the elderly the State psychiatrists have not had an opportunity to give the many groups in the community the benefit of their advice and judgment.

Our Committee believes it will be helpful if State psychiatrists who have cared for the elderly were to meet with a select group of representatives of social welfare organizations, public and private, for an exchange of views on problems of mutual concern. One problem on which the State psychiatrists can help is in setting up standards so that old age homes, nursing homes, and social workers will know when an elderly person should or should not be referred to a State mental hospital.

Since 1933 the State of New York has been placing mental patients in homes other than their own for care. These "foster homes" serve as an opportunity to adjust gradually to the community once more, without disturbing family influences which in some cases were responsible for the mental break down. Social workers aid the elderly person who has been assigned to a foster home, and instruct the family caretaker. Miss Hester B. Crutcher, Director of Social Work, State Mental Hygiene Department, has informed our Committee that of 1,284 persons placed in foster homes from State mental hospitals, 743 are over 60 years old. While this type of care needs to be used carefully and perhaps offers little hope for making an appreciable dent in the total case-load handled by State mental hospitals, it demonstrates sufficient promise to warrant its expansion to the greatest extent possible.

Our Committee further urges that the Mental Hygiene Department allocate Federal research funds to conduct a study, at the William Hodson Community Center, of the place of a recreational day-care center in a community mental hygiene program. The Hodson Center and others have made an amazing record.

In six years of operation with a membership of nearly five hundred whose average age is about 74, not a single member of this center has had to apply for admission to a State hospital. Moreover, the crafts taught, the feeling of usefulness engendered, and the social parties held by the group, seem to give the oldsters a reason for living, and a new and happier outlook on life.

Libraries and Our Elderly

In another section of this report, there is a comprehensive analysis of a survey undertaken by our Committee of the relationships of libraries to the elder people in our communities.

Summarizing here, we found that libraries are rendering many new services especially helpful to oldtimers, including use of ceiling projectors for the bedridden, book delivery to old age homes, nursing homes, hospitals and the ill confined at home, bookmobiles to reach persons in rural areas, and provision of meeting space for clubs for oldsters.

Librarians made a special plea for publication of books in large type for persons with "tired eyes."

Some librarians have taken a key role in community planning for the elderly.

The provision of state-aid to libraries, as presently proposed by various groups, would enable the libraries to undertake far more work with older persons than is now possible, the librarians point out.

Here again our local communities have a challenge that can be met. The libraries are established to meet the needs of all the community, not just the young. Yet some libraries are operated as though an oldster is an intruder.

Libraries can play an important role in a community old age program, not only by merely making available books, but by rendering a host of services ranging from aiding workers to plan for retirement to providing a planned social-educational program geared to older persons.

Insurance and the Elderly

Our Committee, through the cooperation of the State Department of Insurance, recently surveyed the regulations of 71 insurance companies in New York State to determine how the practices of these companies affected our older population.

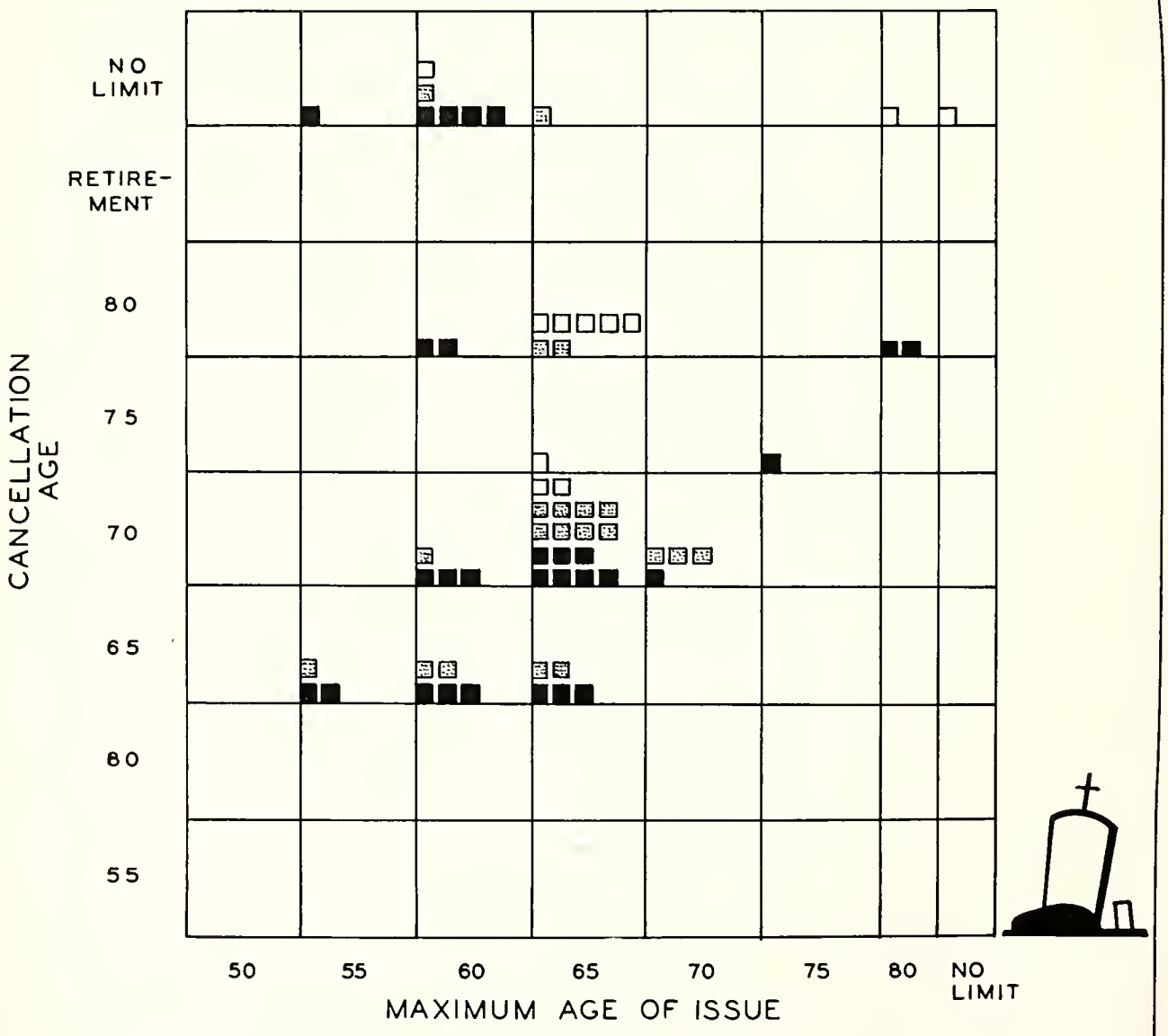
We found:

1. Nearly half the companies will not issue a health

AGE LIMITS FOR ISSUANCE AND CANCELLATION OF ACCIDENT AND HEALTH POLICIES ON MALE RISKS BY INSURANCE COMPANIES LICENSED IN THE STATE OF NEW YORK

FEMALE SAME AS MALE.
FEMALE 5 YEARS LESS.
FEMALE MORE THAN 5 YEARS LESS

ACCIDENTAL DEATH AND DISMEMBERMENT



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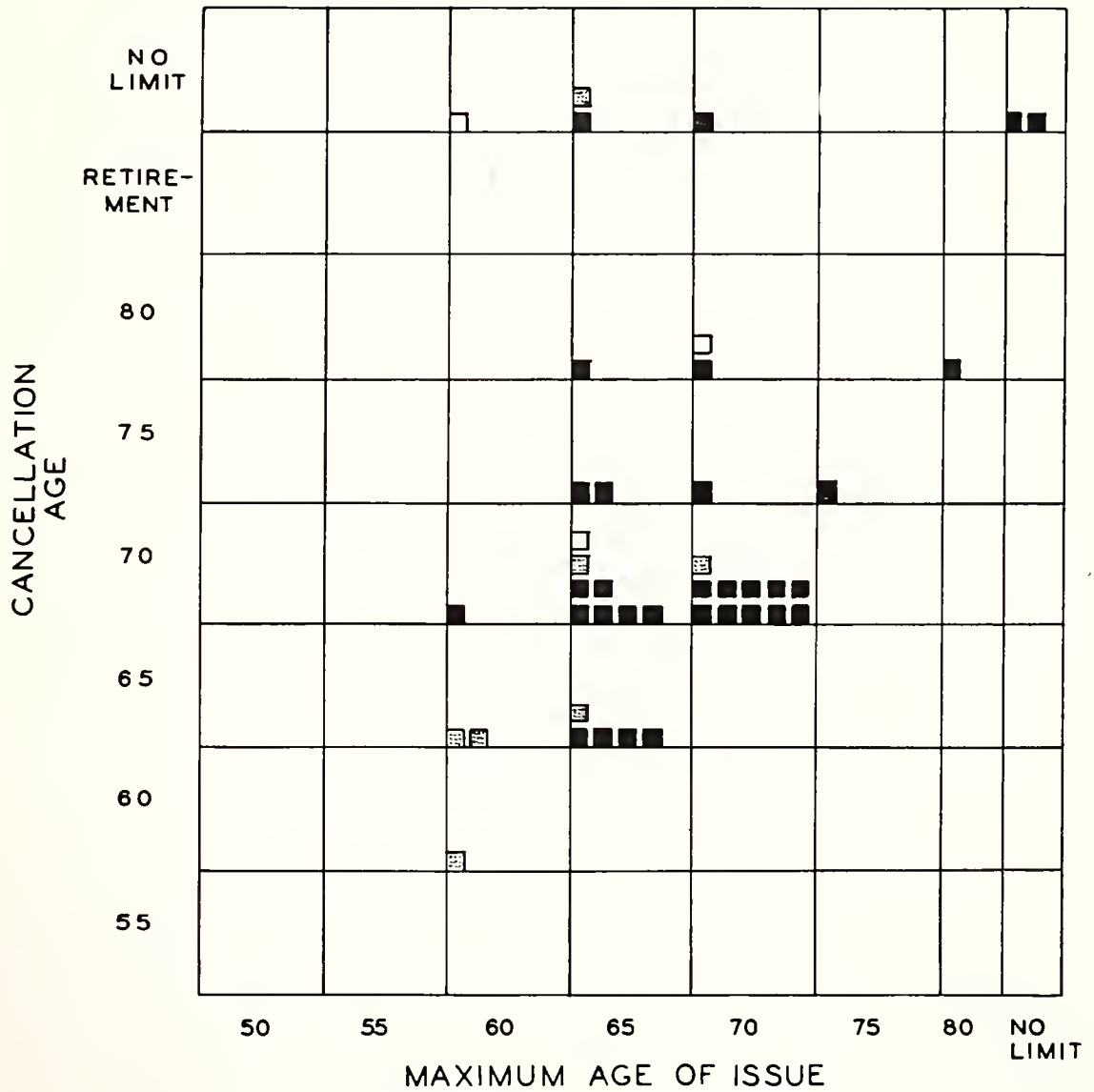
LIMITED POLICIES



insurance policy to anyone over 55; most of the rest set 60 as the top age.

2. More than half the companies refuse to sell hospitalization coverage to persons over 60.
3. Most companies will not sell accident disability policies to those over 65.
4. Most companies will not write accident and sickness policies for persons above 55.
5. Highest age at which life insurance is generally sold is 65, but you're lucky to be able to buy it after age 50, due to physical qualifications that must be met.

Group *health* insurance does not exclude persons of any age working in a covered concern. But upon quitting or retiring, an employee's policy is automatically cancelled. Group *life* insurance provides a conversion right upon retiring or leaving a firm, but the premiums at higher ages are almost prohibitive.

We have reason to believe that the situation is even darker for the elderly than the survey shows because many insurance companies impose lower age limits than their written regulations indicate.

Our findings demonstrate that the elderly, who need insurance most, cannot now buy it. The 22 per cent of our population who are over 50 years old, and their families, are vitally concerned about the age limits imposed by the insurance concerns. It is a problem that has been neglected and will become of increasing importance, for the number of our aged is rapidly increasing.

Health, hospitalization and accident coverage are suspended just at the time when such protection is needed most, in old age, when medical care requirements reach a peak, but earning power sinks to a low ebb or vanishes.

The survey raises a host of vital questions for advocates of both voluntary and compulsory insurance. Does either system intend to provide coverage for the elderly; or will it continue to leave them out in the cold? If oldsters are to be covered, will insurance costs for younger persons become crushingly high? Is it possible to provide some compromise solution, with private companies either pooling their poorer risks, as in workmen's compensation, or receiving a rebate from government for covering older persons? These are issues which must be met.

The wiping out of the savings of low-income and middle-income groups by long illnesses thrusts them on old age assistance rolls, into county old age homes and infirmaries, public hospitals and nursing homes, the expenses of all of which are footed by the taxpayers. Thus taxpayers as well as the elderly have a decided stake in this issue.

Pertinent figures on practices of insurance companies follow:

TABLE I

Age Barriers Erected by Most Insurance Companies

Type of Policy	Maximum Age at Issuance	Cancellation Age
Accident and Sickness	55	60
Hospitalization	60	60 or 65
Accident Disability	65	70
Accidental death and dismemberment	65	70
Limited policies	65	70
Industrial policies life insurance		
paid up at 65	44	—
paid up at 75	65	—
Life insurance	65	—

TABLE II

Cancellation Age for Health Insurance

Cancellation Age	Number of Companies
55	1
60	34
65	15
70	4
80	1
No limit (?)	5

TABLE III

Life Insurance Issued by a Typical Company, According to Age

Age	% of New Insurance
0–49	92.45
50–59	6.67
60–70	.88
	100.00

TABLE IV

Cost of Life Insurance by Age

Age	Life Expectancy	Annual Premium per $1000
25	42.12 years	$20.24
45	25.21	39.53
65	11.55	97.46
70	8.99	127.97

One of the large commercial insurance companies states its age limit for joining is 55. There is no age limit for continuing accident insurance, "except for 80 per cent reduction of the death benefit at age 70; health insurance is reduced 40 per cent at age 60 but may be continued to 65; hospitalization benefits may be continued to age 65."

Our Committee calls upon insurance companies, the Blue Cross Plan, and the Blue Shield Plan, to initiate experimentally at first, contracts which will provide wider services, particularly in diagnosis, and which will provide our older persons with an opportunity to insure themselves.

However, insurance companies have an obligation that goes far beyond seeking to develop contracts that will meet the needs of older persons for life, accident, health and hospitalization insurance, although this is tremendously important in itself.

AGE LIMITS FOR ISSUANCE AND CANCELLATION OF ACCIDENT AND HEALTH POLICIES ON MALE RISKS BY INSURANCE COMPANIES LICENSED IN THE STATE OF NEW YORK

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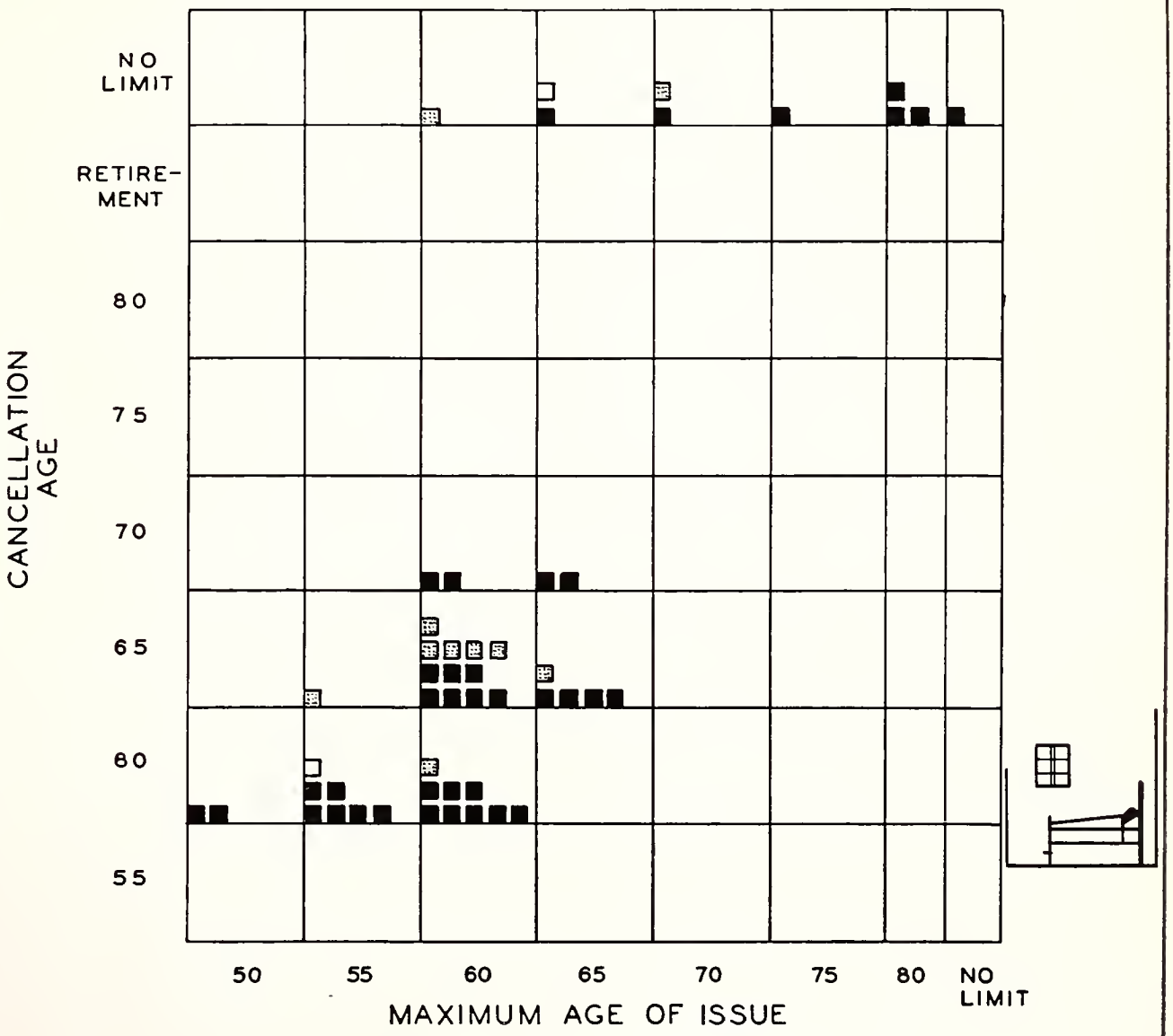
HOSPITAL EXPENSE



The insurance companies have an enormous opportunity to provide leadership in a nation-wide campaign directed to our older citizens. The insurance companies have the finances, the know-how and the direct interest so they can effectively reach our older persons with health guidance material so sadly lacking today.

The insurance companies have a direct stake in attempting to organize pre-retirement counselling programs in industry, as part of a "packaged" pension plan which they could offer to industry. One of the largest manufacturing concerns in this country, with one of the largest pension systems ever purchased from an insurance company, informed our Committee: "You would think the insurance companies would get busy and save industry from the ill-will now developing because older workers simply are unprepared for compulsory retirement called for by the pension plans."

Our Committee believes that the insurance companies themselves have the responsibility of initiating, with the aid of government, industry and labor, a plan for preventing pension plans from restricting the job opportunities of older workers. Today, placement workers from Buffalo to Long Island inform us that it is practically impossible to place older workers in companies that have pension plans. The ill will which such a policy brings forth against private enterprise is too powerful to be ignored. Age barriers against employment of older workers must be reduced and in this campaign the insurance companies must play a major role. Too many of our older persons are being thrust onto relief and old age assistance or are having their spirit sag to new lows because pension plans are believed to be keeping them from productivity. The help of insurance companies is going to be needed, if this problem is to be solved.

Social Workers

Our Committee has come to a new understanding of the value of the work being done in our various communities in this State by trained social workers.

There is too wide acceptance by the public of the caricatured concept of the typical social worker as either an under-sexed or over-sexed female college graduate who wears a fur coat and impossible bonnets and sprinkles polysyllabic impracticalities in her speech as she somewhat haughtily and arrogantly interviews our impoverished people in their slum dwellings.

The joke is in poor taste. Furthermore, the picture is untrue. Most important, it is serving to deter able young men and women from entering a field of work, which like that of the religious leader and the physician ministers to the urgent needs of our people without thought of selfish motives.

Our Committee has found, through its numerous contacts with social welfare groups, both public and private, and through its study of old age assistance cases and how they are handled, that actually our typical, trained social worker is likely to be a hard-working, underpaid expert in the art of human relations, who is helping oldsters to meet life's problems when they can least help themselves. We have found them bringing comfort, hope, and cheer to older persons, aiding them to obtain needed medical help, helping them find a place to live, assisting them in ironing out family difficulties, guiding them to available community facilities, encouraging them to regain their self-confidence, working out family budgets with them, telephoning employers to see if they can get them jobs, arranging for visiting nurse service, fighting with hospitals to get them admitted, calming their fears; yes—and in one instance, shoveling coal for an elderly old age assistance client who was ill!

The social worker in her direct contact with old persons has an unparalleled opportunity to interpret them and their needs to the community. She has not taken full advantage of her first hand knowledge of the human side of the old age assistance programs to do this. She has considered the recipients' interest and their protection against any form of exploitation, this being her primary responsibility and has not been effective in promoting community understanding of the group as a whole because of this.

We have found that our social workers combine a natural sympathy for the unfortunate together with a practical, realistic view which seeks to protect public funds and understands that the most effective help that can be given is self-understanding and the development of ability to care for one's self. If there be cynical wasters of public funds among our social workers, if there be insolent case workers, they are certainly not typical, and certainly no more numerous among social workers than among the general public.

Our Committee has been astounded at the comparatively low salaries, the cost of 80 per cent of which is footed by Federal and State governments, being paid to public social workers whose professional training is often at least the equivalent of teachers, whose work often entails large responsibilities for easing the plight of our elderly and for authorizing expenditures of large sums of public money. Such workers are earning as little as $40 a week in some areas of the state, not only less than teachers but less than laborers, and many of them can foresee with considerable degree of accuracy that they themselves will some day be old age assistance recipients because of the inability to set aside a reasonable cushion of funds for their own old age.

Our Committee urges:

1. That salaries of social workers in our communi-

ties be raised to a level commensurate with the training required for the profession and with the responsibilities imposed on them.

2. That the State Social Welfare Department impose a suitable penalty upon any local government which bars social workers from attending professional social work conventions or State in-service training courses.

Our Committee believes that the social worker has a key role to play in the New York Plan. The social worker has prime responsibility for awakening the local communities to the needs of the aged, for the social worker knows intimately what they need. We believe that the social worker because of his broad training in dealing with human beings is best equipped to bring the program to fulfillment. Social workers are today hiding their work behind a cloud of obscurity and anonymity. Our Committee calls upon social workers to publicize the needs of human beings in their care, for we believe that once the communities truly know the need, they will be generous in supporting the social worker and the destitute.

College Courses in Gerontology

Our Committee surveyed 486 colleges in this country to determine to what extent our institutions of higher learning have adjusted their curricula to the needs of an aging population.

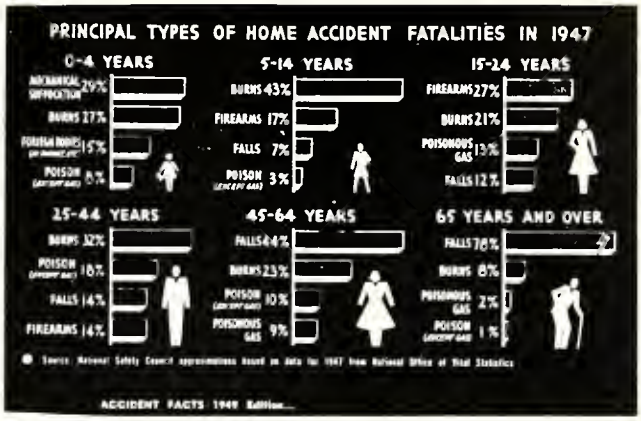
We found that you can now go to college to learn how to grow old successfully, that oldsters are becoming objects of serious study for the first time in the history of higher education, that college students are being taught how to adjust to their elders, how to take better care of oldsters, and how to prepare themselves for later maturity. Courses run the gamut from pensions and social security problems of oldsters to psychological difficulties and recreational needs of the aged.

Many colleges are re-appraising their curriculum in terms of giving liberal arts students some understanding of the medical, social, psychological and economic problems of the elderly, helping students learn to prepare for later maturity, not just for post-college careers, and specialized training of nurses, social workers, medical students, occupational therapists, personnel administrators and psychologists in dealing with the aged.

Accidents of the Elderly

Our Committee recommends that the State Division of Safety undertake an educational campaign designed to reduce the tremendous number of accidents that befall our older persons.

Mrs. G., 72, rises from her bath, slips and breaks



her hip, precipitating a general break-down of her physical and mental condition.

Mr. B., 69, hobbling along with his cane, and a bit forgetful, comes to an intersection, fails to look up and down the road, starts to cross. He sees a truck bearing down on him, but he can't move quickly enough to dart out of harm's way; he is struck down.

Today such accidents are common.

Falls account for 78 per cent of all home accident fatalities to older persons in this country, with burns causing 7 per cent of such deaths.

Deaths by motor vehicles rank second only to falls as the cause of accidental fatalities to older persons. Each year, some 5,000 oldsters are hit by cars or are injured while riding in vehicles.

Of the elderly pedestrians who are injured or killed, 30 per cent were crossing between intersections, 15 per cent were crossing at an intersection but against a signal, and 22 per cent crossed at an intersection where there was no signal.

Our Committee is convinced that the annual casualty rate involving older persons can be reduced by adoption of a state-wide safety campaign directed at our elderly.

The State Division of Safety should, among other things:

1. Stimulate local safety campaigns in our various communities designed to combat the toll taken by accidents to our older folks. Local welfare offices handling old age assistance, district offices handling old age insurance, old age recreation clubs are but some of the agencies that could be used to disseminate information.
2. Encourage wider use of safety equipment and devices in the home, such as grab bars and rails near bathtubs, non-skid rugs, better lighting on stairways.
3. Warn oldsters of the need for special precautions while walking in traffic and use of simple techniques such as wearing white mufflers or gloves while walking on dark roads.

4. Develop among architects an understanding of the special safety needs of older persons, so that old age homes, nursing homes, and other buildings erected for older persons can be as accident-proof as possible.
5. Encourage medical groups to initiate studies of the physiological and mental aspects of falls.

Adult Education

Our Committee in previous reports has indicated the need for developing an adult education program to cover the needs of older persons.

Dr. R. J. Pulling, director of the Adult Education Bureau in the State Education Department, presented to our Committee a stimulating, provocative program for adult education for older persons.

We are happy to report that Dr. Pulling's bureau has employed a part-time specialist to encourage localities to develop adult education programs for older persons, for the older worker seeking to adjust to impending retirement, for the oldster who wants to keep useful and busy, for the elderly who are miserable because they can find nothing to occupy their time, for the oldster who wants to learn a hobby or craft.

New York State thus steps out ahead of the rest of the Nation by initiating an educational program geared to older persons. Today, courses can be given in factories, old age homes, recreation clubs for older persons, as well as in civic centers, libraries, shops, studies and even in private living rooms.

A report by the U. S. Office of Education indicated that there were in 1947–48 only 25 courses for persons past retirement age given in the entire country and said it was the least widespread type of adult education.

The State Education Commissioner, Francis T. Spaulding, has informed our Committee, "We are very much concerned about doing the kind of job that needs to be done in connection with education for older people."

Our Committee believes:

1. The work of the Adult Education Bureau should be expanded to develop a comprehensive program of adult education for older persons, as outlined in "Birthdays Don't Count," by Dr. Pulling.
2. The State Education Department's relationship to older persons extends far beyond that of simply adult education. It covers, for example, library service to the elderly, vocational rehabilitation, licensing of teachers for adult education work, state-aid to recreation centers doing educational work approved by local boards of education, and an examination of the entire elementary and secondary school curricula to determine how youngsters can be prepared to adjust to older persons, frequently a sore-point at present, and how youngsters can be prepared not merely for a post-school career but for a well-rounded life throughout maturity. Therefore, our Committee urges that the department set up an interdepartmental committee to explore all facets of education in an aging population.
3. The State Education Department should allocate funds for research on the educational needs of older persons. Very little basic research has been done in this field.
4. Our Committee urges the State Education Department to re-examine its own discriminatory policy regarding older persons. Today, a person desiring a license as a teacher of shop or trade subjects is barred from admission to qualifying courses of instruction if he is more than 40 years old. Many able craftsmen, technicians, skilled workers who would make splendid teachers and who in their later years might wish to teach are barred by this regulation.

Recreation for Oldsters

Recreational clubs for our elderly are mushrooming up all over the State in heartening numbers.

Churches, women's groups, fraternal organizations, industrial clubs, and local recreation departments are sponsoring recreational facilities for oldsters.

This is a trend that our Committee is stimulating and wishes to stimulate further.

No community should fail to provide recreational facilities for its elderly.

Unfortunately, too many of our localities provide playgrounds for children, tennis courts and baseball fields for adolescents and young adults, but neglect entirely the recreational needs of our elderly. It is as though suddenly when a man or woman becomes 60 or 65 he or she no longer needs recreation.

The day care centers for oldsters such as the William Hodson Center in New York City are proving to be a mental tonic for oldsters. Senescence is apparently retarded by the activities of these recreational and social centers, which replace the activities of the working day for the elderly. The record seems to indicate that at Hodson Center, for example, the oldsters live 10 years longer than most people in the same age group, and retain their mental stamina longer too.

Why do oldsters like to join these kinds of activity? One says: "It's a retreat for displaced persons in our society, the elderly". Another says these clubs "put new energy and love in your heart." A widow says, "it takes your mind off things, like the loss of a dear one."

Fingers that have lost none of their nimbleness with the years help keep these men alert and usefully occupied.

In Newburgh, New York, an outstanding recreational club for oldsters, Club 60, is sponsored by the Junior League. Facilities are provided by the enlightened management of S. Stroock & Co. The club is run on a democratic basis by the oldsters themselves. Significantly perhaps, the idea for the club stemmed from a social worker in the local welfare department, who was aware of the needs of the older persons in the community.

Until the State's recreational work is organized on such a basis that it can stimulate community recreation programs covering all age levels, our Committee believes that separate state-aid for recreation centers for oldsters is justified. The State now provides aid for recreation centers for youngsters. It is no less important that we encourage recreational centers for oldsters.

Our Committee recommends:

1. The State grant state-aid for recreational programs sponsored by local communities.
2. The state aid be limited, at first, to cities.
3. That the larger cities in the State investigate the desirability of establishing day care centers in lieu of or in addition to clubs which meet perhaps once a week or even less frequently.
4. That in accordance with the recommendation of our Advisory Committee on Recreation, the amount of state-aid should be 10 cents per person who is 60 or over in a particular community, based on the most recent census, this sum to be matched on a 50–50 basis by the locality.
5. Every effort be made by the State Education Department to eliminate the snag in New York City where suitable teachers of crafts, hobbies, arts and skills of various sorts suitable for recreation centers for oldsters are barred because they

lack the formal education requirements for academic instructors.

6. Every local recreation department develop special facilities for oldsters, such as lawn bowling, checkers, croquet, horseshoes, etc.
7. That State parks make available similar facilities for oldsters wherever possible and that such facilities be publicized so that more oldsters will take advantage of them.
8. That the State develop a comprehensive recreation program for persons of all age groups, so that special emphasis on one age group, whether youth or the elderly, will be unnecessary.

Housing for the Elderly

In previous reports, we have called attention to the need for providing space in public housing projects for our older persons. We recommend a change in the Federal Housing Law which bars older persons from federally aided housing projects, urged that an analysis of the market for housing the elderly be undertaken by the State Division of Housing, advocated that cottage-type living arrangements for the elderly as now set up in certain Florida and New Jersey communities be explored, and urged that insurance companies explore the possibilities of investing in housing projects for the elderly.

We doubt that the answer to housing the elderly lies in establishing communities for the elderly alone. Our older persons like to be near younger people, prefer not to have to live solely with others of their own age group; as a whole they want to be part of the whole community, not segregated into old age colonies. Of course there are exceptions, but the experience abroad seems to be that when entire apartment houses were set aside in special areas for older persons, oldsters did not like the arrangement. Sweden, for example, after a number of experiments, is shifting from apartments exclusively for the oldsters to ones which contain persons of all age groups.

Foreign countries have had considerable experience with housing of the aged, ranging from public hostels provided for by England's National Assistance Law of 1947 to Cologne's housekeeping park apartments for aged persons of limited income. The experiences of England, Belgium, Denmark, and other countries need to be sifted, to determine what we can learn to aid us in housing our own elderly.

Available figures for this country indicate that most of our elderly live in private homes of their own (68.8 per cent). And there is little doubt but that in most cases the best housing for oldsters is their own home, although this may not always be true especially when they become infirm or senile. About 21.9 per cent live with relatives, which in many cases is satisfactory, enables the oldster to feel useful, solves an economic situation; but which in other cases may prove unsatisfactory if there are problems of adjustment, undue feeling of dependence, and constant bickering. Over 5 per cent share the home of a nonrelative. Four per cent reside in institutions.

The Central Bureau of the Jewish Aged has reported to our Committee: "In the field of private housing, furnished rooms and small apartments are available to older persons but they are not adapted to their specific needs. Frequently an older person lives alone on resources which are not adequate for his comfort and well-being. For example, a frequent occurrence is the dispossession of a lone aged person from a furnished room when he requests or requires extra attention or services from the landlady. We have seen many self-sufficient older persons become fearful and insecure after such experiences."

The bureau advocates that the community take responsibility for further stimulation of the public housing authorities and private endeavor toward the building of housing projects with a recognition of the older persons as a potential and suitable tenant.

Today, in New York State, there are in state-aided public housing projects 99 apartment units of the one-room type presumably suited for older persons, plus 111 more such under construction. These include 56 units specially set aside for oldsters at Fort Greene Houses in Brooklyn, 39 at Lilliam Wald Houses in Manhattan, 4 in Melrose Houses in the Bronx, 100 in the Governor Alfred E. Smith Houses, and 11 in the Farragut Houses in Brooklyn.

There are, in addition, seventy-one 2-room, bedroom units designed for two persons in the Farragut Houses, Albany Houses in Brooklyn, and the Flushing Houses. There are also a total of 772 units, 2-room, 1-bedroom, designed for two persons in our state-aid housing projects.

However, provisions for housing our elderly in public housing projects still consist almost entirely of the 56 apartments in the Fort Greene projects, plus such other apartments as are provided for elderly slum dwellers whose old apartments were torn down in slum clearance projects.

We are happy to note from the 1950 message to the Legislature by Governor Dewey that "active consideration is being given to the problem of housing the aged, which has been repeatedly recommended by the Joint Legislative Committee on Problems of the Aging."

The State Housing Division, we are informed, is sifting all available information on living needs of the elderly. Rochester is making the first really comprehensive study of the housing needs of its older persons. Data which the U. S. Census Bureau plans to compile in 1950 will give us for the first time in-

formation we need to plan a rounded program for housing our older people.

Continuation of Our Committee

Our Committee believes that it is in the public interest that our Committee be continued another year. This recommendation is urged upon us by private social agencies upstate and in New York City, by medical, industrial, labor and community leaders, as well as by Governor Dewey in his 1950 message to the Legislature.

The problems of the aging are so vast that to probe into them is to attempt to cover most of the major problems of life itself. Our entire economy and our entire problem of human relations are affected by the many ramifications of the problems of the elderly.

Our Committee has made an attack on some of the more urgent problems and recommended a broad program that obviously could not cover all the aspects of the problems of the elderly. The Governor has asked that we extend our Committee's activities to enable us to join with national authorities in working out a basic solution to the problem of economic protection of the aged. We shall be glad to do so.

Our Committee believes that a great deal of work needs to be done with personnel managers, housing experts, and mental hygiene authorities. Our Committee, if continued, plans to (a) keep close check on the job counselling experiment mentioned in another section of this report, (b) determine from its survey of old age recipients what further local communities can do to prevent oldsters from needing old age assistance, (c) seek to develop with the aid of the State Insurance Department some sound method of preventing, in a just manner, insurance companies from using the annual renewal clause in health and hospitalization policies to bar continuation of insurance to elderly policyholders once they become ill, and generally to bring the insurance companies to develop their own programs for the elderly, (d) continue to work with industrial and labor groups to break down age barriers in industry, (e) work toward closer liaison between the State Mental Hygiene Department and our private old age homes and social welfare agencies, and (f) appear before congressional and national administrative agencies in the field of labor, social security, health, and education, to give them the benefit of our findings.

Condolences

Our Committee wishes to express to the family of our former colleague, Senator Rhoda Fox Graves, who died at age 73, our deepest sympathy in their loss. Senator Graves was sincerely interested in improving the welfare of our older persons and aided our committee greatly by her sympathetic understanding of the plight of many of our elderly.

Our Committee was also grieved at the loss of one of its able advisors, Dr. Stephen R. Monteith, of Nyack, who was Chairman of the Sub-Committee to Study Geriatrics of the New York State Medical Society, and who was giving the medical profession in the State outstanding leadership in the social aspects of geriatrics.

Acknowledgments

Again our Committee must record its obligation to the member agencies of the Welfare Council of New York for continuing through the year to provide our Committee with information, guidance and inspiration.

We cannot possibly note here all the individuals and organizations who aided our efforts, without extending this report to encyclopedia proportions.

We are indebted to Parke Davis & Co., Newsweek Magazine and Standard Oil of New Jersey Inc. for their cooperation in providing free of charge to our Committee expensive color plates which would have otherwise been unavailable, to NEA for the use of brilliant cartoons dealing with the elderly and various member agencies of the Welfare Council of New York for various photographs.

We must, however, make special mention of the indebtedness of our Committee to the Community Service Society of New York and its consultant on the aged, Miss Ollie Randall, who has given freely of her counsel and her wide experience to our Committee.

The Committee is also especially appreciative of the cooperation given by Miss Gladys Fisher of the State Social Welfare Department, Dr. Charles A. Pearce, and his research staff in the State Department of Labor, and Dr. R. J. Pulling of the State Department of Education.

To the many colleges and universities, labor unions, industrial concerns and councils of social agencies which cooperated in furnishing data to our Committee, we express our gratitude. We are particularly grateful to the medical men, such as Dr. C. Ward Crampton, Dr. Robert T. Monroe, Dr. James M. Dunn, Dr. Frederic D. Zeman, and New York City Hospital Commissioner Marcus D. Kogel for giving our Committee the benefit of their advice and judgment, in some cases at considerable inconvenience to themselves.

Our Committee wishes to thank the various Federal Departments, such as the Veterans Administration, the U. S. Labor Department, the Social Security Administration, and the U. S. Public Health Service for authorizing their key officials to aid our Committee by furnishing data and advice.

Our deep gratitude goes to the members of our Advisory Committees and to the various State Commis-

sioners who have provided information and guidance, to Mr. Albert J. Abrams, who directed the work of our Committee and drafted this letter of transmittal for our review, and to Mr. John A. Ruskowski, who aided greatly in the preparation of this report and in the work and studies of our Committee.

We are also indebted to the many older persons who furnished our Committee with invaluable information on their personal problems and thus enabled us to gain an insight into the real and human difficulties which confront so many of our elderly.

Nature of This Report

Like its predecessors, "Birthdays Don't Count," and "Never Too Old," this report consists of two basic sections. The first contains this letter of transmittal. The second section consists of various papers and reports prepared for our Committee by some of the Nation's outstanding authorities on problems of the aging, and other analyses which our Committee thought should be brought to the attention of all concerned with the plight of our elderly.

NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON PROBLEMS OF THE AGING

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The Governor's Views

By Governor Thomas E. Dewey

(Excerpts from 1950 Message to the Legislature)

THE PROVISIONS for the aged in this country are today in a chaotic condition. The national old-age and survivors insurance system under the Social Security Act, passed fourteen years ago, as now constituted, is a failure. Its benefit payments are inadequate, and unless the system is recast fundamentally, it will continue to fail for another ten to fifteen years to meet the needs of our older people. Moreover, many people are not even covered by the system.

The joint national-state public assistance system was established originally as a stopgap to take care of the needy aged who could not immediately be brought within the scope of old-age and survivors insurance. Actually it overshadows the insurance system. It provides larger benefits than old-age insurance and threatens to become a major fixture in our national life. Yet, it does not provide a permanent solution to the problem.

In the meanwhile, through the efforts of governmental and industrial employers and more recently of labor unions, pension funds for industrial and governmental employees have grown considerably in number and scope. Some of these are contributory, others non-contributory; some are funded on a reserve basis and thus safeguarded to some extent against default; others are completely unfunded and unsafeguarded; some are correlated with the national insurance system while others are not.

The State of New York, with its vast and increasing aged population is vitally concerned with the introduction of some order into this confusion of conflicting trends. We are concerned about a sound reorganization of the national old-age insurance system which will meet the needs of our population and the population of other states.

We also have a responsibility to correlate our State and municipal retirement plans with the national insurance system; and, wherever practical, to assist industrial employers and labor unions to develop jointly soundly conceived retirement systems.

This can not be done without a more thorough study of the entire problem than has yet been made. We must find solutions which will stand through time. I recommend, therefore, to your Honorable Bodies that the Joint Legislative Committee on the Problems of the Aging be continued and expanded in order to carry forward its excellent work in this field and to include within its perspective the problems of old-age pensions and insurance. This Committee should also be able to make effective presentation of the needs of this State in the national deliberations on the problems which may take place during this year.

Housing

Although the low rent housing program is primarily intended to accommodate family groups, active consideration is being given to the problem of housing the aged, which has been repeatedly recommended by the Joint Legislative Committee on Problems of the Aging. In the first project built with State funds, provision was made for one and two room apartments suitable for occupancy for aged persons. In all our State-financed public housing, whether the project is in the planning stage, under construction or in operation, provisions have been made for small size units with a view toward alleviating the housing problems our our older citizens.

Nursing Home Care

All of us have a relative, or friend, or know about someone who is receiving nursing home care or who requires such care. This situation constitutes a health problem as well as an economic and social problem to which your State Administration has given extensive study and upon which it has acted. In recent years there has been a substantial increase in the number of our chronically ill, an increase that stems from the fact that we are living longer and have become an aging population.

Many of our chronically ill do not require hospital care but do require nursing and other services which are not available in the average home. As a result, there has been a tremendous expansion in the nursing home field. To learn what kind of care these aged men and women are receiving and to obtain the fundamental facts of this relatively new nursing home economy, the State Department of Social Welfare recently made an intensive survey of nursing homes in upstate New York. (Nursing homes in New York City are licensed by the New York City Department of Health.) Approximately one thousand homes were surveyed. As one might expect, they were found to be good, bad and indifferent. Many of them should not be called nursing homes. They are merely boarding homes. A report is now being prepared on the findings.

The responsible owners of these homes, which are proprietary in nature, want standards to be set, as a protection to the patients and to themselves. The State Department of Social Welfare, with the help of the Interdepartmental Health Council, is now planning to develop such a set of standards.

We shall also have to plan a program for developing more and better facilities, including both nursing and boarding homes and public and private institutions for the aged as well. These efforts will, I am confident, assure to the chronically sick, elderly people, the kind of care, comfort and safety they should have.

What Can the Local Community Do for Its Elderly

By Miss Alice M. Loomis
Community Consultant on Service for the Aged, Rochester Council of Social Agencies

WHAT can a community do for its elderly? First, very decisively a community can and must *choose* its course of action with its older residents. If no *active* choice is made, it may drift into many unrelated projects, all very kind in intention, some glamorous, but always with a possibility of unseen misery and dissatisfaction and a tidal wave of unwise appropriations. Thus the community's decision has been reached by the default of its citizenry; everyone except a few promotors may suffer.

A local program for the elderly can be effective only when the local community takes the initiative in forming or formulating a sound program for *all* its aging population without regard to social or economic status. To wait until a program has been superimposed from higher levels and then to object to state or national domination is futile. Local initiative and responsibility as a foundation for a sound program are mandatory, inescapable.

Effective service for and with the elderly depends upon a full and sympathetic partnership between the local community and upper governmental units, integrated with a common purpose, and a division of responsibilities clearly determined.

Assuming that a community decides to chart its course, rather than to drift or to be pressured into action, how does it get started?

Eager learners are these oldsters when you have something worthwhile to teach them.

First, a few people with vision urgently feel a certain need and get an idea of doing something about it. Other sponsors soon become interested. Golden Age clubs for lonely older people are a frequent starting point.

The imagination that leads to a first step soon reveals numerous other needs, but limited knowledge, time and funds may discourage the pioneers from attacking all the problems they have brought to light. This is perhaps fortunate, for then other people with competence in various fields must be drawn in.

If these people, all touching different facets of the community begin to consider a central problem, then a community object will be developed. Whether this originates outside or within a community formally organized planning group, the integration of the forces into an effective enterprise can, in all likelihood, be best achieved through the medium of a Council of Social Agencies or some similar coordinated medium.

The problem of what a community must do *for* and *with* its elderly would be overwhelming, if it were not seen in sections in each of which there is a community leader with his own special skill. From the cooperative thinking of these leaders comes the decision as to priority of action.

Guideposts

There must be fundamental agreement on the principle that the program must provide the fullest possible participation of older people. Participation by the elderly was a necessity in our former rural economy. Today in an urban society, with the increasing proportion of older people in the population, the opportunity for the elderly to share, as far as their abilities permit, in the life about them requires a rearrangement of many recent practices. This rearrangement offers a challenge. It is in the local communities where the elderly live, languish and vote that this challenge must be met. When older persons lack outlets for their energy—mental, social, physical—responsibility rests upon the community to find suitable opportunities that will help to keep the elderly off the scrap heap. For example, even the feeble homebound have found satisfaction in as simple a task as stuffing Christmas seals in envelopes.

While there is a wide variety of fields, discussion of the application of the principle of participation is limited here to recreation, health, housing and employment.

Recreation is the starting point in most communities; unfortunately, in some it is the limit of the expression of community interest. Recreation for the elderly in all its forms should have the single objective of increasing opportunity to enjoy to the full the leisure of later years. Three guideposts may be of assistance.

One, the number of older people with leisure is constantly being increased by those who differ from the average old person in the past. They have better health, they have worked shorter hours, had more vacations, traveled more. They have had more opportunity for varied interests and quite a number have larger pensions. With all the pressure that has been associated with these gains, however, the great need of many is knowing how to enjoy leisure, that is retraining for leisure. This is a challenge to the Adult Education Section of our public schools as well as to many other parts of a community.

These newly retired and soon to be retired are probably any community's largest reservoir of unused human resources. They have much to give of time, energy and skill. With their need to learn new adjustments, they should be of immense help in the general thinking on the place of the older person in our modern society. There are no answers in the books.

Two, the less active and formerly busy citizens should be kept fully informed of available cultural resources. This can only be achieved by continuing search and frequent publication. Churches, fraternal organizations, libraries, art galleries, museums, city departments, public utilities, and many others have extension, social service or public relations departments with rich offerings. A Senior Citizens Calendar, compiled by a committee of lay and professional workers, is of value to any city.

Three, there are latent powers in all but the genuinely senile. The response in new paths may be slow and timid, but the joy of learning even the simplest thing is a creative experience that prolongs and deepens life. One has but to visit the occupational therapy department in a home for the dependent aged or chronically ill to realize what skilled leadership can do to arouse and make fruitful the innate desire to learn; or to visit a camp for elderly people where the pains of sunburn and mosquito bites may replace those of arthritis and heart attacks.

A better understanding of the *health* needs of an aging population will lead to many changes. It may be necessary for the higher governmental levels to assume greater responsibility for the chronically ill and for the research needed to reduce their number. Certainly the community will improve its immediate services as it adopts a more constructive attitude toward the treatment of its aged ill. More and better nursing homes are needed wherein illness is not presumed to be a prelude to death.

In one city, the addition of a physio-therapist to the staff of nursing homes, under the direction of a forward-looking County Department of Social Welfare, is hastening the recovery from such misfortunes as fractures and strokes, thereby accelerating the flow of patients from the hospital at $11 per day, to nursing homes at $125 monthly, to boarding homes at $75 monthly and, in fortunate cases, to their own homes. Each step represents an increase in the independence and happiness of an older person and a decrease in the cost of the care.

Preventive and constructive services are needed for both physical and mental health. For example, much more is known than practiced in nutrition of the aged. In many communities there are from one to a dozen agencies touching this subject. Yet physicians continue to prescribe care for the aged persons suffering mainly from malnutrition.

In the prevention of mental illness a community can do much by drawing older people into normal activities. This sounds deceptively simple and the results may seem at times to be miraculous. An old man in one city, formerly an active respected citizen, was beginning to sit quietly and stare blankly, entirely withdrawn and apparently ready for a mental hospital. He was persuaded to become a day visitor at a home for the aged where he met men of his own age. He entered into their activities and shortly an alert, old man was searching for a room near the home where a blind acquaintance could live and share with him the home's activities. Perhaps skilled casework and a progressive home for the aged were part of the miracle.

It cannot be said too often that the physical and mental health of our aging population is conditioned by the physical and mental health program for all ages provided by the local community.

Housing Action

Housing for the aged hopefully is passing from the public conscience and discussion stage to that of definite civic planning and action. Yet does any city know how much of the living space so sorely needed by younger people is in the large apartments and the large houses that are wearing out old people because there are no small comfortable quarters for them? Knowledge is not lacking as to the kind of housing needed. A few units have been built with extra consideration for safety and with services available as needed—food, shopping, laundry, housekeeping.

Private investment in this type of housing is reported to be a sound financial venture.

Even without new housing many feeble old people could remain longer in their own homes or the homes of overburdened families, if only they had supplemented housekeeping, nursing and shopping services. Any hospital can report what the lack of these services is costing the elderly and the taxpayer. One of the next steps in many communities, and it can be an immediate step, is the fitting of these services in with those already established.

In at least one city in New York State the local planning commission is assuming responsibility for a survey of the housing of its elderly residents. From such definite knowledge practical housing plans can be developed.

Employment

To say that older people experience difficulty in securing and holding gainful employment is merely a reaffirmation of the obvious. In the main, this is due to conditions largely beyond the control of local industries and local communities. Many questions of general policy are, as yet, unanswered, but they are continually arising in every community. Should the termination of employment be determined by chronological age or by productivity? If based solely on productivity, how will the heads of young families be affected? This is a serious and unsolved problem.

Should the community offer guidance to the retired person who is contemplating the investment of his life's savings in a small business? Cannot a business clinic be created for the elderly as for other groups? How can job finding for the elderly be best achieved? To what extent will a sheltered workshop contribute to the well-being of those no longer able to meet the demands of modern business operations?

With a better understanding of what *can* be ahead for each of us there should be fewer tragedies such as that of the university professor who, on retirement, had been greatly honored for his 40 years of service. His widow startled her associates by saying that the university would be kinder to shoot its retiring professors than to put them on the shelf alive.

Also, the local community must explore **preparation for retirement.** Too frequently the sturdy and productive worker suddenly on retirement finds himself unadjusted to great blocks of free time and suffers from the "bends" by coming too rapidly from the deep waters of a job to the shallows of idleness. The program of preparation for retirement should cover a minimum of at least five years. It is a major personnel operation by which the employee is helped to appreciate the eventual freedom from the many years of responsibilities. At the same time assistance should be extended in the development of interests which will give zest for living. Here leadership must be given by the employing organizations with the assistance of other community resources. No single group can do this alone. The grafting of a new and fruitful life is a matter of common concern. Interests should be directed into constructive channels, not only for the benefit of those who are retiring, but for the benefit of the community because there is a wealth of untapped skills and abilities which should be used for the community's benefit. One does not lose all his strength the day after retirement. This reservoir of constructive forces should be tapped and the variety and quality are great.

A positive approach must be made; the sense of being needed must be fostered; busy work alone will not meet the needs of our aging people. This can be a realistic program. Already two leading industries in Rochester are attempting to work with such a program which will utilize many of the community's resources.

To develop gradually a durable program for the elderly, including new practices in employment and recreation, housing and health there is needed an underlying social philosophy. One important method of interpreting this philosophy is the consistent selection and vivid presentation of news which portrays needs and how they are being, or should be met. An excellent example of this type of reporting was a series of six articles on the various facts of the local program published in the *Rochester Democrat and Chronicle.* There is a wealth of material which can be used, showing how sound planning and courageous action not only pays in human happiness, but in the long run can save the dollars of the taxpayer and contributor. Through planning and interpretation, many of the mistakes that have been made for creating unnecessary projects or by abolishing others of real worth because of the lack of facts, can be avoided. A program cannot advance without community understanding.

Local Action

There has been a disposition on the part of many communities to await governmental action, especially on the higher levels, to solve the problems of the aging population. However, in those communities where responsibility has been assumed, and discussion as well as action has been had, interest and financial support increasingly have been offered by voluntary sources. Within the past year in one city a long-established local organization, the Women's Educational and Industrial Union, gave a recent legacy to the Council of Social Agencies to carry on a project for the development of a comprehensive program for the aged. A community consultant on services to the

aged has been employed, and a community focus has been established. To further enrich this effort, the Junior League has given sufficient funds to the council for a series of institutes on the aging population. Neither of these generous gifts—and they may be only the beginning of additional financial support—would have been forthcoming had there not been an organized effort in the community to do something for and with the elderly in their midst.

It is becoming increasingly clear that a successful program is dependent upon the courage and action of local communities in close sympathetic partnership with the state and Federal governments. Each has its important role to play. In New York State, we are beginning to see a consolidation of effort, and there is gradually evolving a program insuring the elderly both protection as needed and continued opportunity to share in community life. The recent creation of the New York State Association of Councils of Social Agencies and the proposed unofficial State Council for the Elderly will inevitably act as crystallizing and unifying forces. With the leadership of the members of the Joint Legislative Committee on Problems of the Aging, the communities in New York State can definitely progress in their efforts to meet the needs of our aging population.

What Westchester Communities Are Doing for Their Elderly

By Miss Lillian A. Quinn
Executive Secretary, Westchester County Council of Social Agencies

THERE is growing recognition in Westchester county, its cities and towns, that an aging population brings new community responsibilities that call for new services and the extension or adaptation of established services. A wide variety of organizations are operating specialized services not in existence a few years ago. Other organizations, such as the Westchester Nursing Council and the Westchester Chapter of the American Association of Social Workers, are making the needs of aging people the subject of open program meetings this year. Mention is merely made in passing, to Old Age and Survivors Insurance and to old age assistance, since these are available throughout the State.

The greatest recent strides in Westchester services to the elderly are in recreation. Local sections of the National Council of Jewish Women operate five senior canteens in Mt. Vernon, Port Chester, New Rochelle, White Plains and Yonkers. Neighborhood House sponsors a senior canteen in Tarrytown. The Junior League of Bronxville ran a senior canteen in Tuckahoe on a demonstration basis, which it is hoped the local Recreation Commission will continue.

The Golden Age Club of the Ossining Recreation Commission provides a recreation center for older men. This Golden Age Club started by chance, in one sense. The Ossining Recreation Director saw three elderly men huddled together under the eaves of a closed building on a rainy day. Being a friendly person, he said, "Why not come around the corner, and wait until the shower is over, in the Recreation Center?" They replied that they thought it was only for young folks. "Not at all," he said, "it's for the people of Ossining—no upper age limit."

That was the beginning of a growing group who not only formed the club and meet in the recreation center, but do all sorts of entertaining and useful things together between times, as a group or in two and threes.

The County Recreation Commission has conducted two informal conferences this year on the recreation needs of old people to focus the attention of local recreation leaders, lay and professional, on expanding their programs to serve old as well as young.

The Pelham Junior League with the aid of the Public Library of New Rochelle conducts a "Pony Express." The league delivers books, furnished in the main by the library, to shut-ins, most of whom are in the upper age brackets. They collect the books later, as they bring new ones.

Keeping the elderly occupied at creative tasks is one of the functions of old age homes.
(Courtesy Peabody Home for the Aged.)

County Home

The County Home, a division of the County Department of Public Welfare, has much entertainment furnished by Women's Clubs, Service Clubs, fraternal orders and others. The Committee of 100 of the Scarsdale Women's Club has provided a public address system for the auditorium and improved sound equipment to moving pictures. A well known Children's Theatre, with its base and workshop in the county, has for several years had its tryouts at the County Home, before taking to the road. These are very popular events with the residents of the home. The County Home also has a full time occupational therapist. This position is on the county payroll.

Another division of the County Department of Public Welfare, the Department of Family and Child Welfare, is making progress on recruiting volunteers to take occupational therapy into those nursing homes where their old age assistance clients are boarding. This department is very conscious of the need—for

both psychological and economic reasons—for gainful employment, at least part time, for its older clients, some of whom are able to carry part-time jobs and eager for them. Thus far little progress has been made in finding such opportunity. The local offices of the New York State Employment Service are, however, aware of and concerned about employment needs of older people. To the limit of their facilities they offer employment counselling for older people.

Westchester's seven private family agencies—Catholic Charities and Westchester Jewish Community Service, county-wide; and five non-sectarian societies in local communities in the south of the county—offer general counselling service to aging men and women. Westchester Jewish Community Service has a department for services to the aged. The Yonkers Family Service has a staff member whose special responsibility is for its older clients.

Visiting Nurse Associations, of which there are 16 in Westchester, covering the six cities and all but two of the 18 towns, are providing nursing care at home to many old people. The Westchester Nursing Council (a voluntary federation of these 16 associations) is focussing the attention of its members on their elderly patients and, as mentioned, will have one of its four program meetings on geriatrics this year.

Inquiries received at the Information Bureau of the Westchester County Council of Social Agencies are predominantly about care for elderly people; and among these, the most frequent is for nursing home care.

Nursing Homes are licensed by our departments of health and the Information Bureau lists only licensed homes. Fuller information is often needed than the license report requires. With the assistance of the Medical Social Work Section of the council, a corps of volunteers visited nursing homes which uniformly welcomed these visits.

The volunteers' reports yielded useful data to the Information Bureau; and, as an important by-product, increased interest in the needs of elderly people.

There are a number of instances where a *boarding* home, rather than a *nursing* home, is needed. Though there is interest in many quarters, in the development of *boarding* homes for the elderly, as yet few such homes are available.

The Council's Section on the Needs of the Aging was formed because of the number of inquiries in the Information Bureau about service for the elderly. This report is largely from that section, of which Mrs. Louis Rose, of Scarsdale, is chairman.

What Syracuse Is Doing for Its Elderly

By Dr. Raymond G. Kuhlen
Chairman, Syracuse Committee on the Aged

SYRACUSE has only recently begun organized planning and effort directed toward meeting the needs of its elder citizens. While there have been various activities under way in Syracuse prior to 1949, it was not until March, 1949, that a group of individuals representing various aspects of community life met together under the auspices of the Onondaga Health Association to form a "Committee on Programs for Older People."

The description that follows will be devoted mainly to an outlining of the point of view and general plans adopted by that committee, but will also mention other activities, which have come to the writer's attention, some of which were under way long before this committee was organized and others which were undertaken later, but quite independently of the local committee.

Just who are the "older people" whose needs should be met? I should like at the outset to invite your attention to the possibility that those over 60—and a particular segment, such as welfare cases—will undoubtedly restrict planning. For early fact-finding purposes and initial program planning, the older group may, perhaps arbitrarily, be defined as including those people over 60.

For long-term program purposes, it must not be forgotten that:

(a) **aging is a gradual process characterizing the adult life span,**

(b) **individual differences in rate of aging are tremendous, for example: menopause has been reported in the late 20's, senile dementia as young as the early 40's,**

(c) **people do not age intellectually, emotionally, and physiologically at the same rates and that chronological age is not the best index of any aspect of aging, and**

(d) **perhaps most important for our purposes, that the most constructive efforts to promote welfare in old age must be begun prior to old age.** Admittedly there are advantages in focusing the early efforts of the community on the older groups but long-term efforts will be most effective if objectives are broadly conceived not simply as "meeting the old age problem," but rather as fostering a program which will result in a wholesome maturing of individuals into an enjoyable, full and useful later life.

The best time to begin personal planning for old age is right now. It is in adult life—early, middle and late maturity—that the foundations for good adjustment in old age are laid. The community must be concerned not only with those individuals who become clients of welfare agencies, but with the total group of oldsters many of whom have unmet needs which communities, geared to the welfare and care of youth, have to date largely neglected.

Areas for Action

Now what about projected areas of activity? At the very outset of community planning, there should be explicit awareness of the various facets of the problem, even though progress cannot immediately be made on all fronts. A narrow initial view is apt to result in a narrowly conceived program, and failure to capitalize opportunities that may arrive because their relevance is not sensed. The Syracuse committee has set up the following areas for study and possible future activity:

1. Research and Evaluation: Clearly the scope and specific nature of the problems must be defined if good progressive planning is to proceed. Some pertinent statistics can be obtained with relative ease from census reports or agency files. Much of the more vital information regarding unmet needs of older individuals will require special research, by interview, into needs and problems as they are experienced by older people themselves. Later, when programs are in-

augurated, plans should be made to assess their effectiveness in meeting the existing problems. Only through such research efforts can the most effective programs be planned and revised, and only through a research program can the local experience be made available to other communities in their efforts to meet similar problems.

2. Recreation and Group Activities: Older people, in particular, need activities which will stimulate interests, broaden views, give purposes in living, provide social contacts with others of similar age. Other cities (notably New York City and Cleveland) have reported unusual successful experiences with programs designed especially for the aged. This question should be studied with a view to the development in Syracuse of a broadly oriented program which should include the early establishment of a recreation center for oldsters and the stimulation of various organizations within the city to develop appropriate programs of group activities for their older members.

3. Work and Economic Security: There seems little question but what having something to do, having a sense of personal work and usefulness, are fundamental considerations in the achievement of a well adjusted old age. Early objectives of efforts in this area might include assessing the adequacy of social security and other old age pension allotments, a study of problems of retirement, the possible establishment of a "sheltered workshop" for oldsters. Long range thinking and planning may be fruitful with respect to ways in which industry might better utilize the capacities of older workers and to ways in which retirement might be handled (perhaps *gradual* retirement with an emphasis upon retiring *to* something rather than *from* work) so as to foster better adjustment. Since older workers have been shown to possess certain desirable qualities to a greater degree than younger workers and are only slightly, if any less, productive, it appears that some progress might be made through an "education" program designed to correct misconceptions. The attention of both labor and management should be directed to such matters.

4. Adult Education: It is becoming increasingly recognized in education circles that the great unfilled need in this field involves the adult population. State aid is already available for adult education programs under the public school program, and the University College of Syracuse University is geared to serving the needs of the young adult in the community. Currently these programs serve primarily the needs of the young adult and to some lesser extent the middleaged group. Study of the possible further contributions of these programs might indicate ways in which the needs of the old age group might be met. There appears to be need for education at the adult level which would include special short-term "courses" (perhaps of only a single meeting) designed to meet the demonstrated needs, interests and capacities of various adult age groups.

5. Counseling and Referral: The development of general programs to meet group needs can do much to alleviate the problems of older age groups. However, some agency should be established which would concern itself with the unique needs and problems of the individual. This agency would counsel older adults with respect to their personal problems and marshall community resources to meet the needs of particular individuals. Methods of meeting this need for individualizing a broad program and the drawing up of a recommended program for action (possibly a local old age counseling center) is worthy of attention.

6. Public Information and Publicity: A major problem will be the stimulation of general interest in the problems and needs of the older individual as a means of enlisting support for a program designed to meet these needs. This will entail a carefully planned educational and publicity program including appropriate publicity in press and radio, the planning of general educational campaigns (including for example a possible "conference" or "institute on aging").

7. Institutional Care: A substantial number of old people must be cared for in institutions and homes. Most such homes are crowded and a large backlog of applicants awaits every vacancy. The special problems encountered in the operation of such homes should be identified, and ways of making the programs of these institutions more effective in promoting the welfare and good adjustment of the residents should be explored. Other possibilities for providing custodial care, e.g. in private homes, are worthy of investigation.

8. Nursing and Medical Care: Ill health and other physical defects characterize the older age group more than any other segment of the population. Care of the chronically ill and the incapacitated present a special community problem. Social study should be directed to these methods by which such care can economically be provided to the best welfare of the recipient, to the development of techniques for dealing with the geriatric patient, and to the education of nurses and others in the care of the older person. Special inquiry might well be directed toward a survey of nursing and convalescent homes with a view to possible bettering and extension of their services.

9. Housing: Many communities, particularly large cities, are including in their housing programs

special facilities adapted to the requirements of older people. What the situation is in Syracuse is unknown. Studies should be instituted to inquire into the present housing arrangements of older adults with a view to the preparation of recommendation for possible future construction of public or private housing, and the preparation of reports and recommendations presenting the needs of the older individual, where it seems appropriate to do so, in connection with any pending local or State legislation.

Points of Actual Progress

The foregoing concerns plans, and that represents the main efforts to date. Obviously, however, plans must be translated into action if the community is to benefit. Although the committee referred to earlier has been in existence only about eight months and wheels are already beginning to show some evidence of getting into motion. And perhaps just as important, other things are happening which suggest that various groups are independently interested in the problem and are doing something about it. This is as it should be, because the problem is complex and can best be met through varied efforts of varied groups.

First, what has been the nature of the committee's activities since drawing up its plans? Progress has been made along three lines:

(A) **There has been progress in fact-finding.** Census data have been examined to determine the gross number and the areas within the city whose populations contain the largest proportion of people over 60. The Council of Social Agencies has made available to the committee an analysis of the extent to which the caseload of various welfare agencies is made up of older people, and of the types of problems which they present. Plans are now being made for a more intensive inquiry into the needs of older people who are not clients of agencies.

(B) **Progress is being made toward the establishment of a recreation center and "sheltered workshop."** It is likely that this will be established in a portion of a building recently made available for a sheltered workshop for the handicapped.

(C) **There have been efforts designed to stimulate local interest in the problems of the aging through contacts with various groups not originally associated with the committee,** through appropriate press, radio and television activity, and through the inclusion of a lecture and discussion of problems of old age in local "Mental Hygiene Institute."

What of the activities of other groups? Obviously, almost all welfare agencies are concerned with the problem to some extent, and some agencies, such as the local Social Security Office, have some aspect of the "old age problem" as their primary concern. I have not made an actual survey of all that is being done by groups other than the committee.

(a) Research and Instruction at Syracuse University: Syracuse University was one of the first to establish a course in psychology of adult life (1941) and now in addition to that course conducts regularly a "research seminar in the psychology of maturity and old age." An extensive research program in the psychological and social aspects of aging has been underway for some time and is continuing.

(b) Adult Education: There are two programs of adult education in the city—one under the auspices of the public school system (supported by State funds), the other as part of the program of Syracuse University's "University College," a community college. In the public school program a course on psychological problems of adult living (including old age) is being conducted for the first time and a survey of adult needs in education is planned for next semester.

(c) The local Visiting Nurses Association has long been interested in the problem of aging and is currently conducting an in-service study program devoted to geriatric problems.

(d) A very active women's club (the Onondaga Guild) is devoting most of its attention to promoting the welfare of the residents in the Onondaga County Home, but is at the same time stimulating interest in the problems of aging on the part of a substantial number of people.

(e) The local American Pension Club has an active recreational program. Participants are members of approximately 50 years of age and over.

(f) A "Golden Age Club" has recently been established as a part of the Salvation Army program.

(g) A local group work agency, The Huntington Club, has activities for all age groups, and is now in progress of planning activities for older people.

These are the activities that have come to the speaker's attention. Some have been operative for several years. Others have just begun or are in the planning stages.

To representatives of those communities who already have an active program for the aged and aging this enumeration of activities may seem very insignificant indeed. To those in Syracuse interested in the future, they represent heartening signs of an emerging program. Even in its beginning the picture is characterized by an active and growing interest on the part of various groups who are making very different, but individually important, contributions along the line of their special interests, talents and facilities. And there is a desirable type of cooperation and inter-stimulation.

The Needs of the Aged in New York City

By Miss Flora Fox
Executive Director, Central Bureau for Jewish Aged

The Central Bureau for Jewish Aged, by virtue of its function and unique position in the chain of community services for the Jewish aged, has had unusual opportunity to learn about and understand the problems and needs of the Jewish aged. Established in 1945 as a membership organization, the bureau's affiliates include the Jewish family agencies, homes for the aged and chronically ill, hospitals, recreation agencies and the Federation of Jewish Philanthropies of New York, from which the bureau derives the largest proportion of its financial support. The bureau has become the generally accepted medium for the exchange of ideas, the evaluation of programs and their implementation where feasible.

The bureau functions in many ways: through direct service to individuals and their families, giving them guidance in working out plans for their care and consultation with community agencies on behalf of aged persons; through study of the needs and problems of the Jewish aged; through consultation on aspects of the care of the aged, both general and specific; through cooperation with and participation in the activities of other groups, particularly the Welfare Council of New York City, concerned with the care of the aged in the total community; through leadership in the coordination of present services and facilities for the Jewish aged now provided in the community—institutional, hospital, family service and recreation; through leadership in the establishment of new or expanded facilities and services and in the sponsorship and stimulation of member and other agencies.

The bureau believes that the following are the current outstanding needs of the Jewish aged as based on its initial 1946 Survey of the Needs and Facilities for the Care of the Jewish Aged in New York City whose findings and recommendations have been corroborated and substantiated in supplementary surveys, and in collateral studies and day-to-day experience. The bureau wishes to point out that the needs enumerated here are not peculiar to the Jewish aged but are common to all needy aged persons.

The Chronically Ill Aged

The bureau's 1946 survey revealed a need for additional institutional facilities for the care of the chronically ill aged. Since then, experience has indicated that a growing number of elderly persons need such care because they cannot be served adequately in their own or in relatives' homes. Particularly noted is the increasing number of chronically ill persons in critical condition who require immediate care outside of their own homes but who have no funds for nursing home care—the only resource immediately available. When persons can accept public facilities—we have the added problem of Orthodox Jewish persons who are unhappy in a non-Jewish setting—there is an unduly long delay in gaining admission to the city homes. If admission can be arranged to city hospitals for these patients, experience indicates that they will not be kept indefinitely because of the necessity to reserve beds for the acutely ill. Under these circumstances, patients are frequently sent back to unfavorable living arrangements.

Member institutions, stimulated and encouraged by the bureau, are attempting to help meet this problem. Some have modified building plans to care for additional chronically ill persons rather than for the well aged. Others, who were not planning further expansion, have embarked on fund raising campaigns to erect facilities for the sick. We can look forward, on the basis of the present plans of eight Jewish institutions, to a considerable increase in the number of available beds for the chronically ill. However, they will still serve but a fraction of the numbers of persons requiring this service.

The Mentally Infirm

In this group fall those mentally deteriorated persons who are characterized by such symptoms as forgetfulness, garrulousness, talking to one's self, dwelling in the past, the gradual breaking down of habit patterns, such as failing to dress properly or maintaining former good table manners, wandering off, getting lost. These persons do not belong in a State hospital but cannot be cared for by institutions for the aged under their present set-up. Faced by the lack of proper facilities, the indigent and those whose families cannot care for them find their way to the State mental hospitals. This is an unhappy situation for the aged when they are aware of their surroundings and for their families also because of the stigma which is still attached to mental hospitals. It is also an expensive way of caring for this type of patient.

The bureau gave serious thought to its responsibil-

ity for the problems posed by the mentally infirm aged. After due consideration, it was felt that this problem which is in essence universal might better be handled cooperatively with all sectarian and nonsectarian groups through the Welfare Council already actively engaged in formulating plans for obtaining understanding of the problem and the methods for meeting it.

Nursing Homes

Many of the aged awaiting admission to institutions and many who can continue to remain in the community outside of an institution have needed the services of nursing homes for custodial purposes or for temporary convalescent or nursing care during an acute illness. The bureau has seen the establishment of an increasing number of nursing homes throughout the metropolitan area. These homes which are independently administered, except for minimum health and building requirements set by the Departments of Hospitals and Buildings, have no professional supervision as to physical standards of care, admission requirements, personnel qualifications or facilities. Essentially operated for profit, they present varying degrees of standards of care and have charges for the service which often bear little relation to the care provided and the ability to pay. With few exceptions the clients of the bureau can only afford a minimum rate.

The bureau believes that a sound nursing home program should be set up with adequate supervision, standards and services at a rate that is flexible to meet the various economic groups who need this service. The bureau has taken part with other health and welfare agencies of the Welfare Council in encouraging the Department of Hospitals to develop a program in this area of service which will more realistically meet the demand.

Boarding Arrangements

Many elderly persons no longer have their own family ties and greatly prefer living in a family home to living alone or in an institution. In this kind of set-up, their need for personal attention, supervision and guidance is fulfilled along with their need to continue to be part of the community. They may require varying degrees of physical care, companionship and family life. The bureau advocated that this type of service be explored and studied as to its potentialities. The Jewish Community Services of Queens-Nassau, stimulated by its membership in the bureau, undertook to set up such a program through its Private Residence Plan. Under this pilot project, 35 persons have to date found this way of living a very meaningful one. In a few instances, where the client was on the waiting list of a home for the aged, he deferred admission, preferring the boarding arrangement from which he derived satisfaction and security.

There are other persons, however, who, though they have no desire to enter an institution, still are afraid to remain alone and seek some kind of semi-institutional living arrangement where they will find independence, privacy and freedom of movement along with a degree of protection. The financial status of many of these people is in the middle and lower income groups—some being on public assistance—so that their ability to pay is a limited one. Thus far there are only two projects of this type in the community, the Tompkins Square Houses of the Community Service Society and the Apartment Project of the Home for Aged and Infirm Hebrews which have between them facilities for a total of approximately 150 persons.

The bureau recommended that the experience of the two projects be studied as to their applicability to other groups in the Jewish community and that the possibility of expanding the services of other institutions in the same way be ascertained. The Brooklyn Hebrew Home and Hospital, which now serves the chronically ill aged, is formulating plans for such an apartment project to serve well orthodox aged.

Public Housing

The bureau, as part of other community groups in the Welfare Council, recognized that practically no public housing had been erected to meet the specific needs of older persons.

In the private field of housing, furnished rooms and small apartments are available to older persons but they are not adapted to their specific needs. Frequently, an older person lives alone on resources which are not adequate for his comfort and well-being. For example, a frequent occurrence is the dispossess of a lone aged person from a furnished room when he requests or requires extra attention or services from the landlady. We have seen many self-sufficient older persons become fearful and insecure after such experiences. Many of these people seek admission to a home, though with proper and suitable living arrangements they could remain in the community.

The bureau has advocated that the community, professional and lay, take responsibility for further stimulation of the public housing authorities and private endeavor toward the building of housing projects with a recognition of the older person as a potential and suitable tenant. The bureau has participated in conferences with the New York City Housing Authority along these lines.

Medical Care

There are very limited medical facilities for conserving and improving the health of the aged person liv-

ing in the community. Clinical facilities are frequently inaccessible and just as frequently are not adapted to meet the specific needs of the older person. For those not able to attend clinics, there is a serious lack of provision for home medical care if they are unable to pay for private service or are not under the care of agencies which provide medical attention in the home. Some people in this group may be able to obtain occasional and ofttimes emergency medical care but cannot plan for any continuity which may be medically recommended to insure their maximum functioning in the community.

The bureau therefore believes that present facilities should be expanded and, if required, new facilities be developed to furnish necessary medical care in clinics and in the Homes of aged persons adapted to their particular needs.

Homemaker Service

There are very limited resources for visiting homemakers in general and their availability to the aged is restricted by the individual policies of the agencies providing this type of service, since they are not specifically geared to the needs of the aging. Particular limitations are found in the restrictions on length of time the homemaker may remain in a home, as the aged need long-term service—sometimes over a period of months in view of the long waiting periods for admission to institutions.

The bureau advocated that homemaker service be expanded and adapted to the special needs of the aged individual with recognition of the necessity for flexibility in type, length and cost of service. In line with this thinking, the bureau in March 1948 initiated a Home Care Program to be sponsored jointly with the Home for Aged and Infirm Hebrews and the Jewish Family Service. An important feature of this plan to maintain elderly people in their own homes is the homemaker service. The clients for the project are selected by the Social Service Department of the home and remain under their supervision. All services and facilities of the home are available to the clients. They feel secure because the home has guaranteed to them that they will be transferred to the institution when they can no longer remain safely in their own homes even with homemaker service. The Jewish Family Service with a long experience in administering homemaker service provides homemakers who are especially geared to the needs of the aged. Not only is this an effective and satisfying way of extending service to elderly people but it is also a less costly method of care than institutionalization. In addition, it helps to reserve beds in homes for the aged for those who need them the most.

Visiting Nurse Service

Home nursing care is available in all the boroughs to individuals in all economic levels without discrimination as to age, color and religion. However, the nursing service is most usually set up for short-term or a time-limited nursing need of people and only in special instances are the established nursing services now able to offer indefinite care. Many of our aged fall into the latter group and cannot depend on this service with any real sense of security. The bureau has advocated that the visiting nurse service be expanded to provide long-time service according to the needs of the aged individual.

Recreation

The bureau recognizes that the aged, like all people, need activity and association with other persons of similar interests and age. Frequently problems occur in families with older persons because the latter feel bored and neglected. The William Hodson Center, the first recreation project for the aged in New York City, demonstrated the value of group activities in restoring and building up an aged person's confidence and desire to continue being active. The community, alerted by this example, has made considerable progress in establishing more recreation centers for older persons as part of an expanding program. These programs at this time are limited to those who are able to reach the centers, but make no provision for those who are homebound because of illness or inclement weather.

The bureau has recommended that there be an expansion of the present recreation program and the development of a home recreation program for those patients who are only semi-ambulatory as indicated above, or who are permanently or temporarily confined. In this connection, the bureau together with the Jewish Welfare Board is instituting a program to enlist the interest and assistance of Jewish community centers and "Y's" in making their facilities and technical skills available to elderly persons.

Adult Education

The bureau has recognized the value of the various activities which fall within the scope of adult education as aids in helping people to accept, adjust to, and find satisfaction in their latter years. For some individuals classes, lectures, discussion groups are more satisfying than the handicrafts, for example. These activities can be an important adjunct to, or part of, the programs of recreation centers and institutions for the aged.

The bureau has participated in discussions on this

subject. It supports any planning toward the extension of adult education for the benefit of older people. Its further development to include the homebound would be desirable.

Employment

The problems faeed by the elderly in the employment field are known to the bureau, more through its participation in the Welfare Council's activities in this area than through its own experience, since relatively few persons come to the bureau who are physically able to work. Inability to obtain or hold positions because of age is a most devastating experience, and much must be done to change this situation. Therefore, the bureau supports the employment program for the aged, set up by the New York State Joint Legislative Committee on the Aged.

Federation of Jewish Philanthropies' Plans For the Aged

The Jewish Federation, as part of its Building Fund Campaign for expansion, modernization and research, includes a number of plans for the aged. They are:

Development of an annex to their present institutional facilities with 395 beds to provide full medical, recreational, religious, social and occupational therapy programs. This is the Kingsbridge House in the Bronx, which is already under construction, and hopefully will be in operation early in 1950.

Two 100-bed apartment projects in Brooklyn and Queens or the Bronx.

Establishment of boarding homes in which 15

Shown above are members of the Hodson Center cleaning dishes after a club party. Doing dishes becomes fun when everyone helps.

persons will live with private families on foster home basis.

Three year experimental program administered by the Home for Aged and Infirm Hebrews, providing home medical care for 125 aged persons to continue living at home.

Three-year continuation of the homemaker service demonstration program as mentioned earlier in the Home Care Project.

A new nursing home in Queens or Westchester to serve at least 50 persons.

What the State Can Do

The bureau has itself undertaken and stimulated the development of various services in the community for the care of the Jewish aged, knowing full well that these services would meet but a small fraction of the total needs. It engaged in these activities to demonstrate the validity of certain services, in the hope that not only private agencies would follow suit but that the public agencies would be encouraged to set up similar projects on the needed larger scale. The bureau believes that the State can give assistance in many ways, in the following areas:

1. **The chronically ill**—by helping in the establishment of more beds for those who cannot be cared for at home and the further development of home care under hospital supervision for those sicked aged who can remain at home with the aid of such services as visiting physicians, nurses, homemakers and occupational therapists.

   The mentally infirm—through the provision of more appropriate care for them than is now available.

   Nursing homes—by the establishment of public nursing home services and by enabling public and private agencies to make joint financial arrangements allowing for subsidies. This would permit flexibility in creating a total community plan.

   Boarding homes—by making possible their expansion through the availability of more funds to enable public assistance recipients to pay higher rates.

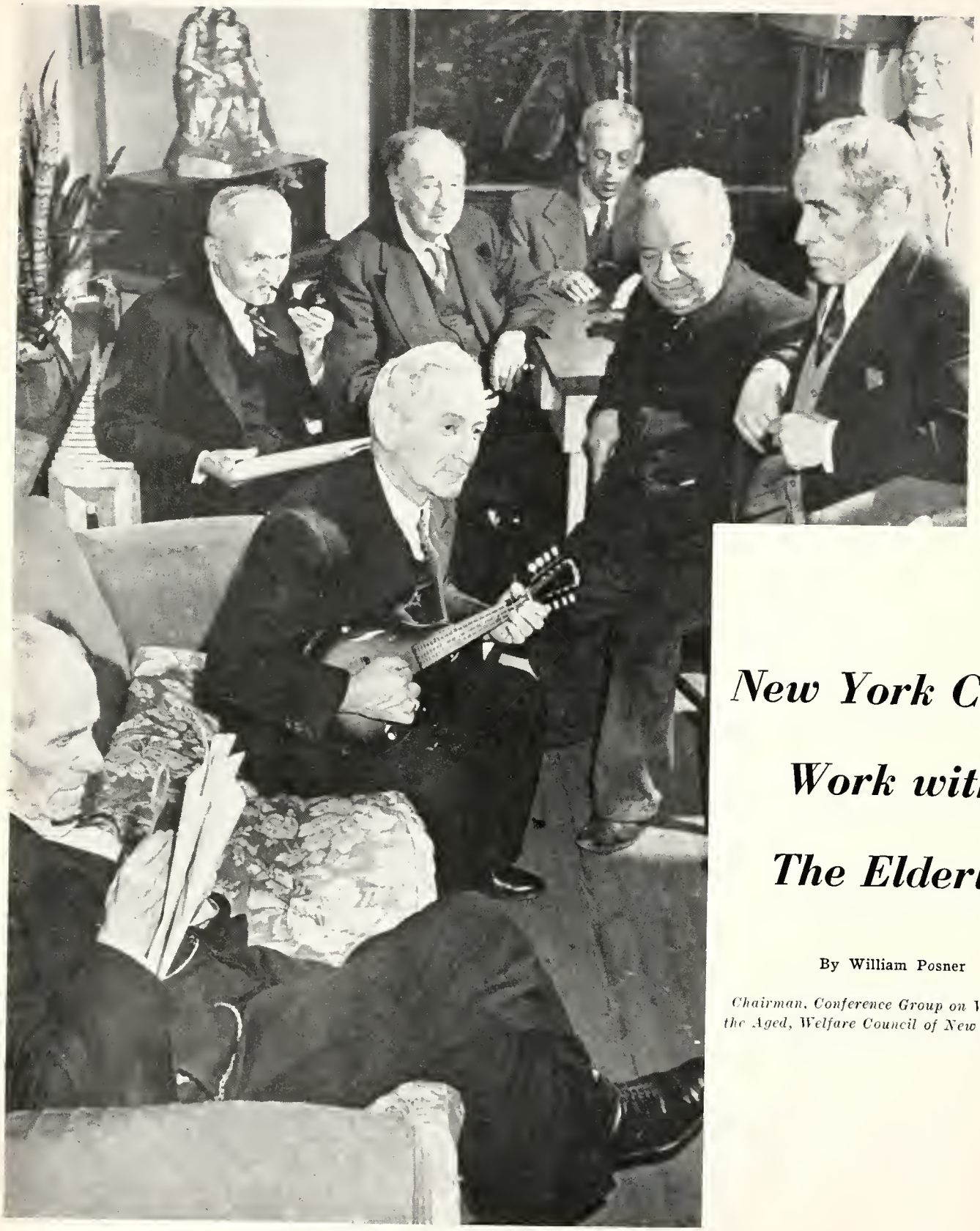
   Public housing—by encouraging the construction of more units especially adapted to older persons.

   Medical care—by promoting better understanding of the diseases which seem to predominate in the latter years, and by taking steps to offset the generally accepted belief that little or nothing can be done about them; by the establishment of better clinic facilities for older people and by fostering greater understanding of the older patient on the part of hospital staffs.

   Homemaker service—by making possible the expansion of this service in public hospitals and public welfare programs.

   Recreation and adult education—by making available increased funds for expansion.

   Employment—by lending administrative support to the educational program of the Joint Legislative Committee on Problems of the Aging—and its successor, with employers and employees.



New York City's Work with The Elderly

By William Posner

Chairman, Conference Group on Welfare of the Aged, Welfare Council of New York City

It has become rather customary, in this complex society in which we live, to speak with gloom about the many social problems that face us and the difficulties that stand in the way of their solution. The problems of the elderly are indeed no exception to this rule. That the elderly are fast becoming our number one social problem is all too clear to informed persons everywhere. Perhaps fewer persons are aware of the difficulties inherent in the resolution of those problems. It would be only fair to say though that even in this regard the past few years have seen a crescendo of activity—at least in the social welfare and medical fields—in behalf of the older person and real efforts have been made to recognize and cope with many aspects of the situation.

Without wishing to minimize the seriousness of the problems facing the elderly nor to underestimate the tasks lying ahead, I should like, if I may, to deviate somewhat from the accepted rule and present a picture of creative activity and accomplishment in behalf of the aged.

Welfare Council of New York City

Any description of what New York City is doing for the elderly must take into consideration the activities of the Welfare Council—the agency which has major responsibility for city-wide planning and coordination. In the Welfare Council, social agencies have found a common meeting ground for the discussion and study of the problems of older people and, in many instances, the council has served as a catalytic agent in facilitating the implementation of programs by these agencies. Although not essentially an operating agency itself, the council has, nevertheless, initiated projects later taken over by others. Represented in its membership are sectarian as well as non-sectarian agencies—private and public agencies alike—all working together for the general welfare of the community.

The Welfare Council can thus point with pride to its record of accomplishment in behalf of aged of New York City. For almost 25 years it has, through its sections, committees and conference groups on the Welfare of the Aged, provided leadership and initiative in helping to focus the attention of the lay and professional community on the older persons in our midst.

The Welfare Council was among the first organizations to establish an Information Bureau for the Aged as an aid to aged persons seeking information about facilities. It established a reporting system to inform member agencies of vacancies, admissions, rejections, and duplicate applications. This reporting system was later taken over by the State Department of Social Welfare. The Welfare Council was active in the legislative area by helping to pass and later to draft amendments to the original Old Age Assistance legislation. The council developed a statement of minimum standards for homes for the aged which became a model for use throughout the country. Through constant revisions, it has had wide national and international use. This important statement had the effect not only of raising standards of existing homes for the aged, but served as a basis for the development of new institutions.

The council worked relentlessly for the employment of trained social workers and other personnel in homes for the aged. It arranged for a course in "Mental Hygiene for the Aged" for lay and professional workers. It worked closely with the New York State and City Housing Authorities in an effort to make special provision for older persons in public housing projects. As a result of this collaboration, 50 apartments were planned and provided in the Fort Greene Housing Project in Brooklyn for elderly persons. As far as is known, no similar public facilities for the elderly exist elsewhere in the United States. This is a real tribute to the public officials responsible for this development.

In the area of recreation for the older person, the Welfare Council was among the first to recognize the need for such programs and has given help and guidance to public and private agencies alike. In addition, the council has since 1947 sponsored an annual hobby show for persons over 60. The third annual Hobby Show in 1949 had 854 individual participants and was seen by more than 15,000 persons. This project has had the effect of pointing dramatically to the recreation needs of older persons.

These and many other accomplishments have had a definite bearing on current developments in programs for the aged in New York City.

Four Areas of Concentration

At the present time, New York City is concentrating its efforts on four major areas of interest: housing, employment, chronic illness and recreation. With respect to housing, it is worth noting that the building plans of many homes for the aged are now coming to fruition. It is expected that within the coming year approximately 500 additional beds will have been provided in institutions for the aged. In addition, this year will probably see the expansion of the apartment project idea. This, as you know, makes it possible for older people to live in the privacy of institution sponsored apartments. An interesting experiment in foster homes for the aged is likewise going on. This has demonstrated the feas-

ibility of keeping those older persons who do not want institutional placement in the community. Similarly, there has been an expansion of home care projects for older persons by hospitals, homes for the aged and family welfare agencies. In providing home medical care, the services of visiting nurses and homemakers, these agencies have made it possible for older persons to remain in their own homes much longer than was previously possible. This has proved valid not only psychologically but has been found to involve less cost and expense to agencies.

Although housing facilities are of immense importance to older persons, there is perhaps nothing which contributes more to their dignity and self-respect than employment through which they can contribute to their own maintenance and needs. Educating prospective employers and the community at large to the advantages of employing an older person is a struggle which is no less New York's than other communities'. This is an area that one group or even many high-minded groups cannot, in and of themselves, tackle. It is a problem that requires the concentrated coordinated, and cooperative efforts of the private social agency, government, industry, labor, and other community agencies, for solution. It is our feeling that in this sphere the State, through its established facilities, can play a role of real leadership. It must be recognized, however, that serving the older person in employment requires special skills and special training. It is our feeling that once specially trained staff is made available, they can function and give help to older persons through the existing employment and placement facilities of the State.

The care of the chronically ill is receiving attention on many fronts. Chronic illness is a scourge which affects persons of all ages. The Welfare Council's concern with the need for special care for this group of our population was instrumental in the setting up of new facilities for them. The council's Nursing Home Study, completed in 1947, recommended the development of visiting housekeeper service and other types of home care, which could help remove many of the chronically ill from hospitals where they hardly belonged and merely added to the congestion of N. Y. City's hospitals. This study has been looked to for guidance in the development of new rules and regulations for supervising and licensing nursing homes in this city.

At the present time, Welfare Council is engaged in studying one aspect of the problem of the chronically ill. This study is concentrating on the chronically ill now living in homes for the aged which have no hospital facilities. It is our hope that this may result in the setting up of standards for the care of these patients in homes for the aged.

Much thinking is going on in New York City in extending recreational and leisure time activities for the older person. The need for such programs has been long established, and the Welfare Council has worked closely with both public and private agencies having such programs. There is still, however, much confusion as to the objectives of such a program. To many older persons, these activities must become a substitute for the lack of employment opportunities. To others, these programs are ways of filling the need for companionship. The definition of objectives is the only way to determine the types of programs to set up as well as the settings in which the programs are to operate. There is a growing realization that programs for older persons must become part of the group work program of the community as a whole. This means that community centers—if they are to serve the total community—must provide for the needs of older persons in the same way they provide for the youth and young adults. A Welfare Council Committee on Recreation for the Aged is now working actively on many of these problems.

Need for Community Action

In pointing up these major areas of activity for the older person, we, of the Welfare Council, believe that the time has come when a concentration of effort on the part of itself and social agencies alone is no longer adequate. The impact of problems which the community is facing in relation to the older citizen is such that it requires the attention of the whole community. The Welfare Council is a coordinating agency for social agencies and as such has its finger on the pulse of the community. Social agencies themselves, however, cannot substitute for the "grass roots" activities which local groups and lay councils can initiate and achieve. We therefore wish to submit for serious consideration the need for organizing neighborhood, city-wide and state-wide councils for the elderly. These groups can serve as the catalytic agents in bringing to the attention of civic groups and governmental agencies the needs of the aged and stimulate activity by and for them as groups and as individuals. To a large extent, the Joint Legislative Committee on Problems of the Aging has been very effective in this regard. It is important, however, to plan a continuing and long range program which the committee has so ably begun.

Looking Ahead

In reviewing the past and present programs for the aged, we cannot help but look to the future. As time goes on there will undoubtedly be an increase in the number and types of programs. It is quite likely that as communities begin to feel the impact of

the numbers of older citizens and the need to do something about the resultant problems, many projects will be embarked upon. One would indeed be hard put to depreeate these projects or to disparage the high-mindedness which may impel the communities to implement them. We should like to submit the proposition that if we are to serve our older citizens intelligently, the essential question we must face is not "What type or how many projects is it necessary to set up" but rather, *How* are these projects to operate in order for the older person and the community to derive most therefrom. The implications of this question are many. Basically it means that once we have become aware of the existence of the need, we must analyze and evaluate existing facilities as well as current thinking in order to know how best to meet these needs. To say that older persons require recreational activities and that programs are therefore necessary is a statement of the need. In considering the implementation of this, we will need to know *how* recreational programs can help older persons. A knowledge of this *how* will make it possible for us to know better what type of facility to set up.

With respect to housing facilities for older persons, the same principle must hold true. It is fairly generally agreed today that the community must consider varied types of facilities for older persons: institutions, apartments, foster homes, etc. Before, however, we embark on these programs, we must first know *how* older persons can be cared for in these facilities. A knowledge of the *how* will often make it possible for us to revise our estimate of what to do.

We recognize fully that all that has been done thus far for the older citizen has only scratched the surface. There is real need for continued creative thinking in this area. Needless to say the Joint Legislative Committee with which Welfare Council has maintained close liaison has contributed immensely to our better understanding of the older person.

In looking toward the future we must evaluate also the past and the present and it can truly be said that in relation to its elderly New York has been in the vanguard.

Some Elements of an Action Program for the Elderly

By Miss Ollie A. Randall

Consultant on the Aged, Community Service Society of New York

THE INTERESTS of the increasing number of elderly citizens are very intimately bound up with the interests of the whole state-wide community and only by a very careful assessment of those interests and ways of safeguarding them can we be assured of the essential balance in the State's program for groups of all ages.

As one examines the almost startling statistics one is impressed by the fact that New York State with its million and more oldsters—65 years of age and over—has approximately 10 per cent of the total national population of persons of this age group, and New York City about 5 per cent. These figures are rough, but they are accurate enough to give us all pause, especially since the ratio of older persons is growing to such huge proportions and the ratio of persons 15 years of age and under is decreasing at a similarly alarming rate.

New York State

Those of us who have made older people one of our major concerns for a number of years are very proud and grateful that New York State has already recognized this situation, and its seriousness, in a number of ways, but in none which is having such wide-spread response as that of the appointment of the Joint Legislative Committee on Problems of the Aging and the Aged under the able chairmanship of Senator Desmond. The approach of this Committee to the task of studying the multiplicity of problems of older people has, it seems to us, been most constructive since they have up-to-date directed their efforts primarily toward discovering the facts as to the employment of older people in the state, and to finding ways and means of keeping persons *still able to work*, in spite of their chronological age, in the numbers of the gainfully employed.

This is not simple, since we are still saddled with attitudes and prejudices about older people as to their ability to perform, which have little to do with either the present day abilities of older people, or with the kinds of demands which are actually made upon them today. These still need to be changed. But one very important thing is being accomplished—that at least both employers and equally, if not more important, employees are beginning to be conscious that they must examine what happens in placement and employment and in firing in the light of new knowledge, new experience, and new social demands.

This is the right kind of education, and is very timely. While action is slow in coming, there is a beginning which is encouraging. New York State may not be actively interested in what it does indirectly and incidentally for citizens of other states, but it is possible to report that everywhere one travels and this subject is under discussion, there is a note of genuine envy in the voices of persons from other parts of the country as they comment, "But *we* don't have a Joint Legislative Commission—You in New York State are way out in the lead!"

Need for Leadership

This kind of leadership is most vital at this time, for we must keep a focus directly upon our aging and aged citizens to be sure that what is done for them is not only in their interests but that it does not simultaneously jeopardize the interests of the rest of the community. We cannot afford a repetition of California, Washington State, nor of Colorado, where the oldsters, admittedly with charlatan or self interested leaders, deliberately took matters in their own hands, with rather devastating results.

Old people are apt to see their needs in terms of money, which essentially they may be, but which they are certainly not in their entirety. However, to most of us who have worked with and for them for a number of years there has come a conviction that with New York's very sound old age assistance program as a foundation, there can be very positive results in ultimately reducing the amounts spent for this program if efforts are directed toward satisfying some of the less tangible but equally vital needs. Speaking as a citizen from New York City I might say that I have hope that the State Department of Social Welfare's study of the needs of people on public assistance may be helpful in this. We especially need its results

in New York City where the present administration's drive for "economy" is proving quite a social and economic hazard for older people who must apply for assistance.

Housing Needs

I should like to emphasize the need of some provision of housing other than institutional housing. I am convinced that now is the time for some very sound planning at the State and local levels which may help reduce to some extent the tremendous State expenditures which loom ahead of us in our institutional program. It has been demonstrated by actual experience that when decent and comfortable housing is provided for older people, with auxiliary visiting services and supervision when and if required, the cost of their care is not only radically reduced but that they often never have to apply for institutional housing.

Therefore we believe that Governor Dewey and Commissioner Stichman can render a real service by studying the potential market for low rent housing among this proportion of our citizens, and make some provision for it in what the State plans to do in allocating funds from the money now available for subsidizing local projects.

With approximately two-thirds of the oldsters in the low income brackets—through help from families, old age assistance, old age and survivors' insurance and pensions—but on fixed income or low earnings, it seems both logical and fair that some proportion of them be so accommodated, even if the number be small. This seems especially true since it will not be

Can adult education attract the older person? Ans.: Yes, present experience clearly indicates oldsters want to learn and can learn.

long before they will constitute an even larger proportion of the total low income group, and that will be long before the life of the newly built housing is over.

The 1950 census schedules are being designed to get information on living arrangements, income, and family status. Some of the facts gathered in several pilot studies are already available and should be helpful. Rochester is through its own planning commission making an analysis of these needs and possibilities. I am no economist, or city planner, but this suggestion seems to make sense from the point of view of both in the light of the estimates of the experts!

Commissioner Stichman has already publicly expressed his interest in the housing needs of older people at a hearing of the Desmond Committee (1947), and of late in the press and over the radio in low rent public housing. It would be extremely gratifying if these two interests could find endorsement by the administration and support in local communities so that accommodations could be included which would be suitable for older people and smaller families. It is my personal belief that eventually this would mean more satisfactory lives for the people themselves, but that it would mean fewer persons having to be admitted to homes for the aged and to mental hospitals.

Adult Education

May I add a word on adult education. In this service, and in the administration's effort to improve the library services in the State, we see a very useful ally in our efforts to maintain for a longer period healthier and more contented mental and emotional attitudes on the part of older adults. If the staff can be made available, along the very imaginative and practical lines being developed by Dr. R. J. Pulling and the State Department of Education, and local boards of education can be persuaded to avail themselves of what the state offers, we are assured of more and better leisure-time activities which can minimize the discontent and unhappiness induced by idleness and uselessness. With leisure time a commodity enjoyed by more and more of us as working hours become shorter, the habit of using it wisely and constructively should bring good results if younger and middle aged adults are encouraged through the use of these facilities.

All of us hope that in 1950 the Joint Legislative Committee on Problems of the Aging and Aged will be continued, and definite plans toward a State group of citizens to succeed it when and if it is discontinued will be made.

Need for a Citizens' Committee on the Elderly

By Miss Ollie A. Randall
Consultant on the Aged, Community Service Society of New York

Lloyd George once wrote that "how we treat our old people is the crucial test of our national quality." Coming nearer home, in both time and space, one of our own local statesmen, Dr. Louis I. Dublin, speaking at the 1947 annual public hearing of the New York State Joint Legislative Committee on Problems of the Aging, pointed out that "we should see to it that a group of public spirited citizens in the community is especially concerned about (them)—older people."

Certainly the existence of the New York State Joint Legislative Committee on Problems of the Aging is evidence of our attempts to improve the quality of state responsibility and of the value of an organized group of citizens who will conscientiously and intelligently address their efforts to the problems faced by older people, which consequently are faced by the community as a whole. That it has had official status is another fortuitous circumstance. The stirring public interest—the actual collection of data—the distribution of those data to ever-growing numbers of persons concerned but not informed about the problems of aging and aged people—all serve a social purpose, the importance and validity of which can no longer be questioned.

The legislative committee has its own peculiar place in our State program, which is to some extent prescribed and circumscribed by legislative statute. I should therefore like to put it to you that one of the problems which we as citizens who are not members of the government in any official capacity must solve is how we are going to capitalize on work which this committee has done, and is still doing; and how to continue in force, as well as to direct, the activity which has been initiated and the momentum of it.

Today, when we go to discuss the special needs of older people—whether those needs have to do with financial support, employment, recreation, hospital care, education, and especially the social services—we are met with the statement that old folks are just people and must be treated just as are other people in the community. This is a fundamental human and social fact—and no one would quarrel with the situation were that fact the guiding principle today. Then there would be no necessity for committees, commissions or councils, about which we are talking.

The fact of the matter is that old people are not being so treated. Let us not fool ourselves about that, nor let us evade issues by lip service to what becomes a wearisome, meaningless platitude. Old people in growing numbers are dislocated persons in almost any family or community, and equal opportunity to participate in family and community life is denied them in many instances on the mere basis of their chronological age.

Consideration of them in relation to any one of the needs listed above is usually conditioned by the age of the individual, and the availability of what the community has to offer a citizen is determined by his age. While age is permitted to act negatively as a barrier, we are on the other hand told it is not sound to plan positively *for* older people on this basis, this in spite of the fact that what is done for children and adolescents is geared to their special needs, which have been isolated and studied in all instances experienced by the persons providing the service. We have not yet reached that stage of development in our provisions for older people.

Basic Knowledge Lacking

Few of us—although years are being added unto many more of us daily—have actually experienced old age when we are trying to help an old person make his plans; what old people in our midst *should* have is only *now* being studied, and rather spottily at that. Our resources—or rather our lack of them—and our prejudiced opinions—really determine what we think about the old person, rather than real knowledge about the individual himself.

Therefore it is my personal conviction that we still must have in the community—at the local, state and national levels—citizens whose appointed task it is to keep a watchful eye upon the interests of older citizens—upon what is being learned that can alleviate their present unenviable status, and to see what action is necessary.

At a City Council meeting in a nearby state there sat two members of that council who saw eye to eye neither in matters of politics nor of conduct. One member was in the habit of coming to meetings somewhat obviously under the influence of liquor, much to the disapproval and disgust of his opponent.

After a rather disturbing experience at one session, in which the intoxicated gentleman behaved in his usual undignified manner, his opponent deliberately

paused and pointedly said, "Mr. Mayor, we have all been hearing recently a great deal about Alcoholics Anonymous. But must we also be burdened with Alcoholics Conspicuous?"

What I am trying to indicate here is that alcoholics, either as individuals or as members of a group, do not become "anonymous" until after a period of rather "conspicuous" difficulty, and that by the same token as that, we cannot expect a constructive or desirable Old Age Anonymous—or even Synonymous—with the rest of society, until after a period in which there has been sufficient focus of attention and emphasis so sharpened that there is, for a period of time, an Old Age Conspicuous. We are, I believe, in that stage of social development now, in the hope that through our planning, old people can before too long a time become socially normal in that they are again natural and integral members of their communities.

To achieve that degree of social normaley they should be able to call not only upon specially interested citizens, but upon those who combine this interest with a responsibility for making that interest count in terms of desirable community action.

For the next few years at least we must then have within *governmental* units those who will make it their business to know how they can improve the status of older people.

We shall in addition require this group of "public spirited" citizens in conjunction with each civic unit of government continuously to inventory and appraise what *is* being done, what *more* should be done, and stimulate the necessary action wherever action is called for. For instance, the Mayor of the City of New York has recently appointed a Mayor's Advisory Committee for the Aged, with a charge which covers the responsibility of advising on the whole broad scope of services which the older citizens of this great city require.

National Organization

Simultaneously there is being considered the organization of a national group which will hopefully have not only the same function and an even more active one for the Nation as a whole, so as to avoid in the future the sporadic and undirected programs now being undertaken without reference to what is already known or available. For these two reasons alone, even if we were not already convinced of the necessity of a state-wide committee of citizens, it would appear to be logical that there be such a group to serve as the natural channel between the local groups in villages, towns, cities and counties, and to the national group.

One of the most prized principles of our national and state government is that of state and local autonomy. There is nothing in the suggestion that there is a statewide committee which would jeopardize the application and operation of that principle. In fact it would encourage the adaptation of services to the individuality of the local situation. It should however also act to stimulate the right *kind* of local action —and to help in coordinated planning so as to prevent some of the necessary duplication in experimentation and effort which is taking place—those motions which are being wasted when every motion should be made to count.

A council for the elderly is proposed for New York State in a bill introduced during the 1949 State legislative session, copy of which is to be found in "Never Too Old." This provides for an official council, with direct participation by members of the administrative units of State Government. This has real virtue and may have a place in our pattern of State organization, but I should still like to see a group of citizens, given official status either by independent organization or on a commission basis or by appointment by the Governor, as being possibly more effective because of the free wheeling nature of their organization.

Since the interest of so large a group of voting citizens is at stake, these should be continuously viewed objectively by persons who have a sympathy for and understanding of older people.

However, they must similarly be so viewed that the present imbalance in social provisions, weighed as it is in favor of the young, is not continued by an equally dangerous overweighting in favor of older people.

California's Sad Experience

Someone in Washington facetiously suggested recently that perhaps what we should or ought to do on a national basis is to buy the State of California and use it for a retreat for all older people with their $100 pensions. This would be no more fantastic than the recent situation in which that State was in effect sold out for the benefit of the old folks in the population at the expense of the younger people, and even at the expense of many of the civic institutions which are essential to maintain a decent level of living for the very oldsters demanding the financial support which was wrecking the State's economy. This experience *can* "happen here"—by "here," I mean New York State or almost anywhere else in the United States, either right now or in the near future. Perhaps this horrible example of charlatan leadership in California has served a very salutary purpose. We still learn painfully by way of what Commissioner Ruth Taylor calls "the obvious" if not actually by way of the very "conspicuous." New York State has almost roughly 10 per cent of the total number of legally aged people in the country—and New York

City has almost 5 per cent of them. While our programs are generally quite sound, it is within the realm of credibility and of possibility that in some sections of the State dissatisfaction could easily lend itself to making people receptive to this dogmatic picture of a personal utopia in old age. It is for all of us to remember that no utopian plan, established at the expense of the rest of society, or out of step with contemporary social life of the community, has ever survived—nor should it. But citizens' groups can undertake to inform and educate all of us that an old person's utopia can and should *actually* be—for each of us—that of having an equal opportunity with others to be persons and personalities in our own rights in society, with our fair and earned share of what the community offers.

The need for a citizens' committee in the interests of older people lies primarily in the necessity for an independent, socially informed group in the community to:

1. Supplement and complement the work of legislative commissions such as the Joint Legislative Committee on Problems of the Aging, and of administrative councils such as that endorsed by this Committee proposed in the 1949 legislative session;

2. To assist in coordinating the work of private and voluntary groups or agencies, so that there may be objective evaluation of resources, services, and the gaps in these;

3. To educate the community at each level of government as to needs and progress in meeting these;

4. To stimulate the right kind of intelligent leadership; and

5. To promote the kind of action which will improve the standard of well-being of the *total* community, whether that be local, state or national.

Employment of Our Elderly

By Robert C. Goodwin

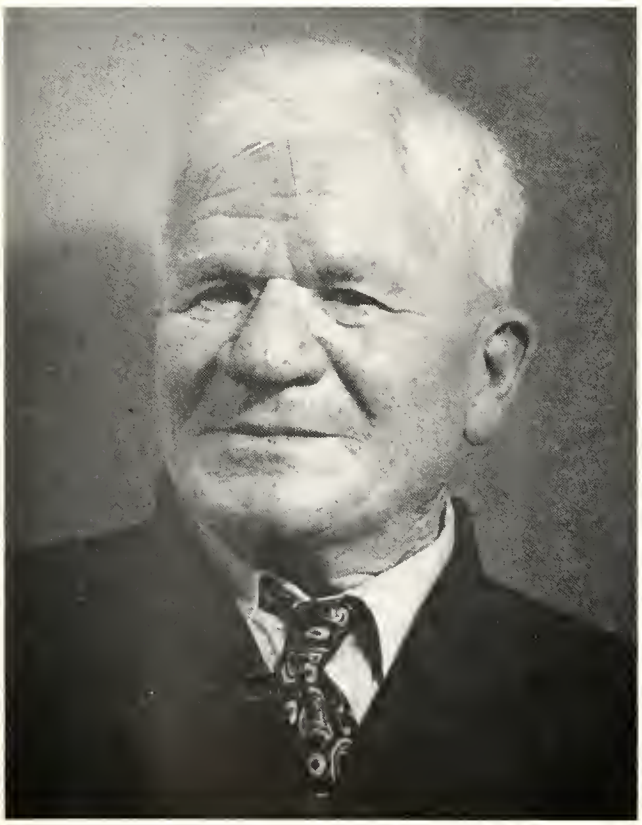
Director, Bureau of Employment Security, The United States Department of Labor

In tackling the problems of the older worker, we are really trying to resolve a paradox. As stated by Dr. Bortz, former president of the American Medical Association, "With one hand modern society does everything possible to extend the life of man, while with the other, it writes him off as useless because of the date on his birth certificate." Our economic and social thinking has lagged far behind our scientific advances so that although we have added 17 years to our average expectation of life at birth between 1900 and 1945, the labor force participation of the elderly has gotten smaller.

This matter is not one of mere academic interest to us who are concerned with the administration of unemployment insurance and employment service programs. Our interest goes beyond the general social, political, and economic significance of the problem to the very heart of our operations—the matching of men and jobs. Hundreds of times a month, the drama of older workers seeking employment is played in our 1,800 local offices across the country.

Basic Trends

An employment service operating only 50 years ago would have been very little concerned with the problems of the older worker. At that time we were still a relatively young nation with a median age of 22.9 and with only 4.1 per cent of our population 65 years old and over. Two-thirds of these older workers were in the labor force. Although industrialization was already well under way, there was still a large farm population, and a substantial proportion of our people were self-employed or worked for small estab-



Too Old? Too Old for What?

This oldster's daily job would tax many a youngster.

lishments—all of which was conducive to the employment of older workers.

The employment service of 1940 was confronted with quite a different set of considerations. A declining birth rate, an increase in the life span, and the virtual cessation of immigration all helped our Nation to get older. Our median age in 1940 had reached 29.0. Those 65 years and over represented 6.8 per cent of the population but only 43.4 per cent of these workers were in the labor force and 13 per cent of them were unemployed. About half had been jobless for at least a year. In periods of large-scale unemployment, the older workers are by far the hardest hit group.

Manpower shortages, resulting from World War II, suddenly opened the door to the older worker. It is estimated that in April 1945, 2,600,000 more workers aged 45 and over were employed than would have been expected from long-term prewar trends. After the war, millions left the work force. Among the men, however, the big decline occurred in the younger groups, particularly those under 20. It is significant that the labor force contracted less among the older workers. Even today, the older worker is holding his own. According to the Bureau of the Census, 4.5 per cent of the labor force of those 55 to 64 years were unemployed in October 1949. The corresponding figure for those 65 years and over is 3.8. This compares favorably with the 5.7 unemployment rate for all ages. Despite this present status and despite the recent spurt in the Nation's birth rate, there is reason to believe that basic trends will reassert themselves and the problem now latent will again become acute.

Results of Recent Study

The Bureau of Employment Security and the affiliated State employment security agencies are in an excellent position to study the job problems of the older worker. One of the more significant studies recently undertaken was an analysis of the experience of older jobseekers in six communities selected from different parts of the country and representing varying conditions in respect to the extent of unemployment. In a sense, the six communities may be considered as reflecting unemployment conditions under different phases of our business cycle. The cities—Dallas, Birmingham, Denver, Rochester, Toledo, and Portland, Oregon—represented labor market conditions that ranged from very tight labor supply to substantial labor surplus.

The survey reaffirmed conclusions previously arrived at and uncovered some new findings.

1. The study revealed that in the labor markets with little unemployment, there are substantially less jobless among the older workers as compared with the younger. In five out of six areas, the proportion of workers 45 years and older registered with the employment services was less than their percentage in total work force. This was especially true in Dallas, a tight labor supply area. Here, older workers accounted for about 36 per cent of the area's labor force and yet only 21 per cent of those registered for work. Portland, on the other hand, with a large labor surplus, was strikingly different. Workers 45 years and over represented 37 per cent of the total work force but were 43 per cent of those registered.

2. As employment increases, employer specifications with respect to age are tightened and the per cent of older workers among the jobless increases.

3. In both tight and loose labor markets, older workers, once separated from the job, take longer to find employment. If not re-employed at their regular work, they are usually downgraded in skill and pay. In all six areas studied, older workers sought jobs longer than did the younger workers.

In Birmingham, for example, 26 per cent of the workers under 45 years remained in the active files for over two months while older workers for the same period accounted for some 35 per cent. Other evidence of longer unemployment is available from unemployment insurance experience. In Rochester, insured workers who used up all of their benefit rights in 26 consecutive weeks of unemployment included larger proportions of the older workers.

4. Older worker discrimination varies not only with the condition of the labor market but also with occupation, industry, and worker characteristics. It was found that (1) low age limits were set on unskilled jobs that required strength; (2) there were few restrictions in the low-paid and undesirable service occupations; (3) restrictions were not too rigid in skilled occupations requiring long training periods; (4) they were, however, quite rigid in white collar jobs.

5. In all six areas, there were significant restrictions against older workers. For example, 51 per cent of all job orders received in Portland specified an age limit of under 45 years. This was the area with the greatest labor surplus. In Dallas, and Denver, discrimination was less severe but still significant. Age limitations in both cities were found on about 33 per cent of all job orders. In Birmingham, 79 per cent of the orders were restricted but much of that was due to the great physical requirements of heavy industry.

Common Fallacies

The reasons for discrimination against the older worker are many but, in the main, are based upon mistaken notions.

I. "Hiring older workers will increase my workmen's compensation rate," is a frequent objection. To this the Association of Casualty and Surety Companies replied:

> "Let this be understood—there is no provision in workmen's compensation insurance policies or rates that penalizes an employer for hiring a handicapped worker. There appears to be much misinformation on this point. Therefore, to erase any misunderstanding, these are the facts. Workmen's compensation rates are determined by two factors: (1) Relative hazards in the company's work and (2) its accident experience. The formula for determining the premium rates makes no consideration for the type of personnel involved. . . . The insurance contract, therefore, says nothing implied or direct about the physical condition of the worker that the insured may hire."

II. "Older workers are more likely to become injured on the job," is another favorite standby. Yet, in the study on "Absenteeism and Injury Experience of Older Workers," prepared by the Bureau of Labor Statistics, Mr. Max D. Kossoris found in a study of work conditions of about 17,000 workers in a variety of 109 manufacturing industries that the only disadvantage of the older worker is that their disabilities last longer once they are injured. But on the whole, they are likely to be absent less frequently and less likely to be injured than the younger worker.

III. "Older workers are less profitable." Why invest in training oldsters who won't be around much longer"—these comments overlook studies that indicate that older workers are more experienced, have less outside distraction, are more conscientious, and often are as productive as younger workers. Undoubtedly, old age weakens ability on those jobs requiring energy and speed. But even on such jobs, the decline from age 50 to 75 is slight and varies with the occupation.

As for an investment in training, there is more than one case on record where the so-called older worker outlived his younger detractor.

IV. Pension plans are a favorite justification for personnel policies that bar older workers. In view of the current widespread trend to adopt pension plans through collective bargaining, this is rapidly becoming a serious consideration. It is, however, possible to adjust pension plan formulas so that the hiring of older workers does not create an undue burden upon employers. The extension of collective bargaining agreements to the extent that they affect seniority provisions have been a major factor in protecting job rights of older workers.

V. "You can't teach an old dog new tricks," or sometimes it is more euphoniously stated as fear that the older worker may carry over old work habits instead of responding to the ways of the new establishment. Stated either way, it misrepresents the case.

Proposed Program

What to do? A program for the older worker must point in two directions:

(a) Toward the elderly who want to retire, and

(b) Toward those who wish to remain in the labor market.

At the present time the older worker has no real choice since pensions are generally much too low to permit retirement regardless of inclination.

For those who wish to retire, the obvious need is for extension of coverage and liberalization of Old Age and Survivors Insurance, old age assistance, and other forms of categorical relief in which older workers participate. Moreover, payments under such programs should be adjusted to changes in the cost of living.

However, there is a great deal of evidence indicating that many workers wish to remain in the labor force beyond the "legal old age" so-called of 65. This was evidenced, for example, by the reluctance of those older workers who came into the labor market during the war to leave when hostilities were over. Moreover, we are told by the medical profession that such participation is good for them. A marked increase in deaths among workers soon after they retire has been noted. The economists add that it is good for society too, since it increases the productive units in the community and permits a higher standard of living.

One particular concern is with that part of the program which facilitates the continued participation of older workers in productive employment. The basic approach to the problem must be a local one. That is not to say that the Federal and State Governments have no role. On the contrary, there are such vital activities of the Federal Government as vocational rehabilitation, public health programs, accident prevention, adult education and training, job clinics for older workers, etc. We do not propose to attempt to legislate older workers into jobs. It may, however, be advisable to remove those legislative barriers which make it difficult for older workers to remain employed. A case in point would be the ban prohibiting Social Security pension payments to accumulate during periods of employment past retirement age. There is also much that the state and private agencies can and have been doing. The activities of this Committee are perhaps one of the best examples of that.

The major program must be individual and personalized. This requires a thorough knowledge of

the local labor market including information on the size, nature and job requirements of employers as well as full knowledge of the job history and abilities of the older job applicants.

The local offices of the Employment Service have, through its employer relations program, been conducting a campaign to promote the hiring of older workers and other special groups by educating the employers to the usefulness of these workers. We have attempted to point out to employers the implications of improved medical science on longevity, and the higher levels of physical abilities of the older workers. We have tried to get employers away from counting birthdays and to have them think in terms of occupational or physiological age. Through its job analysis program, the Employment Service is in a position to undertake job engineering projects that will show the types of jobs best suited for the elderly. Through its counseling and selective placement techniques, the Employment Service has been rendering personalized service to the older workers.

Job Counselling for Older Workers

As was reported to your Committee last year, the New York State Employment Service recognized the special problems of the older worker and has revised its counseling program accordingly. Personnel engaged in interviewing, counseling and job solicitation on behalf of older workers were given special training.

These changes were the result of an experiment which involved setting up a small unit at the N. Y. City commercial office to deal exclusively with the placement of *clerical jobseekers* 50 years of age and older.

Between November 1947 and November 1948, a total of 1,120 referrals were made to employer interviews. Of those interviewed, 305 or 27 per cent were placed in jobs. The usual experience in clerical referrals is 40 per cent. A check made three months later of the 25 workers showed that 18 were still employed.

A majority of openings secured for the older workers were obtained by persistent telephone solicitation. Complete analysis of the applicant's experiences and personal qualifications was followed by careful presentation of his best features to selected employers. A total of 933 such employers were given the telephone sales talk on behalf of specific older applicants.

Most placements were made in small companies where there were no pension plans. It was found that older workers needed individual selling as long as there is employer resistance. It was also evident that a sales presentation placed upon the concept of an age handicap does not get results.

The success of this experiment in spotlighting specific problems and suggesting solutions has encouraged the New York State Employment Service to extend the project to the Queens Industrial office, the Manhattan clerical and professional office and the domestic, and household office. The possibility of conducting similar experiments in Buffalo is also being considered. Any agency like the Employment Service while it can do much, swims upstream until there is more recognition of the problem by employers and positive action to remove artificial barriers.

Another illustration of positive programming for the older worker was reported by the Employment Service in Miami, Florida. Here, several veterans who had held responsible front office jobs in the hotel industry found that they could no longer secure this type of work. The problem of these older workers was discussed with the Hotel Association and a cooperative program set in motion. A training program was instituted covering such jobs as transcript writers, auditors, food control and other jobs in the hotel industry that could utilize the knowledge and skills these older workers had acquired through the years. Jobs were then solicited for each of these veterans in the occupation for which they had been training. No longer were these older people compelled to say to employment managers, "I am 49 years old—and have been for many years."

Any program, no matter how well conceived, runs the risk of being scuttled during the period of large-scale unemployment. Older workers have a very special interest in maintaining the economy at high employment levels. Unless we are able to do this, the rejoinder to "Life begins at 40" will invariably be "Do you call that living?"

Labor and Its Older Workers

By Harry Becker

Director of the Social Security Department, United Automobile Workers of America, CIO

THE LABOR-MANAGEMENT contracts negotiated during 1949 have more than tripled the number of workers covered by some type of health, welfare, or retirement benefit plans under collective bargaining agreements. By the end of 1949 such benefits probably reached 10 million workers and their families.

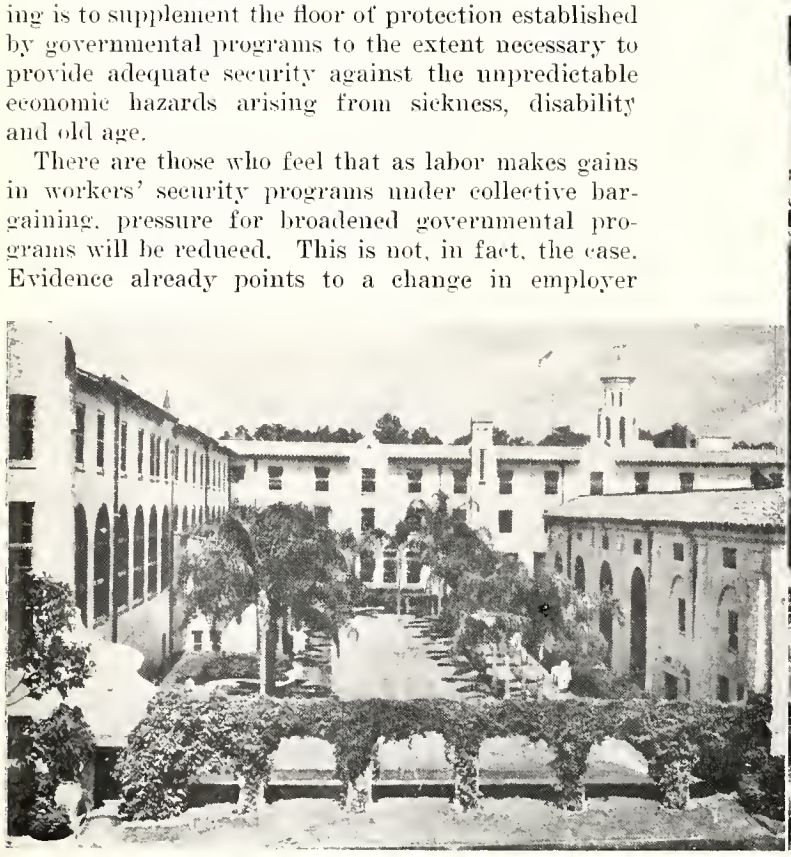
At the same time, labor has continued to work for the expansion and strengthening of governmental programs for social security because we recognize that governmental programs must assure a basic floor of protection for all people wherever they may live and whatever their occupation.

Pensions and Social Security

It is not a question of public programs versus collective bargaining programs. The purpose of workers' security programs set up under collective bargaining is to supplement the floor of protection established by governmental programs to the extent necessary to provide adequate security against the unpredictable economic hazards arising from sickness, disability and old age.

There are those who feel that as labor makes gains in workers' security programs under collective bargaining, pressure for broadened governmental programs will be reduced. This is not, in fact, the case. Evidence already points to a change in employer attitudes toward governmental social security programs. Now that labor has established the principle that social security is a right growing out of employment and that the cost of protection is as much a cost of doing business as wages, employers are beginning to realize as never before that government action is necessary. Employer groups which only a few months ago were indifferent to the expansion of the Federal Social Security system are now saying that it is time to expand this system, if programs for workers' security are going to be established through collective bargaining to supplement inadequate public benefits. As employer groups learn at first hand the complexities of financing and administration of security benefits and services, the need for universal programs becomes more apparent.

One example of current thinking of management on this problem may be seen in a speech made by C. E.



Luxurious old age home established by the carpenters' union

Wilson, President of General Motors Corporation, in Detroit on November 15, 1949:

> "If the present social security pensions were approximately adequate when the law was passed, they are certainly inadequate now. They do not reflect the change in the purchasing power of the dollar. Social security pensions were not increased as wages and collections were increased. It would seem reasonable with the minimum wages increased from forty to seventy-five cents per hour to increase minimum pensions in about the same proportion."

Changing Conditions

Why are workers so concerned about security today? The need for security has grown out of the economic and social changes accompanying this country's development from a pioneer agricultural community to the greatest industrial nation on earth. The need does not arise because individual workers are deficient or inadequate or less self-reliant than workers of an earlier time.

In 1775 when the founders of our American government talked of the Rights of Man—the Rights to Life, Liberty and the Pursuit of Happiness—they thought that the right to own property provided sufficient economic protection for the individual. At that time most Americans were self-employed on farms, or owned the tools needed to earn their living. Today, more than three out of four persons in the United States are employees. As workers have moved from farms to factories they have grown away from self-sufficiency. A lay-off at the factory, or a period of illness can exhaust a worker's savings very quickly, yet he must continue to buy food and to pay for shelter if he is to continue to live.

The problem of security is complicated by the growing numbers and proportion of the aged in our population. In 1900 only 4.1 per cent of the 76 million persons living in the United States were 65 years of age or older. In 1950 more than 11 million people will be over 65. This will be 7.7 per cent of the total population. By 1980, it is estimated that 22 million, or 12 per cent of the population, will be older than 65.

There are several reasons for this increase in the older population. We are producing fewer children, and we have restricted immigration. Then, too, Americans are living longer because of better medical care and public health measures and because of higher living standards. American life insurance companies in the early nineteenth century assumed, on the basis of experience, that the expected life of females at birth would be 18.1 years, and that of males 14.2 years. By 1900 life expectancy at birth had risen to almost 50 years, and by 1940 to 62 years. More recent estimates place life expectancy at 67 years.

Although there are more and more people in the older age groups employers generally are not willing to hire older workers. Furthermore, new inventions and developments continue to make many occupations obsolete. The older worker may not get a chance to learn a new job even when he would be able to do so. And there are not as many job opportunities for older people in towns and cities as there are on farms. During the peak of wartime employment, only one-third of the men and women 65 years of age and over were gainfully occupied. Today, not more than one out of every four aged persons are working for a living. Thus, there is a critical problem of old age dependency.

Savings for Old Age

Few, if any, workers' families are able to save sufficient money out of current earnings to insure themselves a modest standard of living after retirement—even though these savings may be supplemented by Old Age and Survivors Insurance benefits. Similarly, few individuals, acting alone, can budget for protection against major medical and hospital expense. The Detroit auto worker, for example, has an average monthly income of about $260, if he works 11 months out of 12. It costs a family of four in Detroit over $280 a month to maintain a "modest standard of living." This budget includes an allowance of $8 to $10 a month for hospital and medical care, but it requires about $20 more each month than the average monthly income received. Thus there is no margin at all for saving.

Yet the worker who wants to receive an income of $100 a month beginning at age 60 and who buys an annuity at age 30, for example, would have to make payments of about $36 per month for 360 consecutive months. This would mean a total savings of approximately $13,000 which is, of course, out of the question for industrial workers.

Inadequacy of OASI

Our present social security system is completely inadequate to meet the needs of working people for protection when they are "too old to work and too young to die", when they are ill, and when they are unemployed. The old age retirement benefits, for example, fall far below the minimum relief budgets in our cities and towns. The Federal Old Age and Survivors Insurance benefit for a worker and wife, both over 65, averaged $42.39 a month in Michigan in 1949. But an elderly couple living in Detroit needed about $143 a month for a modest standard of living.

Workers should not have to look to poor relief and to charity as their principal floor of security when they are unable to work. Yet this is, in fact, the case. For the country as a whole, in June, 1948—a period of high level employment—there were 216 persons receiving public assistance for every 1,000 persons over 65. Even in Michigan, where industrialization permits broader coverage under the Federal insurance system than in many other states, more than 20 per cent of the persons over 65 were dependent on public relief for security in their old age. This does not include those additional persons receiving poor relief and private charity. These persons are without other resources because savings and property were liquidated before they subjected themselves to the indignity of the "means test."

Insecurity Hastens Aging

The UAW-CIO has extensive data on the problem of the aged and infirm worker in meeting living expenses after leaving employment. Hundreds of case stories have been obtained which show the gradual destruction of personality when the worker realizes that he cannot work any longer, exhausts his resources, faces the public relief office, becomes ill and struggles unto death with the problem of how to provide himself with the barest essentials of life. In the abstract these facts do not have the same meaning as they do when we know the individuals affected.

The social service department at the UAW-CIO medical clinic in Detroit has recorded many stories from individual workers which show this pattern of lost morale and human waste. During the 1930's workers exhausted all of their resources either because they were unemployed or because members of their families were unemployed. With the full-employment years during the war the older workers, particularly, attempted to save. Many made down-payments on homes and paid accumulated debts. Illness struck, as it often does especially with older people, savings disappeared, homes were lost, and finally public poor relief was applied for. In other instances, premature superannuation occurred because of the anxiety of workers who were approaching the time when they feared they would no longer be able to work. Over half of the more than 1,000 workers seen each month at the UAW-CIO clinic have illnesses which the doctors say have been caused or made worse by basic feelings of insecurity. Much of this insecurity is related to fear of what will happen to the worker and his family when he can no longer work.

A "means test" program should not be the answer to the economic needs of the worker when he is "too old to work and too young to die." Charity is not the democratic answer to this need. It is time that we provided income maintenance benefits as a matter of right instead of falling back on charity programs as our basis floor of protection for an aging population.

UAW-CIO Program

To give adequate protection to workers against the economic hazards of age, incapacity (both temporary and permanent) and death, the UAW-CIO is seeking expansion of the governmental social security programs—both in amounts and in coverage—and is asking for a comprehensive and integrated system of benefits in the programs established under collective bargaining. These benefits are: (1) pensions for people who are too old to work or who become disabled and cannot continue to work; (2) medical care programs which lift from the worker and his family the existing economic barriers to necessary hospital and medical care; (3) rehabilitation services to help the disabled worker return to gainful employment; (4) payments to maintain family income during the illness of the wage earner; and (5) survivor's benefits when the wage earner dies prematurely.

These benefits should be adequate for their purpose or they should not be adopted. It is better to start with fewer and adequate benefits than to spread the money available for protection too thinly and fail to provide real security for any of the common hazards of life. Benefits under collective bargaining programs should be sufficient to sustain the worker and his family on a modest standard of living. They should not be so low that supplementation by public relief is necessary. The floor of protection provided by government programs must be considered in establishing the amount of the benefits under workers' security collective bargaining programs. But the necessity for additional relief payments must be avoided.

The workers' security programs under collective bargaining are intended to provide benefits supplementary to the government floor of protection. They are particularly necessary in industrial and high cost of living areas. Programs under collective bargaining are also adapted to meet the needs of particular groups of workers and to provide a flexibility not possible under government programs. This flexibility in the collective bargaining programs makes it possible to establish demonstrations and pilot plans which can provide experience for expansion and extension of much needed public programs. This is particularly true in the field of medical and hospital care, where government experience with prepaid care is still very limited.

There are three important principles around which collective bargaining programs for workers' security are being developed. These are: (1) universal cov-

erage—that is, every worker covered by the collective bargaining agreement as well as his immediate family must be given the protection provided by the program; (2) employer-financing—that is, employer payments sufficient to meet the cost of the program; and (3) joint union-management administration of the employee-benefit fund.

Universal Coverage Is Basic

Why is universal coverage essential? When a retirement income program is won through collective bargaining it is in lieu of other alternative economic gains and is won on behalf of all workers. Therefore, every worker in the bargaining unit must be covered. To restrict coverage to certain classes of workers is neither justified nor feasible.

Restrictions on coverage in pension plans have been developed largely because of the employer's desire to reduce the cost of the plan. Restrictions in pension plans outside of collective bargaining have tended to exclude older workers, to provide for a waiting period, or to establish earnings qualifications. A program under collective bargaining is intended to accomplish protection for all the workers. To exclude the older workers delays the effectiveness of the program and fails completely to meet the immediate problem.

The requirement of a waiting period before a worker may participate has no validity for plans developed through collective bargaining. Under these plans workers earn old age security during their working life as a part of their compensation. Hence they should receive credit from their first day of service, and a waiting period is inequitable.

Similarly, an earnings qualification is not justified in a retirement program established through collective bargaining. Workers in the lower wage brackets need a pension plan even more than the higher wage group; it is more difficult for the lower income groups to save.

Furthermore, coverage of all workers has the practical advantage of contributing to the stability and actuarial soundness of the program and permitting many economies in administration.

The Employer Should Pay

Employer-financing is probably the most debated and the least understood of these principles. There are a number of reasons why employers should finance the security programs set up under collective bargaining. In the first place, it is the only practical and effective way to secure coverage for all the workers in the group. Contributory plans in industry have failed to enroll all employees. Inclusion of all members of a group is essential to an effective program of security protection.

The employer-payments agreed to in collective bargaining are not gratuitous payments. They are not something for nothing. The basis for the employer-payment is that a worker, by the performance of his job, earns a retirement income and other social security protection as a deferred part of his earnings.

Funds for worker security programs come from industry irrespective of whether they are paid directly to provide benefits or whether they are deducted from employer-payments to employees and then used to provide benefits. It makes no economic difference whether the employer makes the payments directly or whether they pass through the hands of employees—if employer payroll deductions can be considered to pass through the hands of employees!

The employer allocates funds for the repair and replacement of his machines as a cost of doing business. The repair and replacement of his "human machines" is no less a legitimate responsibility of industry. The Federal tax regulations recognize employer-payments for retirement and health security programs as an "ordinary and necessary expense" of doing business and allow the employer full deductibility for such payments.

On the other hand, monies technically paid to the worker and then deducted from his wages by his employer are taxable to the worker. A dollar paid by the employer to the worker and then "checked-off" for benefits results in only 84 cents available for workers' security benefits. This means that with employee-financing, or the payroll check-off method of financing, the employer must pay almost $1.20 in wages to produce one dollar which is available for workers' security.

Joint Union-Company Administration

Joint union-management administration of the employee-benefit fund is essential. It is through this joint administration that the programs can be adapted to meet the needs of particular groups of workers and can be kept flexible. It is not practicable to work out all the details of pension and medical care programs in collective bargaining. After agreement has been reached on the broad policy provisions of a program, responsibility for developing it should be delegated to a joint board of trustees who can, in addition, review the program periodically and arrange for modifications which may be necessary from time to time. Workers are the group most directly concerned with the proper functioning of the program, and where they have an effective voice in its administration, a better program results.

Flexible Retirement Age

There is a fourth principle which is important—a flexible retirement age. Workers security programs should permit workers to retire at the point at which they become superannuated. Workers should not be required to retire at a fixed age. The proper point for retirement differs for each individual and the reasons for retirement likewise vary from individual to individual. Therefore there should be sufficient flexibility with respect to retirement age to permit each worker to retire on an individually determined basis. This means that retirement should be permitted throughout the span of years in which workers most frequently become superannuated.

A flexible retirement age is needed because superannuation is only in part related to the individual's chronological age. The onset of disqualification because of old age and infirmity is also a function of the original equipment of the individual, of the effects of environmental factors, and of the appearance of chronic conditions. A worker may become superannuated before 65 as well as after 65. Age 65 has been most often adopted as the retirement age because it has been thought that persons tend to outlive their usefulness on the job at about this age. Age 65 has been generally accepted as the average age for retirement of salaried or office workers.

If it is desirable to permit retirement for sedentary workers at 65 it follows that persons engaged in physical work should be permitted to retire somewhat earlier, if they so desire. There is considerable support for age 60, or even an earlier age, as the point at which retirement may be permitted. For some individuals, however, superannuation may not occur until some years after 65. This variation between individuals as to when superannuation takes place is recognized in Labor's thinking about retirement age.

Individual Security Means Community Security

Workers' security programs have value not only for the worker, but for industry and for the community. The worker need no longer fear the economic hazards of age, incapacity, and death. He can look forward to a decent retirement income when he is too old to work. He will have insurance against death or total and permanent disability. He need no longer fear the unpredictable and unbudgetable cost of hospital and medical care. When he cannot work for reasons of sickness or accident his family living expenses can be met, even though on a somewhat reduced basis. And when he is unable to do his usual job for reasons of accident or sickness, rehabilitation services will be available to help him back on his feet.

All of these things mean that the worker will be more secure about his future. His savings will not be exhausted with a single illness. Homes can be bought with a knowledge that illness in the family will not mean a loss of equity. Necessary medical care and hospitalization will not be delayed for economic reasons. This adds up to an increased sense of well-being and increased self-confidence on the part of the worker—a happier and more secure worker.

The advantages of workers security programs to industry areas great as the advantages to the worker. Companies which have put health and welfare plans into effect have reported that improved labor relations and public relations have resulted, productivity has increased, and absenteeism and labor turnover have decreased.

Worker security programs mean as much to the community as they do to the worker and to industry. They mean fewer persons on public relief and charity programs. They mean a healthier community because the people of which it is composed are happier and more secure.

Such programs mean more assurance for workers who want to make commitments for such long-time purchases as homes. They mean fewer uncollected accounts for merchants. As the President's Steel Industry Board stated, in its report:

> **"The inauguration and operation of insurance and pension programs will make a considerable contribution to the attainment of the economic stability so necessary at this time. With the knowledge that the economic hazards of life will be at least partially met, workers will be more apt to help sustain consumption spending at a high stable level."**

The UAW-CIO believes that the sooner we face the problem of providing an adequate workers' security program, the easier it is to solve. Each year of postponement of security programs is costly for the workers, for industry, and for the community.

How Long Do Our Workers Last?

By Ewan Clague

Commissioner of Labor Statistics, U. S. Department of Labor

THE LENGTH of working life of American workers is a highly important field of inquiry for those concerned with the economic and social problems of older workers in our modern economy. For, by comparing the ages at which workers cease gainful activity with their total life expectancy, we have a significant measure of the magnitude of the problem of old-age dependency as it affects the individual worker.

In order to make available basic data on this aspect of manpower utilization, the Bureau of Labor Statistics has taken the actuarial techniques of the conventional life insurance tables and adapted them to the measurement of working life. These tables show the ages at which men enter the labor force, the ages at which they stop working either because of death or retirement, and the average number of years of working life remaining to them, at given ages. These materials will be published, in detail, in a forthcoming bureau study. I shall refer briefly here to a few of our major findings.

Under 1940 conditions of mortality and of labor force participation, the average male worker aged 20 could expect to remain in the labor force—either working or seeking work—for an additional 41.3 years, or to age 61. However, he could expect to live for an additional 46.8 years, or until age 67. So, on the average, he could anticipate a gap of 5½ years between his working life and his total life span.

I would like to stress two things about these figures. First, they are averages. They include men who "die in the saddle," as well as men who are exposed to protracted periods of retirement, after they have stopped working. Under 1940 conditions, about half of all men workers could in fact expect to continue working until death or fatal illness. For the remainder, the period of retirement was much greater than the average. If we assume the life expectancy of retired men at any age to be the same as for all men at that age, the average life span in retirement for men retiring at age 60 or later was approximately 11 years.

Secondly, as in the case of the standard life insurance tables, the estimates of working life simply describe what would happen if an existing pattern of mortality and retirement prevailed throughout the life history of a generation of workers. They are not forecasts and do not attempt to predict, for example, the conditions a young man will in fact be exposed to in the course of the next four or five decades.

By comparing the pattern of working life of 1940 with that prevailing in other periods, we can however gain valuable insight into the factors underlying the growth of the present problem of old-age dependency. A century ago, or even more recently in our history, there was very little difference between a man's working life span and his total life span. Life expectancy was short and only a small proportion of the population survived until ages which are now considered conventional for retirement. Moreover, we were predominantly an agrarian economy. As an independent farmer or craftsman, the older worker was often in a position to continue in an active, productive role until the very end. For most workers, there was no sharp break in employment, but rather a tapering off. Retirement, as we know it today, was the exception rather than the rule.

Changes in Work-Life Pattern

Let us consider the work-life pattern of men in 1900, since comparable data for prior periods are not readily available. At the beginning of the century, the 20-year-old white man had an average life expectancy of 42.2 years, or about 5 years shorter than his counterpart in 1940. His working life expectancy of 39.4 years was, however, only 2 years less than in 1940. On the average, therefore, he could expect slightly under 3 years outside of the labor force, as compared with 5½ years in 1940.

From this simple comparison we can diagnose two of the basic elements in the long-term economic problem of the aged. On the one hand, the advances of medical science enabled a growing proportion of the population to survive into old age. On the other hand, employment opportunities did not keep pace with this increase in the aged population. There was a steady shift from agriculture and the small handicraft trades to large-scale urban industry, with its emphasis on speed, its rigid work schedules and its dilution of skills. The older worker was no longer

able to slow down gradually on the job, but at some stage—often at some fixed chronological age such as 65—he was forced to make a complete break with employment. As a result, there was a long-term downtrend in the average age of retirement and a widening gap in the period of old-age dependency.

This basic problem was, moreover, intensified by the great depression of the thirties. The burden of unemployment fell heavily on the older workers, who —once laid off—found it increasingly difficult to secure reemployment. By 1940, after a decade of severe unemployment, there were many older workers, in their fifties and sixties, who were still able to work and willing to work, but who, after prolonged unemployment, had given up the search.

But with wartime mobilization and postwar prosperity came ample evidence that many of these older workers were in fact capable of productive employment. Large numbers re-entered the wartime labor force while others postponed their retirement. This pattern moreover has continued into the postwar period, so that substantially greater numbers of older workers are now in the working force than would be expected from prewar trends.

These changes have had a pronounced effect on the pattern of working life. As a result of further advances in medical science and the general improvement of living standards, the 20-year old male worker, under 1947 conditions, could expect to live an additional 48.2 years, a gain of almost 1½ years over 1940. At the same time, his average work life expectancy also increased by 1½ years, to 42.8 years, largely due to the increased proportions of older men, in their late fifties and sixties, who were found in the postwar labor force. Thus, in contrast to the long-term trend, there has been no further widening in the retirement gap during the current decade.

These comparisons suggest alternative patterns for future trends in the work life span. A resumption of prewar trends, on the one hand, would mean a rapid widening of the period of dependency and would correspondingly add to the economic burden of old-age dependency. Under this assumption, the gap between total life expectancy and working life expectancy will widen to almost 10 years in 1975, as compared to 5½ years in 1947 and less than 3 years in 1900. On the other hand, if we can maintain the current pattern of labor force participation, the increase in life expectancy will be added mainly to the period of productive life. Even under these conditions, there will, however, still be an increase of about 1½ years in the average period of retirement, due simply to the fact that under the improved mortality conditions projected for 1975, a larger proportion of young men are likely to survive to retirement age.

Old Age Dependency Increases

It is clear from these comparisons that we are faced with a major and growing problem of old-age dependency, even under relatively favorable assumptions. However, if we fall short of our full employment goals and if we fail to provide adequate work opportunities to those older men and women who want to and are able to work, the problem will be greatly magnified.

There will be mounting pressures for an expansion of old-age benefits and growing demands for a progressive broadening of the eligibility conditions. The increased span of enforced idleness in old age will place a heavy financial burden not alone on the aged themselves, but on those in the labor force who will be contributing to their support, either directly as individuals, or by increased levies on their current earnings.

There is, however, nothing inevitable about these long-term trends. I believe that legislators, who are in a position to determine public policy, can do a great deal, in conjunction with labor and management, in promoting employment opportunities for the older workers and extending their working life span.

As a guide to constructive action, we shall, of course, need much more detailed information than I have thus far presented. The public health specialist has available detailed statistics on the incidence of disease and the causes of death, to guide him in formulating an effective health program. In similar fashion, we must know much more about the types of workers who are at present most vulnerable to premature and involuntary retirement, about their occupation and industry and their geographical location. We also need direct information as to the specific causes of their withdrawal from gainful activity. At present this area is still largely unexplored from a statistical viewpoint.

The City vs. Oldsters

On the basis of our present knowledge of the American labor market and of conditions in various occupations, it is possible, however, to focus on certain broad sectors of the labor force, where the problem is likely to be most severe. First, we know that the working-life span is shorter for the city worker than for the farmer. Secondly, in the nonagricultural sector of the economy, the period of retirement is likely to be longer for the wage or salaried employee than for the man working on his own account, as a businessman or an independent professional.

In this broad area of nonagricultural employment there are wide differences, too, in the severity of the employment problem of older workers. There are many employees of mature age, in executive, supervisory and professional positions, whose experience and judgment render them increasingly useful to their firm. However, in the great mass of industrial and clerical jobs, which bulk so large in our modern economy, the opposite is more frequently the case.

For many of these workers, the major threat to a full well-rounded working career is the gap between the individual's *occupational* working life and his total *potential* working life. The most obvious illustration is in the case of those jobs which involve very high physical requirements. Professional athletes or airline pilots or other men engaged in hazardous or strenuous activities are required to be in perfect or near-perfect physical condition. At some stage, and well before the end of their normal, working life, men in these jobs—even though a select group, to begin with—are compelled to shift to a less exacting type of work.

The situation of airline pilots, though extreme, may serve to point up the problems which may be encountered under these circumstances. Airline pilots as a group are predominantly young men—both because of the very stringent physical qualifications they must meet under the Civil Air Regulations and because of the very recent growth of the occupation. Thus, since 1940, the number of pilots employed by the scheduled airlines has tripled. Although there have, of course, been individual problems of superannuation for pilots, there has not as yet been a mass problem. But within the coming decade or two, a large proportion of the present pilots will be in their forties and fifties; clearly many of them will no longer be able to meet the current physical standards. Where will they go? The types of ground jobs on the airlines for which they may qualify or which they are likely to consider suitable are necessarily limited. Retirement also is not the solution for them. The only alternative for many will be a completely new occupational orientation.

Less spectacular, but of much wider significance, is the situation of many other workers who find that as they grow older and slow down, they can no longer meet the pace of modern industry, although they may still be capable of gainful employment. If they retain their jobs with their employer, this problem—though still a real one—may be dealt with in a quiet, unobtrusive fashion. In many industries, seniority gives the older worker a substantial measure of security. And, apart from this form of protection, many employers have adopted policies to shift their older employees to lighter, less exacting duties.

Stranded in Middle Life

However, in our dynamic economy, there is the ever-present danger that these workers may get stranded in the middle of their working life. Periodic business recessions, or simply the normal turnover of business establishments, may cast them in the role of a jobseeker. Technological or style changes may depress their industries or render their skills obsolete. Shifts in consumer demand and the changing pattern of industrial location may also have the same effect.

Once the man past his forties is forced into the labor market, his problem of adjustment may prove to be a difficult one. Many employers are reluctant to hire older workers, unless they have some special qualifications. The very seniority rules which protect him on the job work to his disadvantage when he is on the outside. And the prospect of "starting all over again," to a man of mature years and responsibilities, is not a very appealing one.

What can we do about this dilemma of the older worker? I will not presume here to attempt to spell out any detailed solution. From this brief review it is apparent that we are dealing with a highly complex problem. It is a problem that we are approaching with all too meager factual resources, although the New York State Joint Legislative Committee on Problems of the Aging has performed an outstanding service in this respect, in assembling and evaluating the available data. It is, moreover, a problem which is growing in dimensions each year, and which will command the combined resources of the Federal and State and local governments, of labor and management, and of many community groups, if it is to be dealt with effectively.

In conclusion, I would, however, like to refer to one general course of action which merits your consideration. You are all familiar with the general theme of "physical fitness." Institutions such as life insurance companies, particularly, have a strong and obvious interest in promoting improved health standards, proper diet, adequate exercise and other hygienic measures which will have the effect of extending the average life expectancy. The community at large has an interest, too, in extending the period of *working* life.

To this end, we should inaugurate a program of "vocational fitness," designed particularly to meet the needs of middle-aged workers. We must first, of course, determine what particular types of jobs are adapted to their background and abilities, by careful studies of the job requirements, the conditions of entry, the productivity of older workers on these jobs and other pertinent information. We must, at the same time, improve our technical know-how in testing and counselling older workers.

With this type of information, we may be in a position to conduct an effective campaign to encourage mature workers to undertake adult education and vocational retraining programs. Preferably, these programs should be conducted, not when the worker is out of work, but when he is still on the job. In order to be effective, these programs must obtain the wholehearted cooperation of labor and management groups and must be part of a broader campaign to expand employment opportunities for the older worker.

All this may seem like an ambitious project, but if it succeeds in extending the period of productive life for even a fraction of our labor force, it will prove to be a sound investment.

Business Conditions Today Demand Seasoned Executives

By John R. Powelson
President, Forty Plus Club of N. Y., Inc.

THE EXECUTIVE, over 40, seeking employment is often ruled out of competition without even a hearing under today's employment practices. The following alleged reasons are those most frequently given:

1. Company pension and group insurance plans.
2. Company traditional policy of employing only younger men.
3. Reluctance, based on fear by young company executives, to employ older men.
4. Company fixed policy of promotions of executives from within.

To arm the executive, over 40, against such hiring procedures, the idea of the Forty Plus Club was born. More than 10 years of successful operation have proved that these employment problems and prejudices can be overcome. Since 1938 Forty Plus Clubs have been organized coast-to-coast, including such cities as New York, Boston, Buffalo, Philadelphia, Cleveland, Detroit, Chicago, Los Angeles and San Francisco.

Typical of the overall operation, is the Forty Plus Club of New York, Inc., which maintains headquarters at 250 West 57th St., New York City. Founded in 1939 the objectives of this non-profit organization are to secure executive employment for members by their own cooperative efforts; to offer members encouragement, inspiration and assistance; and to create in the minds of prospective employers a realization of the value of mature experience, seasoned judgment and trained business knowledge.

To function efficiently the club maintains five committees:

1. The Admissions Committee—which carefully screens and investigates applicants.
2. The Marketing Committee—which keeps up constant liaison with industry and business by means of personal calls and printed matter.
3. The Placement Committee—which recommends members for job openings, and arranges personal interviews at the request of the potential employer.
4. The Public Relations Committee—which prepares press releases, radio scripts, paid advertising, trade paper press copy, and supplies speakers for Chambers of Commerce, Trade Associations and Service Clubs.
5. The Resume Committee—which helps members prepare resumes of business experience.

The Forty Plus Club has strict membership requirements which act equally for its own protection as well as that of the employer. To qualify a member must be an American citizen, 40 years old or over, show a satisfactory educational record, have demonstrated executive ability, and have earned a minimum of $5,000 yearly.

As a result of this strict screening, only 8 per cent of the applicants are accepted. Experience shows that most of the club's members are undergoing temporary unemployment not through any basic faults of their own, but rather through the inevitable industrial readjustments following a national emergency, mergers and combinations of circumstances beyond the individual's control.

The club realizes that the American economy—vast, successful and envied by all nations—represents in the last analysis the sum total of the know-how, energy and creative genius of all elements of the population. America today is taking positive political action in the matter of conservation of natural resources; water, forests, oil and soil. Failure by government and business and industry to conserve equally important human values, to gainfully employ the hard-won experience, the seasoned judgment, the ingrained habit-of-work, as possessed and best exemplified by the over-40 executive age group, only serves to subtract from the maximum productive effort which is the American goal.

As evidence of the success in this direction of the club's efforts, it is interesting to note that since its formation in New York, more than 1700 have been

placed in executive jobs. Employment records reveal moreover, that virtually no labor turnover has been created by the hiring of Forty Plus members, which in itself is at once a tribute to and justification for the strict admittance standards in force. The seasoned employee appreciates and holds his job.

The Forty Plus Club of New York, Inc., invites the cooperation of Federal, State and local government agencies. The enlightened employer can profitably utilize the club's services by passing along to the Placement Committee executive job specifications as they develop, thereby extending to the club's membership an opportunity to compete for such positions. The club cannot emphasize too strongly or too often the time tested fact that there is "no substitute for experience."

New Jobs at 65 *

By Thomas C. Desmond

Chairman, New York State Joint Legislative Committee on Problems of the Aging

You might have wondered why a squad of oldsters, with lunch boxes under their arms, were trooping daily into industrial Schenectady's squatty, red-brick savings bank. Were they coming to carry off their life's savings in food boxes? Or was the savings institution providing an assembly hall for the local Townsend Club? Neither explanation seemed plausible.

The man who had the answers was a 72-year old honorary Kentucky Colonel, Laurence A. Hawkins, slight of build, but no light-weight in the engineering profession.

For 33 years Hawkins was executive engineer of the research laboratories of Schenectady's mammoth, sprawling General Electric Works. He holds more than 50 important patents, mostly in railway signalling, and is still young enough to enjoy motoring and swimming.

But when World War II ended he was told, "You're too old. You'll have to retire." Hawkins found himself idle for the first time in his life, in the midst of a veritable reservoir of highly skilled workers who had been shelved in this home of the giant General Electric and American Locomotive Companies. "Wouldn't some of these men," Hawkins asked himself, "be happier if they could find some way to utilize their valuable experience, skills and knowledge?" He wasn't sure, but he decided to find out.

Hawkins sought out two other men who had been sacrificed by industry on the altar of compulsory retirement. One was tall, black-haired Arthur R. Smith, 70 years old, former manager of the Turbine Engineering Department at General Electric. The other was short, stocky, bespectacled Ray Stearns, also a septuagenarian, for many years manager of the Aeronautics and Marine Engineering Department of General Electric, and prime developer of the B-29

71-year old J. H. Bush studies designs for turbo-generator.

* Reprinted, with additions, from Reader's Digest, June, 1950.

David Lockerby, 70, works on a turbine design.

J. R. Foulder, 69-year old draughtsman, talks over a production problem with 73-old President Hawkins.

Two 68-year olds, Manager H. S. French (left) and John Bach, cut tracing paper.

armament system during World War II. "This retirement is hell," they told him. "There's still plenty of spark left in our systems. But the young bucks don't want us around."

The trio remembered a top designer they knew in turbine, an engineer in railway signalling, a leading draftsman in switchboard engineering. All had been forced out of their jobs by age limits. What had become of these men? Were they in Florida or California, sunning themselves on the beaches; or were they still in their home town, chafing at their enforced idleness, with time weighing heavily on their hands?

Hawkins and his SS men went on a man-hunt. Most of the men they wanted to see were still around. And they weren't happy. True, some were collecting pensions, and social security besides. But these were old-timers who had been in the harness for 30 or 40 years. They were beginning to show the effects of being suddenly shaken from their orbits and sent home to think about the past. "Go back to work?", one exclaimed. "This sounds like a dream come true. But who's going to hire a man in his late sixties?"

There was one answer which Hawkins and his associates saw: a company made up entirely of retired employees! If you're rejected by employers become your own employer. "That will show them we're no old fogies", they chorused. But there were many questions and problems. What could such a company sell? Where was the capital to come from? Would there be enough work to make the venture worthwhile? Where would a new company find plant space in booming, already overcrowded Schenectady?

This time it wasn't a man-hunt. Hawkins and his band, in grim earnestness, set out on a survey to determine what product they could sell. "Sorry", they had to tell one manufacturer. "Materials for what you want are still too scarce. We couldn't risk it." "Wish we could do business with you," they told another, "but your potential market is too limited." Finally the opportunity struck. Skilled draftsmen were found to be in demand to take work on a contract basis. Hundreds of old-timers in Schenectady could do drafting. And the business was there waiting.

The big trouble now was that practically all the prospective employees had been retired by the same large company, General Electric. This new business organization was to be no mere offshoot of a huge electrical corporation. It wanted to stand on its own.

It needed an "uptown" man with no industrial connections.

Encouraged with their initial progress, but still beset with serious obstacles, Hawkins and his men placed their ideas and their headaches before handsome, aggressive, and fortyish Kilgore MacFarlane, president of the Schenectady Savings Bank, an uptowner known for his business acumen. "You fellows are doing a grand thing," MacFarlane told his visitors. "Count me in to help in any way I can. Incidentally, we have some unused space here in our bank building. If I talk this over with the Board of Directors and tell them your story, maybe you can locate here."

MacFarlane agreed to serve as treasurer of the nebulous company, which now incorporated under the name of Mohawk Development Service. The rest of the roster of officials and employees sounded like a "Who's Who in Engineering and Drafting." Hawkins became president. Stearns was made secretary and general manager. Smith assumed the title of vice-president and chief engineer. Among the employees were 70-year old Ellery Steadwell, who was responsible for the design of 60-inch searchlights. J. Roy Foulder, a 69-year old graduate of Brown University who had been supervisor of drafting at the American Locomotive Company, and a group of other oldsters as familiar in engineering as the slide rule.

Labor Satisfied

Things were looking brighter for the infant concern. Maybe too bright. Rumors were rife that MDS had come under the watchful eye of organized labor. Members of the Draftsmen's Union at General Electric demanded to know what this new venture was all about. From the soot-covered, dingy building in the congested railroad area, which houses Local 301 of the United Electrical Workers, there was an ominous, uneasy silence. The men of MDS waited anxiously to see if the axe would fall. Finally the attitude of labor began to crystallize.

"We're not opposed to the employment of older workers," explained Local Business Agent Leo Jandreau, veteran of many a tough labor scrap. "On the contrary, we're all for it. But this could be a move by some of the corporations we have contracts with to get around the retirement rule."

There was a campaign underway to get Schenectady's big plants to liberalize their pension provisions. Labor officials didn't intend to have these industrial giants arguing that more and better pension plans were unnecessary because they had found a way to take care of their older employees by letting them work for themselves as long as they wanted to. Why was it, labor wanted to know, that Mohawk Development Service was drawing its employees from the retired ranks of only one company, and that the same company had already offered some contracts?

The men of MDS had the answers ready: General Electric had a surplus of work which its own employees couldn't handle. The men in the new company were familiar with General Electric products. They could do a good job from the very beginning, without extensive training, and without delay. True, most of the original work was coming from one company, but Mohawk Development Service was free to take, and indeed was anxious to get, work from wherever it might come.

Labor was soon satisfied that the new company was not a "branch" of General Electric, and that it was serving a useful purpose by preventing the rusting of skills, and probably adding years to the useful lives of older men who wanted to work. MDS went ahead with the blessings of organized labor.

Started on Little Capital

The corporation was launched with a capital of only $2,000. That isn't enough to buy a new automobile, even a low-priced one these days. But it paid the rent for a while. It bought pencils and stationery. It paid for drafting boards, paper, drawing ink, T-squares, desks and filing cabinets.

From there on the oldsters pitched in themselves, swung hammers, pushed planes and saws, and out of rough boards constructed needed work tables. They designed their own lighting equipment. There was no thought of the arthritis, stiff joints, and wrinkled, tired hands which supposedly make the elderly unfit for any kind of physical effort. These oldsters, sawing boards, skillfully putting the pieces together, helping to construct a modern workshop by their own sweat and toil were unmindful, in their enthusiasm, of the common picture of the elderly, tired, weak and miserable.

In March, 1948, not many months after a bold, new idea stirred in the imaginative mind of the old "Colonel", the doors of MDS were wide open for business. Six old-timers rolled up their sleeves. In a long, low room, where floating lamps flooded tables sticking up in rows like tank traps, they quietly took their places and went to work. They turned out designs and blueprints for turbines, turbo-generators, diesel engines and large motors. No "E's" for excellence were sought by the oldsters. The many favorable comments from satisfied customers, the new contracts that came rolling in from American Locomotive, Ludlum Steel, the Oil Institute of New York, and a host of other concerns, were the only citations the oldsters wanted. As orders piled up more pensioners were taken off the shelf.

At the end of its first year Mohawk Development Service had 16 employees. The number zoomed through 1949; and President Hawkins is looking for other fields in which to siphon machinists and engineers, de-activated by private industry solely because of the number of birthdays they have seen.

MDS has been cleared for work on government contracts connected with the defense program. In fact it has taken contracts from the Atomic Energy Commission. Grasping the sturdy, prison-like bars which cover the long, narrow windows of the Schenectady Savings Bank, Hawkins once remarked, "We couldn't be better prepared to protect any kind of secret material."

MDS, like many other companies, has erected rigid age barriers. You might be the best draftsman or engineer in the world, but you don't stand a chance here unless you can prove that you're over 65, and once retired by private industry. Present employees range in age from 66 to 74. They have a good income. They are happy, because they are contributing something to society, and, above all, because they have a chance to prove that older workers can produce profitably. They are paid the same hourly rates as prevail at General Electric for comparable work. They can utilize their skills, and they are not subject to another compulsory retirement age rule. There are no time clocks at MDS, for none is needed. When rows of bright lights are flicked on, and the rustle of drawing paper heralds the beginning of a new work day, you can be sure that it's never later than 8:30 A.M.

The old-timers took a lot of good-natured ribbing when they went back to work again. Their younger, former fellow-workers at General Electric and American Locomotive greeted them with "Hello, Tom. How are things at the old age home?" or "Making another try at it, Bill? Why don't you old duffers admit you're through and take it easy?"

It might have been just such barbs which helped the company to succeed, for the oldsters made up their minds that they simply couldn't afford to fail. Success became a matter of personal, self-esteem

Typical of the employees at MDS is 68-year old Charles Spinnler, an able, retired G. E. Engineer, now "un-retired". He had been on the shelf for two years when he was contacted by the Hawkins, Stearns, Smith team. Does he feel that the older men are capable of doing as good a job now as they did when they were with G. E. or Alco? Here's his answer: "These men are better now than before they reached retirement age. They still have their skills. There's no fooling around on the job here. Every man knows his work and goes right at it. We still take a lot of kidding from our young friends at other plants. We're confronted with a challenge. It's a matter of preserving our own esteem and confidence. We are working harder and better than we ever did before, because we know we just can't fail and still hold our heads up. It's a matter of proving to ourselves, as well as to others, that we aren't old or useless. We're going to show everybody that we're far from washed up."

Low Absenteeism Rate

Employees at Mohawk Development Service work on an hourly basis. Since they are all in the upper age brackets it was anticipated that some of them might be laid up occasionally, and unable to work because of illness. One employee was out for five months. The company paid him nothing for this time, but when he was able to come back he resumed his old job. However, this case of prolonged illness is unusual in the brief history of MDS. The absentee record shows that the men are actually out less than they were before they were pensioned by their original employers. "All our men put together," President Hawkins laughs, "couldn't keep a doctor in aspirin, or a hospital in ether."

Today, MDS is a bustling, profitable concern. It offers to industry services in the fields of engineering and drafting, and consultants on any electrical or mechanical problems. As General Manager Stearns explains, "Undertakings such as ours can be planned to supplement, not necessarily to compete with, local industries. Setting up a reservoir of skilled older men to serve as a stand-pipe to take on peak loads of existing industries helps them to stabilize their payrolls, minimizes frequent hiring and firing, and heightens their employees' sense of security in their jobs. We do not fear competition if it comes. MDS is not a charitable organization. We have unsurpassed efficiency to sell. In our field we are satisfied that we have the best skills, minds and experience that money can buy."

The books of MDS have consistently shown jet black instead of red. Employees have been well paid, and have even been given sizeable bonuses at Christmas time.

Hawkins' only complaint is that government tax policies are hard on new companies like his. Rates on gross income and undistributed profits are so heavy that the accumulation of capital for expansion is next to impossible. He would like to diversify the type of work being done. For instance, Hawkins is dreaming of the day when MDS will be able to open a machine shop, and hire some of the skilled, pensioned machinists in Schenectady. In fact he is already looking around for a spot to locate the machine shop. But it will take considerable money to do this. A machine shop is quite different from a draftsmen's

office. A more elaborate and expensive plant will be necessary. And machines cost money, far more than tracing paper, thumb tacks and drawing boards. The head man at MDS figures that about $25,000 will be needed before the company can expand into other kinds of work. But to a small, young lamb in the industrial jungle $25,000 is more than just pin money. Nevertheless, the man who has already performed a modern busines miracle on a shoestring is confident that his dreams will be realized.

Supposing that Hawkins can eventually hire 15 or 20 "superannuated" machinists to make models of new products, or to take other special development work. Perhaps the total number of MDS personnel will reach several hundreds. The possibilities are great. If older men can form their own profitable business corporation in Schenectady, why can't the same be done by other groups of oldsters in Detroit, New York City, Chicago, Boston, or Pittsburgh, or wherever you find men with skills? A hundred elderly employees here and another hundred there can, in the aggregate, number many thousands.

Dr. Roger I. Lee of Boston, former president of the American Medical Association, warns us that "Death comes at retirement." One of America's leading experts on aging, Dr. Edward J. Stieglitz, informs me, "Premature retirement while still vigorous, ambitious and anxious to serve can be a major disease." The eminent physiologist, Dr. Anton J. Carlson, says, "We are contributing to biologic parasitism and degeneration of human society as well as wasting valuable resources by keeping in idleness older workers able to perform useful service. Work is a biologic and social duty as long as we can carry on."

Laurence A. Hawkins and his associates have found a way to do something that these experts on aging have been advocating for years. Their imaginative and financially successful attack on premature retirement and widespread prejudices against hiring the elderly may set the pattern which will not only keep many off public old age assistance rolls, but which will provide satisfying work, make men live longer, and give society the benefit of an untapped reservoir of mature judgment and unequalled skills.

Public Health and Our Older People

By Dr. Leonard A. Scheele
Surgeon General of the United States

THERE is no question that the increasing proportion of older people today presents the Nation with its foremost problem in the conservation of human resources.

Public health is only one facet of the very broad problem this Joint Legislative Committee on Problems of the Aging Committee is considering. But I hope it will not, be thought mean to subordinate the importance of other aspects of the problem when I say that public health is the key, if not the definite solution to the total problem of aging.

I am sure that my colleagues from the Social Security Administration, the Bureau of Labor Statistics, the Veterans Administration, the hospitals, and other related fields will agree that plans for the employment, welfare services, housing, recreation, medical and hospital care for older people depend primarily upon the health status of the group. Of equal importance in our joint considerations is what public health does—or could do—to improve the health of all adults.

The effect of the aging of the population on public health, and vice versa, has been described many times. Reports of the Bureau of the Census show that the proportion of persons 45 years of age and over, rose from 18 per cent in 1900 to 27 per cent in 1940. It is estimated that these age groups at present account for 29 per cent, and that by the year 2000, 40 per cent of the population will be 45 years of age or over. One in every five persons is in the middle age group—45 to 64 years; fifty years from now, that ratio will be one in four.

Age Shifts

These shifts in the age composition of the population have been brought about largely by major decreases in mortality among children and young adults since 1900. The decline in the birth rate (up to about 10 years ago) and restrictions on immigration have also contributed to the trend.

Some students of demography have been concerned lest the proportion of aged persons impose a severe burden upon the economy of the Nation, and particularly upon the young adults in the producing age groups. From the public health point of view, however, the aging of the population, in itself, is not an alarm signal. On the contrary, it testifies to advances made by public health and medical services in reducing the mortality among children and young people.

There is one fact associated with the aging process, however, that is a clarion call to public health. The aging of the population is reflected in mortality statistics with a greater proportion of total deaths now occurring at the older ages. Nearly 80 per cent (78 per cent) of all deaths occurring at the present time in the United States are among persons 45 years of age and over.

The increase in the proportion of deaths among older people has accelerated during the past 30 years. In 1920, only 50 per cent of all deaths occurred in the 45 and older age groups. By far the largest increases have occurred in the definitely old age brackets. Whereas in 1920, persons 65 years of age or older accounted for only 29 per cent of the deaths, today practically half of the Nation's mortality occurs among our older people.

Public Health a Practical Science

Public health is not only a humanitarian science; it is a practical science. The philosophy and practice of public health are to attack the causes which produce the highest proportion of deaths and disability in the population. As in the past, mortality statistics are the most accurate indices available to us for determining our major problems both as to causes of death and disability and as to the specific population groups exposed. Today, those data tell us that most of our problems are the chronic and degenerative diseases, and that mortality from these and other causes is concentrated in the older age groups. This is the challenge to all agencies and groups concerned with the well-being of our older people.

About 45 years ago, public health workers heard another such challenge. The Bureau of the Census in 1904 published a report on the mortality and vital statistics recorded in the 1900 census. It showed that more than 30 per cent of all deaths occurred among children under five years of age. Childhood and youth—from birth to 25 years—then bore about the same burden of mortality that our older people now bear. Moreover, the principal causes of death in these groups were infectious diseases.

The answer to that challenge is written in the history of public health. The major causes of mortality were attacked vigorously in the succeeding years. Control of infectious diseases, maternal and child health care, improved sanitation and nutrition, combined with advances in the medical treatment of many diseases, have brought about a striking reduction in the general death rate and in the mortality from numerous specific causes.

It is not possible to select a single year in which the impact of scientific advances "begins" to be reflected in our mortality data. To bring the accelerating trend into closer perspective, however, let us consider the past thirty years.

Death Rates by Age

The general death rate in the United States has declined from 1,300 per 100,000 population, 1920, to about 1,000 at the present time. During that period the death rates for nephritis, pneumonia and influenza, and tuberculosis have declined markedly in *all age groups*. However, the decline has not been so rapid in the age groups over 45 as it has been at the younger ages.

The death rates for accidents, except motor vehicle fatalities, have declined in all age groups among persons 75 years or older. The reductions among infants under one year and among persons 65 to 74 years, however, are relatively slight.

The rates from motor vehicle accidents have increased among all age groups except among children of school age, 5–14 years. The proportion of deaths from this cause among older people, however, has not increased substantially.

The mortality experience due to heart disease, cancer, blood vessel lesions of the brain, and diabetes mellitus, illustrate most forcibly the growing problem of degenerative diseases among the older age groups, 45 years and onward.

Since 1920, the death rate from heart diseases, all ages, has more than doubled. But in all age groups under 25 years, the rates have been amazingly reduced. The rate of decline has been fairly constant since 1925 for the age groups 1–24.

In the same period, the death rates from heart disease have increased in every age group from 35 years and over, but most markedly at ages 55 and onward. Because large numbers of persons are surviving to advanced ages, we can assume that the death rate from heart diseases for the total population will continue to rise. As the infectious diseases, such as measles, scarlet fever, rheumatic fever, and syphilis, come more and more under control, we may also expect a greater concentration of heart disease deaths in the older age groups. That trend is already apparent. About 95 per cent of the heart deaths at present occur at ages 45 and over, as compared with 84 per cent thirty years ago.

It has been estimated that by 1980, even with no increase in the death rates for heart disease in the older age groups the total death rate from heart diseases would be about 452 per 100,000 population, as compared with the present rate of about 321 per 100,000. On such a basis, heart ailments would then be responsible for about one-third of all deaths in the United States.

The situation with respect to cancer somewhat resembles that of heart diseases. The cancer death rate, all ages, has increased from 83 per 100,000 population in 1920 to about 133 at the present time. Except in infancy, the age-specific rates have risen in all age groups, with the major increases among persons 65 years of age and over.

Although there has been some decline in death rates by age, vascular diseases of the brain has become the third leading cause of death in the United States. All but a very few deaths occur at ages 45 years and over. The decline in the death rate from diabetes mellitus all ages, is due principally to reductions in the younger age groups. The rates from this cause increased constantly at ages 55 to 74 between 1920 and 1940. Part of the increasing death rate in the older ages may be attributed to the prolongation of life of the young diabetic through the use of insulin.

Killers and Cripplers

I am well aware that these data do not present the still larger problem of disabling illness among our older people. The conditions I have mentioned not only kill—they make invalids of millions. But we are all aware that many of the major crippling diseases do not at the same time produce high death rates. Arthritis, rheumatism, high blood pressure, other metabolic diseases, mental and nervous ailments, for example, are responsible for a large proportion of the disabilities that keep older people from leading a normal, productive life.

That older people can be productive, has been proved over and over again. More than one-fourth of the 16 million women employed during World War II were over 45 years of age. The number of older men working during the war was even greater.

If we are to deal effectively with our aging population, however, we must plan to conserve and employ the productive capacities of our older people to a far greater extent than in the war years. And we must plan to do so continuously and not as an expedient in emergencies. Work and a respected place in

society are as essential to healthful living as food and shelter. If the longer life which modern technology has fashioned for us is to be worth living, we must try to make it healthier, happier, and more productive.

This objective points up my earlier statement that public health is the key to the solution of our problems. Building on the experience of our health agencies, both official and voluntary, we must rapidly develop effective methods for combating the chronic diseases which are concentrated among older people. We must at the same time learn how to restore to their highest possible levels of health, the millions of men and women who are already disabled by disease or premature "old age." These goals can be attained if all groups who have anything to contribute join together, with firm purpose to solve the many specific and difficult problems inherent in such a task.

The task undoubtedly is formidable. It will draw upon practically all fields of medical and public health sciences. It will reach deeply into the social sciences.

Research Needed

The fundamental solution, of course, will come from scientific research. At present, we have scant knowledge of the causes of some of the major chronic diseases, such as arteriosclerosis, hypertension, arthritis, cancer, coronary occlusion, mental diseases, and so on. We must eventually learn the causes. In the meantime our abilities to control the course of these conditions in the patient, and even to reduce their incidence in the general population, are much greater than is often realized. There are reasons for real optimism.

The most recent drastic proof of progress is the discovery that hormonal compounds, such as cortisone and ACTH, may be effective in the treatment of arthritis. Even more promising is the fact that these and other steroids provide new research tools for the investigation of many of the most baffling chronic maladies. Our ignorance today may disappear in the light of new knowledge tomorrow.

Recalling progress in other chronic diseases, we find additional grounds for optimum. Malaria, one of the most devastating chronic infections, has almost disappeared from the United States. Syphilis and tuberculosis—two other chronic infections—are being rapidly reduced to a relatively low rank as causes of death and disability. The control of syphilis eventually will show, even in the older age groups, substantial reductions in syphilitic heart disease and psychoses due to syphilis. Recent improvements in treatment now make it possible to control undulant fever as a chronic disease.

In the past two years, the Federal Government, numerous voluntary agencies and private foundations have greatly augmented research in the chronic diseases and physical medicine, through aid to the Nation's institutions and individual scientists. From this expansion of scientific study, we can expect rapid advances in one or more phases of chronic disease control.

How, then, shall we begin to apply widely the existing knowledge of chronic diseases? How prepare for future advances?

Control of many of the chronic diseases is a practical goal. The public health concept is to build a long range program upon prevention, early diagnosis, adequate and continued treatment, and rehabilitation.

As in the great campaigns against syphilis and tuberculosis, we can go out into the highways and byways and search for the undiscovered cases among the supposedly healthy people. We can not only search for the frank cases of disease, but for the conditions that predispose to chronic illness or that are its precursors.

Mass Screening

The Public Health Service, in cooperation with State and local health departments, is already experimenting with methods to extend mass case finding techniques for several chronic ailments. In about 30 minutes, an individual passing through a "screening" line can be given a chest X-ray; blood tests; urine analysis; blood pressure determination; measurement of height and weight; and tests of vision and hearing.

The results of such combined case-finding programs indicate that if 1,000 apparently well adults are given the battery of tests, over 900 instances of chronic disease or defect would be found.

Tuberculosis, other diseases of the lungs, syphilis, diabetes, anemia, high blood pressure, obesity, and defects of vision and hearing can thus be "screened" out for diagnosis and corrective treatment. Many individuals will have multiple symptoms, especially in the older age groups.

Chronic diseases occur singly, over long periods of time, usually without obvious signals to the patient. Epidemic diseases strike swiftly, affecting large groups in short order. No community can or would ignore an epidemic. The multiple screening plan would serve to arouse both families and communities to active concern for the prevalence and threat of undetected, untreated chronic disease.

Watch That Fat!

On the preventing side, early treatment can greatly reduce the disability due to chronic disease and can prevent premature death. One of the immediate

values of public health activity in this field would be the control of obesity. The relation of obesity to heart disease, hypertension, and other chronic diseases is well known. The death rate among persons 55 years of age and over, who are 40 per cent over weight, is 65 per cent higher than among people in the same age groups who are of normal weight. Such data support the need for developing an obesity control program.

It is far more difficult for an obese person to maintain normal weight, once he has achieved it, than to bring his weight down to normal. Medical supervision may be needed for long periods. The Public Health Service is supporting joint projects in obesity control, with the New York City Health Department and the Boston, Mass., Dispensary. In the latter, experiments are being conducted to determine whether psychological factors that adversely influence weight control can be overcome by group therapy.

Many new and improved tests are being developed. Mass case-finding tests for heart disease and cancer will be added in the foreseeable future. If, in the meantime, our multiple screening methods are organized and operated to smooth functioning, we will be in a position to detect and place under treatment many more adults who need preventive services, treatment, and rehabilitation.

Community Services Needed

The quality of medical and hospital care for the chronically ill and for the aged can be improved most rapidly by organizing our existing community services effectively, even while we are trying to build the additional facilities which we need. The home care project developed by Doctor Bluestone at Montefiore Hospital in New York is destined to be emulated in many parts of the country. The outstanding characteristics of this program are the planning and teamwork which assure the patient continuous supervision and expert care, without the often fatal break between hospital service and discharge to the home or to a nursing or boarding institution.

Rehabilitation

Rehabilitation—the fourth basis of chronic disease control—is of equal importance with the other three. All services designed to care for the chronically ill and aged will contribute in some degree to improvements in their health status. The advantages of a rehabilitation program to restore physical and mental functions are so obvious, however, that the provision of facilities and services for this purpose cannot be omitted from any sound plan for older people. Rehabilitation services can be integrated with a chronic disease control program, despite the variation in organizations concerned.

The citizens of every community possess qualities of leadership needed to plan and establish a system of integrated hospital, medical, public health, and rehabilitative services. We only need to find better ways of organizing and administering out services. Recent amendments to the National Hospital Survey and Construction Act make it possible for the Public Health Service to aid State and local governments, public and private non-profit institutions in studies and demonstrations leading to coordinated systems of hospital care. Such research will involve the integration of large teaching hospitals, regional and small community hospitals. It will involve, in many instances, the relation of nursing and convalescent homes, out-patient services, housekeeping, visiting nurse, and medical social services to hospital care.

In no other field is there greater need for coordination of facilities and services than in programs for the better health of older people. Public health workers, social welfare agencies, hospital administrators the country over are increasingly aware of the need for action. Such official groups as this joint legislative committee illustrate the widening public interest and the deepening public concern. The problems are both perplexing and vast. I am confident that if the persons all concerned with solving the problems of aging will work together with firm purpose and selflessness, keeping the interest of the individual patient uppermost, we shall work out effective methods for ensuring better health to our older people.

Medical Care for Prolonged Illnesses

By Dr. E. M. Bluestone

Director, Montefiore Hospital for Chronic Disease, New York City

THREE vital agents are involved in any discussion of the economics of medical care for prolonged illness: (a) the patient, (b) philanthropy and (c) government. In the voluntary, non-profit hospitals of this country the income from all patient sources toward the cost of their maintenance last year was 89 per cent. The relative burden of cost for their care on philanthropy and government was, therefore, 11 per cent. It is only necessary to add that if philanthropy does not make good its share, it is clear that government must be invoked and no one has the right to complain when, in circumstances like these, government does step in to help dependent people who cannot help themselves or get volunteers to help them.

What I am stating here applies to any hospital, or any type of medical care, which the sick, the near-sick or the recently sick may require. However, as we transfer these observations from the so-called "acute" general hospital to the "chronic" hospital, in an age when such artificial and demoralizing distinctions are still being made as a matter of actual practice, we cannot help noting that the contribution of the patient toward his care is progressively reduced with the continuance of his illness. Patient suffering from prolonged illness, known too often as "chronic" patients in the hopeless and incurable connotation of the term, become involved eventually in a vicious circle from which the philanthropist, with or without the help of the taxpayer, must provide an escape. Poverty and prolonged illness pursue each other relentlessly where society does step in to break the circle.

In the only voluntary general hospital of its kind in America devoted to the scientific care of prolonged illness, namely Montefiore Hospital in New York City, the total contribution of all of its patients toward their care, on a comparable basis, is 24 per cent. In this hospital ward patients, as part of the total patient group, contribute only 6 per cent toward their maintenance. The burden that must be borne by philanthropy and government, with patients suffering from prolonged illness, becomes heavier as the patient's financial reserves disappear.

This financial problem is before us more pressingly than ever, in view of the sheer numbers of people suffering from prolonged illness and, in particular, the relation of such illness to the aging process. There are worse things in this world than dying young, or dying suddenly. We are learning painfully that there is such a tragic thing as dying on your feet, in a wheelchair, on a stretcher, or in bed, over long period of time. We should therefore be as much concerned with the discomfort and unhappiness as we are with pain and with the prevention of death. Prolonged illness is more characteristic of age than of youth, though by no means limited to age. The reason for this is that the human body, as it wears out and as it acquires a succession of medical episodes through life, becomes progressively less resistant to the ravages of illness. We are getting considerable help these days through the wonderful contributions of scientific medicine, but the net effect of these contributions is to prolong life in terms of years. The productive medical scientist has been placing in the eager hands of the social worker golden opportunities for joint effort in the exercise of a relatively new specialty, known as social medicine or human ecology, which has for its ultimate objective the happiness of the aged as well as of all others who can benefit from its ministrations. It is to this specialty that philanthropy and government must look in a joint effort to solve the problem created by age and by dependence generally.

Acute and Chronic Cases

These thoughts lead me to complain about the difference between acute and chronic or, what is more to the point, between the urgent and the non-urgent in community-reaction to varying pressures. It is now clear to any student of medicine and the social sciences, that the distinction still being made, to the detriment of the patient suffering from prolonged illness, between "acute" and "chronic", is a survival of the pre-scientific era. The response to urgency has thus far governed the charitable heart, but I submit that the acid test of charity, in its most philanthropic sense, is the response which it makes to less urgent situations—to the unvoiced appeal of the patient sufferer from prolonged illness. Response to urgency is compelling and relatively satisfactory. As long as the feeling of mutual aid prevails among men we will be able to count fully and heavily on it in acute situations. But we have come into an era of longer life, and of relatively longer periods of illness which may

lead to social dependence. We have also come into an era of greater availability of medical and social ways and means of dealing with them and the sooner we plan for the less urgent, the better. The threat of imminent death, and the presence of agonizing signs and symptoms, will revoke an immediate response in almost every case.

We must now accept a cardinal principle of preventive medicine coupled with a cardinal principle of social medicine, under which every effort must be made not only to prevent illness but, if we are successful in these efforts, to prevent death, chronicity, complications, sequelae, relapses, and social dependence. How is this to be achieved; what is the cost of achievement, and what are its benefits?

How long can we continue the unjust, inequitable and often indecent distribution of medical facilities which characterize our time? The acute general hospital has a try at the condition. If it succeeds through its own efforts, with or without the help of Nature, well and good but, if the condition does not respond quickly to treatment, the patient must look to his safety and his comfort elsewhere. But where does one find a medical facility which is the equal of the general hospital? It is not enough to point with pride to the achievements of the modern general hospital and to say, which is relatively true, that it is the very best resource of civilization for the practice of scientific medicine. Why does it limit its benefits so severely? What about the non-acute—that vast segment of suffering humanity which is less vocal, still needing a hospital bed and equally deserving of the best that scientific medicine affords. The clinical and social problems confronting the "acute" general hospital are relatively simple and more quickly dealt with. They are more dramatic for the philanthropist and more spectacular for the clinician. However, it is the patient suffering from prolonged illness with a difficult, stubborn, and often complicated clinical condition which gives a slow response, if any, to treatment, that remains an eternal challenge to the man of science, to philanthropy and to government.

No one seems to differ, in principle, in the contention that neither age nor duration of illness should stay the hand of the planner in the field of medical care yet, in practice, all but the acutely sick are outsiders as far as the superb facilities of the modern general hospital are concerned. Look into your non-acute medical facilities, and the exceptions which prove the rule, and you will agree that we must seek new, more equitable and more decent ways of dealing with humanity's problem of medical disability. The science of medicine must share the wealth in such a way that those people will benefit from it who need it, for this is the essence of medical philanthropy. The social workers, and the rehabilitationists working in the medical field, are leading the way. How long can the "acute" general hospital limit its magnificent facilities to those alone who enjoy the benefit of a snap diagnosis, as well as a snap diagnosis of a short-term illness in the admitting room?

The Plight of the "Chronics"

Let me state the case this way. There are three major reasons why an "acute" general hospital transfers patients suffering from non-acute illnesses to other institutions. The first is the progressive loss of interest in such patients by the medical staff. This is due to the fact that these patients are considered to be unproductive and therefore undesirable. The result is that the administration of the hospital is under pressure to get such patients out, regardless of the fact that there is no better facility in the world for their care at a time when their need for a hospital bed continues. This lack of clinical currency as well as the lack of financial currency can, however, be compensated for by (a) financial subsidies to doctors to make up their losses from private practice; (b) laboratory facilities for the stimulation of scientific talent and scientific interest in the problems of prolonged illness, and for the recruitment of additional doctors with selective interests in the various aspects of prolonged illness; and (c) classrooms and conference rooms to stimulate the teaching.

Every bed in every hospital, no matter where it is located or by whom occupied, is potentially a teaching bed and potentially a research bed.

The first reason for the transfer out of the "acute" general hospital of a non-acute patient will disappear as the planner proceeds to apply these remedies and integrates functional and structural facilities for the combined benefit of both stages of illness.

The second reason for the transfer of a patient suffering fom prolonged illness out of an "acute" general hospital in his progressively meager financial contribution toward his care. But this reason for transfer too can be satisfactorily met by a subsidy to the hospital from one source or another. What the patient cannot contribute himself toward the cost of his care must obviously be contributed either by philanthropy and/or government. Once the medical needs of this kind of patient are established he should be assigned to whatever facility can do him the most good regardless of his financial ability.

The third reason for transfer is the greater relative need of the available bed in the "acute" general hospital by the acutely sick patient. If the supply of beds is not equal to the demand then obviously the most urgent must be dealt with in the order of their urgency, but this reason for transfer must disappear

where supply can be made to meet the demand. Instead of establishing the additional required bed at a distance from the prime diagnostic and therapeutic facilities of the general hospital, it should be established within the hospital compound. This can indeed be done much more inexpensively within the general hospital, since it avoids the expense of duplication and the handicap of distance to all concerned, unless, the hospital can continue to furnish the required medical care to the patient in his own home. We shall still face the danger of neglect of the chronic sick in the presence of the acute, because of the transfer of interest, sympathy and attention from the former to the latter, but this will in the end disappear. There is far more danger of neglect with the rustication of the non-acute patient at a distance from the best of medical care at a time when he may need it most.

Medical Crumbs

Besides, the tenacity and stubbornness of prolonged illness must be matched equally by tenacity and stubbornness in the medical and social scientists who are, in turn, supported by philanthropy and government. This can only be accomplished if the patient is kept before their eyes and not transferred to a spot where he can gaze at the landscape while waiting for medical crumbs to be thrown in his direction.

These remarks are limited to the patient suffering from acute illness as well as to the patient suffering from prolonged illness. It is of the greatest importance not to confuse either of these with (a) the convalescent type of patient or (b) the so-called custodial type. The convalescent patient is safely on the road to recovery from an acute or chronic illness and may or may not need the continued use of a hospital bed. The custodial type has made only a partial recovery and is left with a burnt-out disease, an irreversible scar or a residual handicap, which may or may not require a hospital bed, but for social reasons sometimes requires some kind of institutional care. It will readily be seen that the aged patient falls into one or the other of these four categories: acute, chronic, convalescent or custodial. He is, besides, an unattractive problem in preventive medicine and in social medicine. It is a mistake to thing of his illnesses as coming under the single heading of any such social specialty as geriatrics. Whatever his illness, it belongs to the specialist who has been trained to deal with it. The geriatrician can only hope to be a case-finder, a coordinator and a general practitioner to the aged, as the doctor often is to the young.

New Criteria for Hospitals

Let us now bring these thoughts together, developed largely in a great hospital laboratory for the study of social medicine, and see the program for medical care as a whole. Until such time as we are able to build in accordance with this blueprint, we can at least elaborate a functional coordination which will lead by planned steps to the ultimate achievement of the program.

To begin with, distinctions between acute and chronic should disappear and a new criterion for the admission of a patient to the general hospital should be recognized and implemented, namely the need for a hospital bed. Regardless of other consideration, this need for a hospital bed should control admitting policy. A patient who needs a hospital bed for the care of his condition, acute or chronic, should get it in one location, the general hospital. Broadly speaking, these needs are (a) a period of close observation in the highly concentrated diagnostic and therapeutic atmosphere of the general hospital, where medicine is practiced intensively and scientifically on a group basis; (b) what is popularly known in the hospital as a "workup"; (c) some form of service like a major surgical operation; and (d) some form of treatment which can only be administered on the hospital premises, like deep radiotherapy. These are the four major criteria for admission to hospital beds. The poverty of the patient, or the desire of the doctor for the concentration of his patients in one area for his personal convenience, are in themselves invalid criteria for hospitalization and represent a very expensive form of care which can in fact be avoided. When the patient does not need a hospital bed for his particular condition, or when he no longer needs a hospital bed, the same quality of care must be offered by the hospital to him in his own home, or in a substitute for his home—an intermediate type of institution, preferably though not necessarily on hospital grounds.

Transit of Patients

Let us see how the factor of urgency applies in such a combined and integrated intra-mural and extra-mural setup where the hospital radiates scientific care directly to the patient if he is indigent, or in co-operation with his doctor if he is not. With the disappearance of the solid wall of the hospital, figuratively speaking, and the appearance in its place of a combined stationary and mobile service, by which most of the scientific facilities are centralized intra-murally, the factor of urgency can be related by a simple formula to the factor of distance. The greater the urgency of the patient's condition, the less the distance between him and the central facilities of the hospital. The less the urgency of his condition, the greater the distance. To illustrate, the patient who is exsanguinated, or in shock, must remain within the hospital operating room till the urgency of his condition is at least partially relieved. With progressive

relief he can be removed (a) to a recovery room alongside (b) to a room on the same floor (c) to a room on a floor above or below (d) to a room in a pavilion alongside (e) across the street and, finally (f) to his own home, or to a substitute for his home. Hospital care accompanies him in every case, reducing its intensity to meet the requirements of medical necessity. Hospital quality is guaranteed to the patient at all times. He is as much a hospital patient in his home as his former neighbor who remained on the hospital wards. The same social and scientific hierarchy stands guard over him, under the protecting wings of the hospital, and there is a free exchange of intra-mural and extra-mural patients on a priority basis.

In a teaching hospital, the teaching material and the opportunity for teaching thus provided in a combined program, are priceless. In a hospital fortunate enough to do scientific research, the patient is under observation and control under this combined plan for a period of time which is limited only by death. Such a complete, comprehensive and continuous plan of medical care has no equals and no competitors in a democratic society. The hospital and its out-patient department representing the intra-mural services, and the home and the substitute for the home representing the extra-mural services, employed for the benefit of the indigent, the insured groups and those who can afford care on an individual fee basis, can do away with the inequities and the indecencies which are still being tolerated. In no other way can the taxpayer, philanthropist, medical man of science and social worker generally serve the sick and the near-sick to better advantage. Select your patient, or the clinical condition from which he is suffering, and the doctor working in collaboration with the social worker can find for him in this combined plan of medical care the place he needs most. And let me remind you at this point that when the problem of prolonged illness will be solved we shall know that we have solved almost all of the problems of medical care.

We shall doubtless find that we need less beds within hospital buildings than we thought we needed when we were engaged in expansive and expensive post-war planning only a few years ago, and also that we need more trained personnel, combined with more scientific facilities, in the hospitals that we now have. We need more financial subsidies, more teaching and more scientific investigation in modernized buildings which, until structural unification can be worked out, should have the benefit of functional unification. On the other hand, the housing expert should take into account the incontrovertible fact that better housing means less of a burden on the community for hospitalization.

We have oversold the hospital to the public. Fortunately the way back is inexpensive. With a cost of two dollars per cubic foot of hospital construction, and with the present-day requirement of 10,000 cubic feet to serve every hospital bed, the capital investment is rapidly becoming unbearable when the facility is used indiscriminately. Moreover, the cost of maintenance has risen to unbearable heights on behalf of too many people who do not require such costly facilities. In circumstances like these we must look to the inexpensive bed in the home of the patient and use it to his best advantage. Far more important, however, than the prevailing high costs of medical care is the opportunity which extra-mural hospital service radiating into the patient's home affords for the individualization of care on a personal basis. The maintenance of the identity of the patient, his privacy, his self-respect, his freedom of movement unhampered by demanding neighbors who are strangers to each other in the hospital ward, and his presence in the bosom of his family in the natural environment of his home, improve his comfort and speed his recovery. The patient has, indeed, the pleasant illusion that the hospital exists for him alone and that it stands ready, as it indeed does, to serve him under all circumstances. Let me remind you that, with the best intentions in the world, the hospital, knowing the patient an average of only eight and a half days and applying a mechanical routine in his care, cannot help adding insult to injury. It should not be offered as a resource unless there is no better method of dealing with the patient's problem.

Home Care Cost Lower

With an experience of almost three years in the field of comprehensive home care under hospital auspices, we found the cost of such care to our hospital, on a comparative basis, to be approximately one-fourth of the cost of ward care. Moreover, we have approximately one-fourth of the cost of ward care. Moreover, we have found that patients are more comfortable in their homes and we confidently expect to prove by statistics that they get well quicker at home because of the added factor of personal comfort which dominates the mental attitude of the patient and his family.

It is our hope that hospitals generally will adopt the criteria for admission which I have outlined here, and distribute patients in wards, in out-patient departments, in the homes of these patients and in substitutes for these homes, under the protecting wings of these hospitals, to the end that every man, no matter what his age or how long the duration of his illness, will find readily available to him the exact facility which he requires to restore him to health.

Hospitals and Our Elderly

By Commissioner Marcus D. Koegel
Commissioner of Hospitals, New York City

Hospitals are places for the congregate care of the sick whether the illness be acute or chronic, and the victim of disease young or old. However, the two extremes of ages are often forced upon hospitals even though no disease is present. The hospitalization of the well baby, because society has failed to provide a more suitable shelter for the infant or of the elderly, and for no better reason, constitutes the imposition upon our hospitals of a great burden aside from the potential and actual damage to the innocent recipients of our charity, by an intimate association with disease and disability.

The problem of the child, however, is a minor one compared to the growing problem of the aged. In dealing with this situation we must develop some fundamental concepts. One of these is that general hospital facilities should be used for the elderly requiring active treatment of either an acute or chronic illness and that some other type of accommodation is needed for the infirm aged, the physically handicapped aged or for the oldsters who are well and homeless.

We can shout this principle from the rooftops but as long as those other types of accommodations are not provided—the backlog of patients unsuited for active hospital care continues to tie up costly hospital beds and services.

Our adult general hospital population has undergone a shift in age distribution in the direction of the older age groups. This is not unexpected when one considers the increase in the percentage distribution of the elderly in the general population of New York City. The 1948 population estimate assumes a total of one-half a million people (541,678) 65 years of age and over which is more than double what it was in 1930. Older people get sick more often and stay sick for longer periods. As Professor Ginzberg so aptly puts it, by lengthening the average span of life we have "traded a lessened mortality in the earlier years for an increased morbidity in the aged."

Glamour Cases

Our general hospitals do not take kindly to the elderly sick. They have been geared to the dramatic illness, the crisis, the hectic flush, the high fever. Our whole philosophy is one of youth and glamour and plenty. The aged patient brings apathy, garrulousness, irreversible damage and incontinence. None of this is pleasant.

Our reorientation must begin in the schools of medicine and in the schools of nursing and we must find some means to awaken the present schools of nursing and we must find some means to awaken the present generation of practitioners to a greater interest and a more dynamic approach to the problems of the aged sick.

An important reason for the disinclination of the general hospital to treat the oldster is that there is often the strong possibility that the bed will be tied up indefinitely. Delays are frequent in discharging elderly people after they have received the maximum benefit from hospitalization. Often there is unwillingness on the part of the patient to exchange the sheltered environment of the hospital for the discomforts of a home long since preempted of affection or warmth. Then there is the resistance on the part of the family to the return of the aged one to the family hearth. In a city such as ours with restricted accommodations and every cubic foot of space worth its weight in gold and filial devotion at a low, the burden of care of the aged at home may become intolerable.

There is one segment of the elderly sick whose reception in our general hospitals is downright hostile. I have reference to the senile psychotic. There is no hiding place for this unfortunate individual and irrespective of the physical condition, he is summarily relegated to a facility for the care of the insane. Many mental conditions of the aged are transitory but the disturbance must be brief indeed if the patient is to escape the stigma of commitment to a State institution.

I do not propose that the municipality assume the responsibility for the patients with personality disintegrations and psychoses which have every appearance of being permanent. We must however develop a more compassionate approach to the short-lived episode of confusion and disorientation so often a concomitant of medical and surgical ailments in the elderly.

Five-Point Program

What rearrangement is necessary so that the general hospital may adapt itself to provide properly and economically for the steadily increasing number of aged patients?

1. It should develop a chronic disease wing or unit where the aged patients can be transferred as soon as the acute episode of the illness is over and prior to transfer to home care or discharge to home, to a nursing home or custodial institution. The close relationship of such a wing to the general hospital will make readily available all of the hospital services and good care can be furnished the patient at a cost much below that in the acute section of the hospital.
2. It should provide a small suite of sound-proof rooms and ancillary facilities for the temporary care of the non-custodial psychotic.
3. The general hospital must organize a dynamic program of rehabilitation which in the aged will be geared to develop in the patient the ability to meet the daily demands of living and to restore him to the greatest degree of usefulness and self-sufficiency.

   Idleness and inactivity encourage deterioration and a breaking down of morale; therefore, if planned activities and interests are available, mental and physical deterioration is less progressive. It is well for these patients to know that while they are ill there is a definite plan for their rehabilitation—a program of activities, within their area of accomplishments, which will help them to re-establish the normal pattern of living and restore feelings of confidence and self-respect.
4. An active home care program must be established. The extension of hospital care into the home is no longer in the experimental stage or on a demonstration basis. The highly successful program of the Department of Hospitals and the splendid pioneering efforts of the Montefiore Hospital in New York have established home care as a necessary tool in any system of comprehensive hospital care.
5. The general hospital must strengthen its services for the care of the ambulatory patient and make it possible for the ambulant aged to receive prompt attention and good care in its Outpatient Department. In order to insure the maximum utilization of outpatient services it may be necessary to develop a voluntary motor corps for the transport of the elderly to and from their homes. Thought will have to be given to the elimination of the architectural barriers which render access to clinic services a nightmare to the disabled and infirm. Above all, the bustle and the hurry and the attitude of disinterest and irritation will have to be replaced and the elderly patient made to feel that he is wanted and that the hospital services are there to benefit him.

Whatever the initial outlay for these changes, the end results will reflect great savings. The bottlenecks which tie up active hospital beds with inactive patients, the mental and physical deterioration of the neglected elderly patient—all these will cease.

Reorganization Only Part of Answer

Unfortunately, however, the problem of hospitals and the elderly is not solved with the reorganization and modification of the services in general hospitals. Today the patient over 65 makes up almost 7 per cent of the population of New York City. By 1960 he is expected to account for 9 per cent of the total population and by 1980 for over 11 per cent.

To supplement the chronic disease service of a general hospital we still need in a city such as ours a hospital of the type of the Bird S. Coler Memorial Hospital. This 2,000 bed facility now going up at the north end of Welfare Island will provide the outlet for the chronic disease units of the general hospitals. It will take the bedridden chronically ill and aged patients, the handicapped and the infirm for whom other arrangements cannot be made. This will be by no means considered the end of the line, for the most active rehabilitation program will be developed. Care will be individualized and every effort will be made to get the patients out of bed—to take care of themselves and restore self-confidence and some measure of independence.

Affiliation of the hospital with a medical school will assure a continuation of professional interest and the availability of even the most highly specialized medical services. Experience has taught us that it is unwise to isolate a hospital of this type geographically from the professional skills that are required to service it. In fact, the closer this type of hospital is to a general hospital the better for all concerned because it is then possible to integrate the services with a general hospital and to arrange for the rotation of the house and resident staffs through this unit.

To maintain the interest of the professional staffs it is imperative to provide incentives in the form of research facilities. This not only attracts good men to the hospital but pays valuable dividends far out of all proportion to the small investment in space and equipment. At the Bird S. Coler Memorial Hospital we not only failed to do this but we were lax in

planning adequate X-ray and laboratory services. These deficiencies will be remedied. Actually it was no one's fault. Our thinking hadn't crystallized to the point where we were sufficiently sure of ourselves. We know now that the apathetic era of care for the chronically ill belongs to a bygone day and that we have now entered a new age when the most hopeless patient is approached in the spirit of hopefulness and with an enthusiasm and zeal that transcends all difficulties.

In a city the size of ours there is room for still another type of hospital in which the elderly make up a considerable proportion of its population. I have reference to a research center in chronic diseases of the type of the Goldwater Memorial Hospital. This was planned as the laboratory where selected patients and selected diseases would be studied so that some light could be shed on the aging process and the long term illnesses that plague our people. Here new techniques would be developed in treatment and specialists and technical personnel would be trained to take care and take their place on the staffs of other hospitals to practice and teach what they have learned.

Unfortunately the numbers of chronically ill, aged and infirm grew rapidly to such large proportions that in no time they choked the adult services of our general hospitals and flowed over and inundated all of our homes and units designed for their care, including the Goldwater Memorial Hospital. As a consequence, the research activities of the Goldwater Memorial are limited and this great hospital will not be able to fully carry out its purpose until our construction and modernization program has been considerably advanced.

In spite of all handicaps, however, the Goldwater Memorial Hospital has made many significant and fundamental contributions.

Full justice cannot be done to the subject of hospitals and the elderly without some discussion of the special needs of the aged and what specifications are required in the hospital environment to meet those needs.

Special Environment Factors

The aged require a familiar, pleasant and homelike environment with more than the usual physical comforts, protection from accidents, and special psychological and emotional support.

Physical comfort includes such items as warmth, good lighting, an adequate place for personal possessions, easily accessible toilet and bathroom facilities, privacy (small units), quiet (soundproof areas), comfortable furniture, suitable clothing and shoes in good repair, between meal snacks if and when desired, a magnifying glass and hundreds of other little things which make for comfort and which are of paramount importance to the elderly.

Protection from accidents is particularly important in this group as older bones are more brittle, older eyes are less keen and the recuperative powers of older bodies are less responsive. Protection from accidents implies attention to well-lighted stairways and corridors, sturdy railings in good repair, ramps where possible instead of stairs, stairs free from impediments, non-skid floors, rubber mats in the bathroom for use in the bottom of the tub to prevent slipping, thermostatically controlled water, plumbing in good repair, hand rails and elevated rests in bath tubs to eliminate the possibility of slipping and to make getting in and out of the tube less taxing, electrical equipment in good repair, wires completely insulated and sturdy plugs and switches conveniently placed to eliminate the need for searching for them in the dark, low beds for the ambulatory patient to prevent falls.

Furniture in the patient unit should not be too hard and not too soft, not too high and not too low. It should be anchored, as the elderly patient is apt to lean against beds, tables and chairs and lose his balance. Armchairs should be provided. Wheelchairs should be equipped with special foot pedals. Mechanical devices facilitate lifting heavy, helpless patients from their beds and prevent injury to workers. Beds equipped with protective sides prevent falls from bed. Doors sufficiently wide to admit wheelchairs permit easy transportation of patients.

Furniture should not be moved after the older person retires so that if he awakens during the night he will not be unfamiliar with the arrangement. Night lights eliminate the confusion caused by darkness. All of these are means of protecting the elderly against injury.

The older person must be encouraged to give thought and attention to items of personal hygiene. Good planning of the bathroom and toilet facilities will help the oldster take better care of his personal needs.

Bathrooms should be equipped with movable shower sprays and the cubicles should be sufficiently wide to permit the entrance of wheelchairs. I do not know the solution to the bathtub situation except to eliminate bathtubs. However, we need bathtubs at the appropriate height for the ambulatory patient; at stretcher height for bed patients; low tubs for arthritics so that they can step into them without danger and portable tubs for patients who cannot be transported to the bathroom. Some day somebody will actually take the bull by the horns and eliminate all bathtubs.

The toilet stalls must be wide enough for wheel-

chairs and hand rails must be provided so that the patient can support himself. Commode-like toilet seats are necessary. Call bells should be provided in all areas, and patients taught their function. Wash basins and mirrors should be placed at a convenient height to enable wheelchair patients to use them comfortably.

Feeding the Elderly Patient

The elderly patient offers a challenge to the dietitian who has advanced to the point where she is ready to revise the old concepts and discard the practice of limiting their diet to the bread, tea and applesauce regime which has been too long a common and widespread procedure.

It is essential that the nutritional elements of an adequate diet be supplied in generous amounts, and in a form which can be masticated and digested by the elderly person.

We in the Department of Hospitals have in recent years accepted this challenge and completely revised the feeding program in the units devoted to the care of this group. The menus were greatly expanded to insure a higher nutritional value, a greater variety of foods was provided, and the preparation of many foodstuffs elaborated.

Specific food increases included a greater allowance of milk, ice cream and other dairy products, more citrus fruit in a form suitable for the aged, a wider variety of frozen and fresh fruits and vegettables, larger allowances of meat, poultry and fish and a wider selection of desserts and food adjuncts. The size of the portions were somewhat reduced in order to allow for the patient's capacity.

Too much emphasis cannot be placed on the improvement of the food's appearance, the adjustment of tableware and cutlery to the handling abilities of the elderly person, and the decor of the dining area.

Certain structural arrangements must be made for feeding areas—gently sloping ramps leading into the dining rooms, or small dining rooms close to the patient's bed location, wide aisles between tables and specially sturdy construction of chairs and tables.

Table service is usually the wisest choice for elderly people, but where the psychological aspect of self-help is important, partial cafeteria service can be effective therapy.

In hospitals where the stay of the chronically ill or the elderly is prolonged and the number to be cared for is great, beauty shops must be provided for the ladies and barber shops for the men. The ladies also need readily accessible to them a place to wash intimate personal things.

There is a great need among the elderly patients for recreational and social activities and they should be given the opportunity for religious observance.

I have carefully steered clear in this presentation of the public home for the aged and the nursing home. Both these facilities are essential elements in a program for the elderly. The large nursing home in fact often approaches closer to the hospital and our public homes frequently become filled with sick aged who overflow their infirmaries and should be in hospitals; on the other hand the chronic disease service of a general hospital or the chronic disease hospitals have many patients who require only shelter and affection.

The nursing homes can stand considerable improvement in the quality of care they render and this is an area in which we hope to exert some influence in the future. We are very anxious to develop a type of association which will permit us to transfer to the nursing home from the hospital patients suitable for home care but who do not have a proper home. Today our home care program is limited to patients where the home environment is suitable for the extramural care.

The hospital care of the aged is merely one facet of a large problem. A major effort of the community should be to keep the aged at home as long as they can be kept there with comfort and safety. Serious thought should be given towards the provision of dwelling units and community services designed especially to make the same possible and every assistance should be rendered to simplify the extension of hospital care into the home when this becomes necessary.

We will never have enough hospital beds for the aged sick or public homes for the homeless aged if the individual permits himself to be easily swayed to surrender to the community the very personal responsibility which is his for the care of the aged and infirm.

No public home can ever take the place of the family hearth and no hospital bed can ever compete for comfort and security with the bed in one's own home.

The Physicians' Contribution to a State-wide Program for the Aged

By Dr. Frederic D. Zeman

Chief of Service of the Home for Aged and Infirm Hebrews, New York City

THE WORD "geriatrics" is an extremely useful word, gathering into a very short space a number of varying concepts. But the word geriatrics should not be interpreted to mean that the care of the aged is necessarily a medical specialty, for actually all the medical specialties with the exception of pediatrics and obstetrics have to do with old people in one way or another.

Furthermore, it must be realized that these problems are increasing so rapidly that we may reasonably expect that the care of the aged is going to, in a very short time, comprise 75 or 85 per cent of what we call internal medicine.

It is, therefore, worth while today to discuss what the physician's responsibility is in relation to these problems and to point out the many ways physicians come into the picture, and, furthermore, to point out something as to what physicians have been doing in this State and throughout the Nation.

About two years ago I spoke before the Annual Conference of the New York State Conference of Social Welfare at Buffalo on a state-wide program for the aged and the chronically ill. At that time I drew up as much for my own information as for the information of my audience a diagram which indicates the set-up or the possible set-up of a state-wide program.

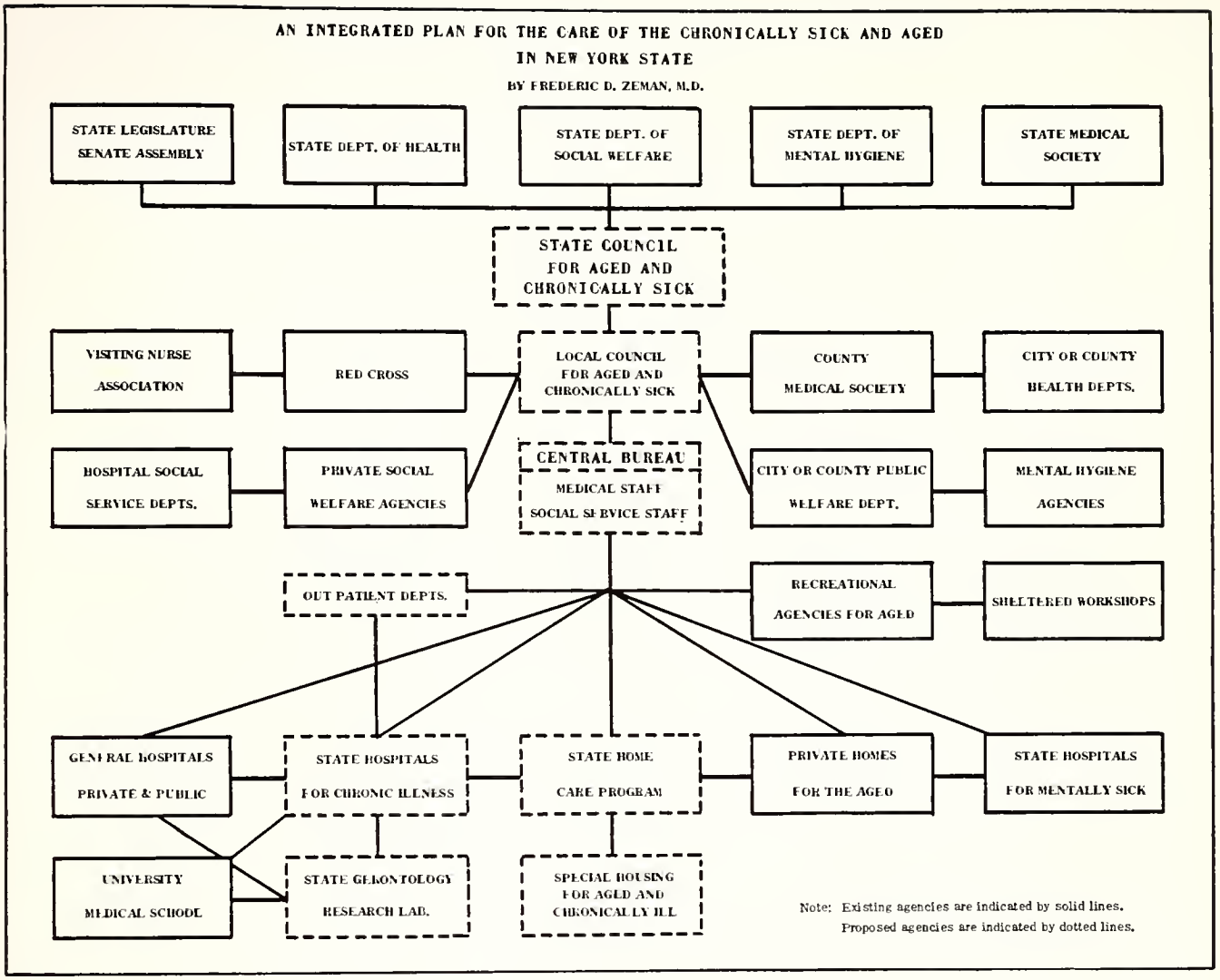
Socio-Medical Aspects

Now, I have been very fortunate in my own training. I was taken in at a very early age by a very remarkable group of social workers associated with the Welfare Council of New York City. And, through their efforts and through their continued queries, I was led to go further into the social aspects of these problems than many of my colleagues, and so thereafter I began to be confronted with two concepts. One is the general principle of the Welfare Council as a coordinating agency for all of the activities in a community, and, secondly, the principle of a central control bureau for the care of a particular group in the community. I was helpful a few years ago in setting up such a bureau for the care of the Jewish aged in New York City, and this bureau has been functioning most successfully under the direction of Miss Flora Fox for a period of years, now, and it serves as a central office where old people in need of assistance can not only find information but can be examined, their functional capacities can be determined, and advice can be given to them on the basis of a careful medical and social service study.

Now, as chart indicates, you will find on the topmost level the Legislature of the State, meaning the Governor, the Senate and the Assembly—all the elected representatives of the people—and, in association with them on this highest level I have placed the State Health Department, the State Department of Social Welfare, the State Department of Mental Hygiene and the State Medical Society. These groups would send, according to my plan, delegates to a State Council for the Aged and the Chronically Ill, and the State Council would work in each community through a Local Council or Welfare Council for the Aged or Chronologically Ill.

You will be interested to see how many agencies in each community would naturally share in the work of the local Welfare Council. You will find that immediately involved are the hospital service—social service departments, private social welfare agencies, the Red Cross, the Visiting Nurses Associations, the County Medical Society, and the city or county health departments, the city or county public welfare departments, and mental hygiene agencies. That is a very large and diverse group, and each one is particularly interested in certain aspects of the care of the aged, and each one has a definite and important contribution to make. Therefore, their co-ordination, the integration of their activities, is something we must try, as citizens, to accomplish.

These agencies, working together, would then set up a Central Bureau, and that would have a medical and social service staff, and operate out-patient departments. They would also operate recreational agencies for the aged, which have been so successfully designed in this city by the Department of Public Welfare under the leadership of Mr. Harry Levine. Sheltered workshops would also be one of their functions, but I want you to realize particularly the other agencies that would be involved: the general hospitals,



public and private. As Dr. Monroe pointed out, the general care in the hospitals has steadily increased. Two men on the staff of Bellevue not long ago wrote an extremely interesting article under the title of, "The Patients Are Older and Stay Longer." Then, coupled with that, you have the private homes for the aged, the state hospitals for the mentally sick, the state hospitals for chronic illnesses, and the university medical schools. Then it would be necessary to include a State Gerontology Research Laboratory as well as special housing for the aged and chronically ill.

Now, as you see, many of these agencies are already in existence. It would be necessary to create certain new ones, such as the State Gerontology Research Laboratory. The state hospitals for chronic illness, I believe, may be on the way. They have been highly recommended by the Health Preparedness Commission of this state.

The home care program is something we should give a great deal of attention to. It is actually the future hope for the care of the aged. We have set up such a bureau in the Central Bureau for Jewish Aged, and in cooperation with the Jewish Family Service, particularly through their home-maker's service, and under our home care or extramural program, as we prefer to call it, we provide for old people in their own homes, visiting physicians, visiting nurses, visiting houseworkers or homemakers, and we hope, in time, to supply visiting occupational therapists and visiting volunteer visitors.

The number of old people is increasing so rapidly that institutional care is no longer possible, even if it were desirable. It certainly is not desirable except for people who are chronically ill in one way or another. Our whole effort must be to extend this home care program. But I want to say, however construc-

tive theoretically this home program is, it presents certain defects from the standpoint of the mental attitude of the prospective client. We have found from experience when old people come to us asking admission to the home they only do so after they have spent long hours of soul searching, long hours of study and discussion with the family, and when they have finally made up their minds they want to go into an institution they will not be put off with a substitute program. It is, therefore, necessary that we educate the public in the ways of the home program, and one of the ways we do that is to assure our home care clients when the time comes they need institutional care they will have a first priority on the services of the institution.

Attitude of Physicians

I want to point out particularly that the physicians of this state and the physicians of the Nation are deeply and profoundly interested in and aware of these problems. I have had the same experience that Dr. Monroe has had with colleagues who seem to think that they can still practice on what they learned in medical school about old people, and who seem to think there is nothing more that they can learn, even today. I have also had the experience of being treated with rather poorly concealed contempt and condescension by some of my colleagues who can't understand how I can possibly be interested in old people. Actually these men are missing out on one of the great experiences in a physician's life if they have never had the opportunity of taking care of old people. Whereas the younger person expects everything as a matter of course, the old person is so used to being pushed around by his family, and so forth, than when he meets a physician who brings to him the understanding that Dr. Monroe does, for instance, he is put a little off balance and he doesn't know just how to take it, and his gratitude is something that is really touching and puts the physician distinctly on his mettle and makes him think that this is a human being for whom he must put forth his very best efforts.

As Dr. Monroe pointed out, today we are able to do most important things for people medically. The control of infections of old age by antibiotics has changed the picture completely. The death rate from pneumonia has dropped spectacularly. A fatality from disease like erysipelas is almost unheard of nowadays, and it is possible to treat infections of the genitourinary tract and infections of the peritoneal cavity with the greatest success. There was a time not so long ago that a surgeon who would operate on a patient 70 years or over would have been looked at askance by his colleagues—as one who had an itching scalpel. Today it is a common practice in your hospitals to operate on patients over 80—and to operate on them successfully. And the two most important things that contribute to that are improved anti-operative and post-operative care, and improved anaesthesia, and the use of anti-biotics and the abundant use of penicillin and plasma.

The physician's responsibility is in his institutional work, in his work in the general hospitals, in the hospitals for chronic diseases, and in the homes for the aged, too. The homes for the aged, as presently constituted, form a great area for the practicing young physician to earn his reputation. They contain material which is, for the most part, untouched for the physician with an investigative turn of mind, and which will afford him the opportunity of doing work of real value.

Now, the physician in industry has a responsibility to old people because it is up to the physician to decide what a man's functional capacity really is because, as this Committee has so widely publicized, birthdays don't really count—it is what a man can do really counts—his functional capacity—and it does not parallel the number of years you have spent upon this earth, as we all know.

The physician has a great responsibility for education. At the Home for the Aged and Infirm Hebrews we are conducting a course for graduate physicians and have, for the past five years and, with my colleagues, we give about 18 hours each semester, under the auspices of the College of Physicians and Surgeons, given partly at the home and partly at the Mt. Sinai Hospital, in the care of the aged. The registration is gradually increasing—although I must say the biggest registration we had was in the first two years after the war, when men could take the course under the G.I. Bill of Rights.

In addition, we have at the home an affiliation with the Division of Nursing Education of Teachers College, Columbia University. I think it is greatly to the credit of the educators that they realize that the work later on of the nurses is going to be largely working with the older people. We started off two years ago with a one week course for those people studying for higher degrees of nursing in Teachers College. That work has been extended to a two-week course, one week of which is devoted to work in our occupational therapy department and the second week to taking care of old people. In addition, we now have student nurses sent down just briefly for a visit from the St. Luke's Hospital and Presbyterian Hospital. Which shows that these teachers of even undergraduate nurses appreciate the significance of the problem.

Research Needed

The need for research does not need to be emphasized or enlarged upon. We have gone a long way but

there are still many basic, fundamental problems to be explored. The research in this department must be forthcoming in order for us to make further progress. And that brings me to the responsibility of the physician as a member of the district professional societies—as a member of the county, state and national organizations. These organizations are also doing their part. The American Medical Association has co-operated with the American Public Health Association and two other national organizations in setting up the Committee on the Care of the Chronically Ill, which is about to start functioning under the leadership of Dr. Morton Levin, late of the New York State Department of Health and the Executive Secretary of the Health Preparedness Commission. The New York State Society has a Study Committee on Geriatrics and the New York County Medical Society has a Sub-Committee on Geriatrics, headed by Dr. C. Ward Crampton. So that I think you will realize that these problems of the aged require intense and hearty co-operation between physicians and the social workers and the nursing profession for the proper functioning of any kind of set-up that is devised for their solution. I think it is interesting to realize that the very first group in the field met at a meeting of the New York Academy of Medicine in 1928, and at that meeting some of the noted authorities from this country and from England spoke and really gave us the first impetus to the scientific study of the problems of the aging in this country, which culminated some 11 or 12 years later in the publication of the work of Dr. Cowdry "Problems of the Aging," which has gone into a second edition and is just about to go into a third edition, and which actually forms the Bible and reference book of physicians working in this field.

The Functions of a Geriatric Clinic

By Dr. Robert T. Monroe

Peter Bent Brigham Hospital, Boston, Massachusetts

Old age is the time of life when persistent diseases occur most frequently, and when scars of accidents and disease, and deficits of all sorts, steadily accumulate. No one, in fact, can live beyond middle life without showing some evidence of the ravages of time. And so, old people are the big problem in our hospitals and other institutions. In the Peter Bent Brigham Hospital, with which I am connected, one in every three medical service admissions is over 61 years of age. This hospital does not take children under 12, and the proportion of old people in general hospitals probably is less, but it is not likely that they are under one in five.

A survey of the almshouses of Massachusetts four years ago showed that two-thirds of the occupants were over 65 years of age, and two-thirds of them were bed or semi-bed patients. I would guess that age-composition of our nursing homes is equally weighted in favor of old people. Yet old people make up less than 10 per cent of our population.

Old people need their full share of hospital facilities. They respond as favorably to the amazing antibiotics as their younger neighbors. Surgical procedures are now about as safe for them, also, and they need no longer be denied curative or palliative operations because of age. A very great improvement in the quality and the duration of life is available to them.

But I do not believe that they need as large a percentage of our general hospital facilities as they now preempt. It is obvious that many sick old people go to hospitals for minor troubles because they have nowhere else to go. This is a waste of both money and space. For hospital study and care are the most expensive form of medical service, and in many areas there are too few beds to permit them to be occupied without regard to a priority of needs.

When we have hospitals for chronic diseases, and wards for the same purpose in general hospitals, they will be used very largely by old people. In them we can take excellent care of patients with complications of diabetes mellitus, others with persistent heart or kidney failure, and those with fractures and arthritis. They can be our best resource to study the means for rehabilitating patients with paralysis and inadequate circulation. But, again, we must guard against their becoming repositories for terminal care. It is unlikely that we shall ever have so many beds for chronic disease that we can tolerate indefinite residence in them.

Nursing homes enter the picture here. Some will be for custodial care of patients who have been demonstrated unable to improve on active treatment. Other homes will be for the advancement of convalescence to the point where families can take over. Still others may be for minor acute illnesses, such as grippe and sprains, in patients, especially old ones, whose resources at home need such supplementation. If enough of these nursing homes are administered and staffed by local general hospitals, the quality of their care will raise the standards of all above their present deplorable level.

Geriatric Clinics Needed

This completes the list of buildings that seem to be needed to provide for all types of medical care. Yet one needs little acquaintance with old people to see that there must be one more facility. That is a clinic set up especially for them—geriatrics clinic, if you wish. It is the purpose of this paper to describe its functions, and it is based upon 10 years' experience in one. We are well aware of the value of heart clinics, cancer clinics, well-baby clinics, child guidance clinics, and many others. I believe that geriatric clinics will become as useful in time.

The functions of a geriatric clinic are three, in general. In the first place, it fosters the maximum physical fitness in old age. The disabilities of old people require only occasional bed care. Most of the time the patients are able to be up and about, and it is at this level, in these intervals of relatively little trouble, that much can be done to promote health and stave off the recurrences. When a patient has recovered from heart failure or a coronary artery occlusion, he needs to be seen frequently if he is to regain confidence in living and to learn what he can do and what he cannot do. His heart disease is not cured in the sense that his heart loses all traces of trouble, but in the great majority of instances that heart can give a satisfactory account of itself for a very long time. Most old people have high blood pressure; they, too, need to report frequently to learn that it is not dangerous or disabling. Most old people have pain that suggests arthritis and all of them can be shown to have the degenerative changes that are called hypertropic arthritis. Yet the correction of postural and

other mechanical stresses, and constant instruction in the need for exercise and physical play, relieve most of them. Physicaltherapy is helpful but not often necessary; it cannot take the place of teaching old people how to regain comfort and the exhilaration of active normal living. Patients with peptic ulcer need frequent consultation, to be sure that they eat normally and regularly, and to catch the significance of symptoms that might mean activity of the ulcer or other indigestion. The diabetic needs regular review of his diet, his insulin dose, and his general status. The old man who has had a stroke does better if he is coached to restore function in paralyzed muscles or to develop substitute function in others, and to face the future without undue fear of other strokes. My experience has been that these, and other chronic diseases, can be kept from progressing, or can be kept at tolerable levels, and patients can be maintained in independent living outside of hospital situations to a surprising degree, by regular visits to a geriatric clinic. The difficulties of seeing, hearing and moving about, which we assume must come with years, makes other old people, without obvious disease, relax their grasp upon objective living. They, too, perform better with suitable mechanical contrivances and with the will to play that comes from ability to plan. This is the modern meaning of Juvenal's phrase "Mens sana in corpore sano," a sound mind resides in a sound body.

The second function of a geriatric clinic is to offer general guidance to old people. Probably few of us enter upon old age with delight. The general custom is to shudder as we come into each decade, starting with the age of 30, and to have well developed fears by the age of 60 that we are losing or soon will lose mental competence. We picture the farther reaches of age as a twilight darkening into night. But the facts are not as bad as fancy. A recent statistical survey of 8,000 men and women over 61 years of age, who were studied on the medical service of my hospital over a period of 30 years, revealed that only 2 per cent were senile, 12 to 15 per cent more had arteriosclerotic psychoses, and about 10 per cent had temporary psychoses in relation to serious bodily disease. Most of the rest of these individuals, around 70 per cent, were normal mentally or depressed by their circumstances. The reactive depression, then, looms as the big hazard to normal functioning in old age. The loss of a spouse, the loss of family or friends, the loss of a way of life, the loss of a job and economic independence, the necessity for resort to charity, lack of resources to express an aptitude or make new attachments to life, preoccupation with pain or difficult breathing, inadequate care in illness, inadequate contact with surroundings due to poor eyes and ears, are a few of the causes. Malnutrition, whether from disease, from poverty, from faulty habits, or loss of appetite due to sadness or lack of incentives to eat, adds to the depression. The vicious circle is made to spin faster by sympathetic friends and physicians who take old people at their face value and say, "At your age, what can you expect?"

Empathy and Sympathy

The geriatrician knows that empathy is better than sympathy. He has the difficult task of looking through both ends of a telescope at once. He focuses as sharply as he can upon the mental or physical disease of his old client, and he does all that is possible to improve it; and he uses a wide-angle lens upon the total circumstances of the person who has the disease. He knows that satisfactory adjustment to persistent disabilities and deficits may be attained only after the patient's general health is attended to or after life has again come to have value and interest for him. Happy degrees of recovery are possible at every age, but the best results are to be obtained among persons in early old age. Here is a field of preventive medicine that is, currently, practically untilled. No geriatrician can do it all alone. His clinic must provide him with many resources or he must have access to them.

In or near the geriatric clinic there must be a physician who can assess the capacity and the mental status of an old person accurately without bias. Only thus will mistakes be avoided which arise from acceptance of his impracticable day-dreams or from dismay with his present situation. In other words, harm can be done by untutored uplift as well as by a faint-hearted spirit. One who dares to advise an old person must know the facts and abide by them. Next, the clinic must have access to means for re-education. Some education can be directed toward new jobs, to the development of hobbies and handcrafts. Adult education courses in public schools and as private ventures are available for a few; they will have to be directed more particularly to old people if they are to fulfill their needs. Old people need general education also. We must remember that education is a drawing out process, an unfolding that can be made to continue as long as life lasts. It is most effective in association with others. Public library lectures have been shown to be useful in Cleveland. I hope, eventually, that regular classroom work can be instituted for old people who wish replenishment and reactivation of their minds.

The geriatric clinic must have an agency that can place old people in jobs. Normal old people wish to work, to be useful, to be independent as long as possible. Those who do not, have a psychological or physical impediment worthy of correction. Present difficulties in finding employment for old people demand solution. For denial of work means sentencing an old person to charity and its psychological trauma

or to existence on savings and pensions with isolation from active society.

The clinic must concern itself with the living situations of old people. It must find quarters for them where they can have harmonious contacts with others, where they can be assisted to maintain independent homes by making housekeeping and shopping easy. It must see to it that optional diets are possible and that appetite is stimulated by sociability. These are difficult goals to meet, and lead us to plan for special housing facilities for old people. The clinic, in its program for rehabilitation, must also seek to provide social association for those who have lost family and friends. Therefore it is interested in the formation of clubs in churches, schools and other neighborhood locations; it tries to find opportunities for physical play on public playgrounds and parks, and in square dances and bowling alleys; and it hopes to promote reasonable vacations in the country or on the seashore.

These are the tools for general guidance. All these activities are slanted toward the poor because there are so many of them. It must be recognized, however, that the independent and wealthy are equally in need of rehabilitation and the means to procure it. And it cannot be emphasized too often that our attention should be directed primarily toward preventing and repairing the breaks which produce physical and personal deterioration in old age.

The third function of the geriatric clinic is research and teaching. The field of research is broad, as already shown. It involves studies along social, psychological, educational, occupational, recreational and financial lines. In the more narrow field of medicine, the clinic must collect statistics on the incidence of diseases and disabilities of all kinds in old age, and discover important interrelationships. They are profuse and valuable in pediatrics. It must produce a new medical history form, because the old patient's past experience with accidents and operations and disease mean much in his current standing, and because his family relationships, occupation, education, social resources, living arrangements, food habits and daily schedules show what he is. It takes an hour to produce a good history on middle aged patients. It takes four or more interviews of an hour each to produce one on an old patient. It is time well spent; it is, indeed, indispensable if the patient is to receive intelligent care. In the physical examination, the clinic needs to study the significance of such items as changes in body weight, changes in blood pressure, variations in vital capacity, the sensitivity of the carotid sinus, the status of the peripheral circulation, and the integrity of the main nerve pathways in addition to the usual complete survey. In the laboratory, the clinic wishes to obtain data that will help to identify anemia and diabetes early, and by X-ray films to pick up any form of pulmonary tuberculosis. Therapeutically, the clinic can study proper methods of caring for minor illnesses and for persistent disease and disabilities, and it can learn what happens over a long period of time to old people who are supported in their illnesses and their total situations. At present our textbooks contain little information and much misinformation on these points. Pharmacologically, the clinic studies the differences caused by age in dosages of drugs and in the selection of sedatives and analgesics.

All of these projects are planted most fruitfully in research and teaching institutions. They have the resources in equipment and workers, and they have the drive and the critical capacity which the geriatric clinic needs to share. In them the geriatricians can secure opportunities to supervise the care of old patients on the hospital wards as well as in the outdoor department, and in them medical students, house officers, nurses, social workers, physiotherapists, dieticians and others can come to understand old people.

But chronic disease does not attract temporary researchers, who wish short problems, and old people are so complex and individual that they usually overwhelm beginners in medicine. I have not been able to produce a single disciple so far. Discounting personal inadequacies, I blame this failure on the youth of medical students and the fact that I do not yet have the clinic services in full operation. When we do, I have confidence that we can employ the services of students of all sorts for short periods and make the experience an exciting and useful one to them. But since there are many old people in every locality, it seems proper to suggest that geriatric clinics be established in every general hospital that has clinics. They should also be placed in community health centers, and, when we get them, in old age housing projects and old age centers. The more of them there are, the more adequate will be our real knowledge of the problems of aging, and the more we can claim that there is a science and art called geriatrics.

Staffing the Clinic

As to personnel, the geriatric clinic needs, first of all, a physician willing to study chronic diseases and the wide-ranging influences that bear upon old age. Without him, there is no clinic. He ought not to be hard to find, now that we are beginning to realize the functions of the clinic. The second indispensable member of the clinic is the social service worker. She knows much more of the human side of old people than doctors do, and she can unlock the community resources that are available. The other members

of the team can be borrowed on part time from the hospital or parent organization. They are a clinic secretary, a laboratory technician, a dietician, physiotherapist and psychologist. A nurse is necessary if much treatment is done or if supervision is extended to the homes of the patients.

My friends object to all this saying that they are more geriatricians than I am because they can take care of more old people than I do, and that there are so many oldsters that we must rely upon the general practitioner to do the job. Granted. But this assumes that there are enough general practitioners, that they are alert to the problems of age, and vigorous in their attack upon them. The general practitioner learns his pediatrics from child specialists and clinics for children. We must produce clinics and specialists that can supply him with a comparable body of information on patients at the other end of life. It is also objected that all this is highly theoretical and complicated, and that it presupposes a nonexistent faith in the value of old age and a degree of cooperation from old people that is doubtful. I agree only that these ideas are not yet demonstrated in operation. I contend that they are sound, that the faith in age can be evoked in most of us, and that old people will respond when they find the understanding guides. It is hard work, for it must be with individuals, and not with large groups; and it does not always succeed. But it is satisfying work, and the quality will improve. Finally, it is objected that the clinic is very expensive. It need not be so at first. Even with all the workers and resources that have been mentioned, the annual expenses would be met, in terms of community cost, by the rescue of no more than a score of old people from charity and their restoration to economic independence. Then the claims of Robert Browning's Rabbi Ben Ezra will not seem absurd.

"It isn't age that's causing your trouble—why, even I get a crick in my back when fall sets in!"

Medical Aids and Benefits at 40, 60 and 80

By Dr. C. Ward Crampton

Chairman, Subcommittee on Geriatrics, Medical Society of New York County

THERE are aids, benefits, advantages and blessings which medicine can bring to men at the age of 40, 60 and 80 who have been given only the ordinary treatment for obvious disease. The treatment of disease in the elderly is receiving increasing attention. The provision of aids, benefits and life enrichment is not.

We propose, therefore, that every community should establish a clinic primarily to develop a service for these higher degrees of health and vigor for the elderly. In this field much more can be done than is generally supposed. We are wasting money; we are losing years of happiness and service. Hospital beds and wheelchairs can be relieved. Many a weak and hopeless old man can be brought to his feet alert, cooperative and eager. This and more has been done for many individuals and groups in hospitals and homes. It can be done again and again when people know the facts, and are prepared to give the time and make the effort. How can this be done? Let us examine the facts.

At the age of 60 a man's body is a documentary record of his past years. He shows accumulated damages, defects, tissue poisoning, stagnation and starvation with half-cured illnesses and infections—evil things. These are the results not of time but of hazards that occur in the passage of time. Our enemy is not age, it is damage. It is not chronological age but anatomical, physiological, pathological and psychological damage. At any age, 40, 60 or 80, these accumulated burdens, defects and deteriorations by thorough examination can, in large part, be discovered and identified. This examination takes much time, skill, experience and devotion.

The evils thus disclosed can be partly removed or neutralized. The man is thus unburdened and refreshed. Although this may look like rejuvenation, it is not, for nothing will restore youth. But it does take away removable burdens incidental to aging. We may call this rehabilitation or we may coin a term "de-aging."

The examination takes several visits. In introduces the de-aging procedures. These, in turn, continue to develop into a continuing program of medical watchfulness, care, coaching and pre-trouble maintenance throughout life. Thus, there are three services: (1) Examination (2) De-aging (3) Medical Care and Guidance. The examination has been developed and reported. It is brought up to date in the January 1950 issue of *The Journal of Geriatries*. At this time we shall present in brief the seven essentials of de-aging, outline the cure and security program and suggest a basic plan for the Geriatric Clinic designed to give all three services. Now, the essentials of de-aging which have already proven themselves in practice:

1. Attack Infections: These can be found locally in teeth, tonsils, sinuses, gall bladders, prostate and tubes. Undiscoverable infections may be evidenced by the sedimentation test, leucocytosis with a blood shift to the left, blood complement fixation, pulse speed, as an element in constitutional diseases—arthritis, iritis, neuritis and myositis often endured as "just aging."

These infections can be attacked locally when found and attacked from the rear by anti-biotics, antigens, selective chemical agents and supported by other de-aging efforts.

A single method of attack is always incomplete. Mono-diagnosis and mono-treatment are always deficient. Holism is wisdom and modern science applied. Illness has as many roots as a tree and health has as many branches.

2. Nutrition: There are both dangers to be avoided and privileges to be gained by diet. Protein, calcium and iron are commonly sub-optimum and fats in excess.

This topic was fully presented to the meeting of the Joint Committee on Nutrition in December 1947. It was widely noted and utilized, most recently in *Nutrition Review* VII, 10, October 1949 where examination and techniques are presented. While diet is important, digestion, processing, transformation and utilization of food by body cells are far more important and more often neglected. All of these essential life processes may be found disordered and all may be ordered to advantage.

3. Vitamins: Selected vitamins taken in quantities far in excess of dietary needs may be used as

medicines and as cures, aids, benefits and blessings. B_1 may rescue an old person from mental stagnation. B_{12} has a special service in an anemia and the oil solubles, A, D and E may demonstrate results in tissue improvement. Shrunken subcutaneous tissue of the clawlike hands of the aged sometimes seem to be changed most happily. Further reports await clinical trial, more exact measurement of benefits and accumulation of data by the years. This urges more research.

4. Remove Stagnation: Life is action. Stagnation probably kills more people than fatigue. Bed rest has its dangers. Bed exercise will help rehabilitation. In our geriatrics examination every organ should be tested for hidden sabotage. For example, colonic delay of a week is possible for one with daily evacuation. This is damaging, discoverable and correctable. Body condition depends upon inter-organic teamwork. A fine hard-working heart can be ruined by a lazy liver and an harassed kidney which in turn are helplessly damaged by poor nutrition badly guided by a negligent mind. It might often be written "he died of a heart attack caused by undiagnosed mental anemia."

5. Endocrines: The endocrine glands give a good example of a team of specialists working together as in football. The efficiency of each gland and their interdepartmental teamwork should be assayed as an "endocrine efficiency formula" written for each person. A single hormone, even the male sex hormone is less and less used alone. The male and female gland extracts, prescribed together with pituitary, adrenal or thyroid (depending upon the personal endocrine formula) is an example of the direction of progress. One physician reports from the use of balanced hormones "improvement in well-being, strength, endurance, initiative, energy, sleep and sex with less headaches, nervousness, arthritis pains and tensions." In short, less evil, more good in life. The teamwork principle in endocrine therapy is, in turn, only one part of the seven-fold program of de-aging.

6. Structure: The years bring fatigues and damages to the body structure. The head is bowed, the back is bent, ribs and chest cramped, joints stiffen. This is anatomical aging. Much of this is preventable and correctable. It is thrilling to see a man five years in bed, get up and walk, dress himself and go back to work. Rusk, Deaver and Trevor Howell and others have done this. This is structurable rehabilitation, anatomical de-aging. It releases hospital beds and saves hospital bills. It re-makes lives. It can be done.

7. Psychological Techniques in De-Aging: You cannot get a man out of bed if he wants to stay there and it pays to be sick. Where there is no vision of interest, action, service and personal worth he will slowly perish. Yet the last five years may be the finest of all life.

An effort may be made to take a man from grubbing in the refuse of existence and bring him to the Land of Beulah, content with life and eager for his next estate. This is a challenge to physician, psychotherapeutist, family, nurse, social worker and spiritual guide.

The physician can do much. The body can be made to help the mind and the mind taught to help the body, for the body and the mind are at the mercy of each other. Early as well as late psycho-aging can be much prevented and corrected by the use of techniques in the anatomical, psychological and pathological de-aging referred to above. Thiamine chloride alone may lift the burden of despair, defeat and dullness but accompanied by such things as prostatic massage, physiotherapy, calcium, iron and needling of painful trigger points in crippled muscles may with teamwork and psychotherapy open new and bright horizons with all the later years.

This is an outline of the seven factors of de-aging. Much has been done but it will readily be seen that much more needs to be done. New methods to be explored, present plans further tested, improved, discarded or extended and given wider application. This is work for every community under state aid and guidance. De-aging introduces the third geriatric service as follows:

1. Life-Long Geriatric Service: The program of de-aging continues and develops into life-long service of medical watchfulness, care, protection, prevention, benefits, blessings, cure and security. This is like the service of an athletic coach who watches his athletes and keeps them in best condition for the race of life.

The medical coach has the great advantage of the full record of the de-aging service and the examination and the life record upon which it is based. He knows what troubles have been conquered or half-conquered and tend to crop up again. He knows tendencies and weaknesses as well as sources of strength and tested ways of cures and repair. The "trainee" may get advice at any time by telephone and save a call. He will come in to be re-checked on the actual condition of his heart, circulation, blood pressure, nutrition, digestion, cholesterol, blood sugar or nitrogens, capillaries and veins, joints, nerves, exercise and diet. He will be inspected for any possible signs of oncoming chronic disease, deterioration or breakdown.

The service is preventive, constructive, curative and life-sustaining and life enriching.

Community Approach

This is the ideal. It has been done. It can be done better and better. This program of medical service, care, cure and security and benefits should be extended to all. How should this be accomplished? Each community should give its own answer for itself in the establishment of a Three Service Geriatric Service Station. The following may serve as a guiding plan.

The Geriatric Clinic and De-Aging Station

The clinic should be established in connection with a standard hospital. This clinic should be manned by physicians of experience over 50 or 60 years of age, preferably over 70. They may even be called back from retirement or old age homes and they will render a great service.

In advance of the opening of these clinics it may be suggested that the State Department of Health call upon the several communities to nominate physicians to take charge and direct the clinics. They may be brought for a refresher course to Albany, New York and Buffalo and put through the Geriatric Examination and De-Aging Service themselves. This will give them an intimate experience with the working of the plan. They will benefit themselves and become good examples. Nothing could be better than personal demonstration. This is a further development of the reciprocal examination plan of the Committee on Longevity of the Class of the College of Physicians and Surgeons of 1900, of which the writer is a member.

The clinic may be open once a week, for example Wednesday morning from nine to twelve. The examination will be made on appointment and will consist of three visits of one hour each. The first visit will be devoted largely to interview, thorough history and consultation. The man will be given time to tell all his troubles. The usual medical examination will be given with special geriatric tests; stress tests will be given on each organ.

The next visit will be at the end of seven days. This week's interval is used to great advantage. A complete record will be made of four days' diet, rest, work, smoke, drink, et cetera in detail and in writing. A complete history questionnaire of the medical type will also be filled out.

Tests of the kidneys and intestinal tract efficiency will be made covering four of the seven days. A urinalysis made immediately after this four day food and test record gives far better information than can be obtained by the customary methods.

The second visit sizes up the whole man, his whole life. We write down a diagnosis, efficiency indexes of each organ, and each system, lay out a program for rehabilitation and de-aging.

A full written report is given to the examinee to take to his own physician or to go to one or more special clinics for treatment and further diagnosis if necessary. A most important feature is this complete record in writing which is furnished to the examinee for him to take anywhere to any doctor, at any time for the rest of his life, a Basic Record.

The basic record idea has made some headway in the last 40 years, The New York State Medical Society approved the plan 10 years ago and recently reaffirmed its opinion.

The Geriatric Station will work with all medical social and educational services in the community. It will give its services in clinics, hospitals, homes and institutions.

The clinic, in addition to examination, de-aging and service, will have a special division for record and research; men of 40 years or under will offer themselves as guinea pigs. They will be examined thoroughly (the whole man, the whole life.) A record will be filed. They will be re-examined annually as long as they live. Our purpose is to gather data on the hitherto unknown processes of aging and the hidden beginnings of chronic disease.

This plan was announced two years ago and has been generally approved. The University of Minnesota and the Mayo Clinic have already independently begun work in this direction and others have the matter under consideration.

We now suggest that each city and county in the State call a council of medical, social and civic leaders to start these stations at the earliest opportunity.

We recommend the development of a Bureau of Geriatrics at Albany consisting of the several commissioners of health, welfare, education and other services with representatives of the medical, social, civic, economic, industrial and educational organizations of the State. Let them organize, guide and sustain Geriatric Stations based on the plans outlined above but developed, improved and applied by the combined wisdom, experience and devotion of all concerned.

The Veterans Administration and Geriatrics

By Dr. James M. Dunn

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Modern medicine and the modern standard of living have raised the life expectancy of man to a new high level. This trend is continuing. It has resulted in an intensification of all the problems that concern the aging whether they are sick or well.

If one spends the first 20 to 25 years of his life in preparing himself to assume the responsibilities of his vocation and is required to cease those activities at some arbitrarily determined age, it may be readily seen that the productive years of his life are markedly limited.

Throughout the history of the United States, the rights of the individual and his co-equal responsibility to his fellow-citizen and to his government are traditional. Does one become less of an individual when he reaches a given birthday? Must he be declared obsolete? Is it necessary for him to become a burden to other people?

It has been said that the average individual uses about 15 per cent of his potential physical and mental abilities. It appears that there should be ample scope for one to contribute to his own support and to continue to make his contribution to his community within the 85 per cent not ordinarily used, provided he is mentally and physically able to do so.

The normal individual wants to work so that he may support himself and his dependents and make his contribution to his community. Within the foreseeable future, roughly one-half of the population of the United States will reach retirement according to present retirement procedure. It is estimated that 40 per cent will be 45 years old or older by 1980. Present economic trends seem to indicate that relatively few people will be able to acquire enough means to support themselves adequately during a lengthened expectancy after retirement. Consequently, the working half of the population will be saddled with an intolerable burden through taxation or otherwise, unless a solution is found to the economic problems of the aging. That is the thing we have to think of in going into this entire question of the aging population.

Now as to women in careers outside of their homes, I attended a meeting down in Washington the other day where somebody made the mistake of calling the guiding spirit of the household a housewife, and he was very promptly told they were not housewives but they were homemakers, and that is a career.

Women in careers outside of their own homes present similar problems. Women whose sole career centers in the home usually continue in their life vocation until they attain their full expectancy. They tend to slow down gradually and naturally. Perhaps this is one reason why the life expectancy of women is generally longer than that of men.

It would seem that aging men and career women have the inherent right to continue in gainful, pleasant and constructive occupations as long as they live, provided they are physically and mentally able to do so. Such occupations may well be avocational. One who has been able to acquire a competence should be free to pursue the activities of his choice. However, he too should pursue a regular and productive occupation if he so chooses. Many aging people are happy when they are able to earn the means, over and above whatever pension they have earned heretofore, to live in their own homes; it seems that they should be afforded the satisfaction of doing so.

The aging who are not mentally and physically fit are entitled to the best medical care through hospitals, rehabilitation centers and out-patient services.

Treat Aged as Individuals

I had been a physician engaged in private practice up to the end of World War II, and I know the philosophy of the physician. He is out to earn his way through life by creating as much happiness as he goes along as he is capable of doing. The cornerstone of his ethical conduct is always and ever that which concerns the welfare of the patient. I say that here because I feel that each of the different partial solutions that we have to the problems of the aging has a limited value. I couldn't take exception to one of them. But we must not forget that the catalytic agent that goes on in the crucible containing all those different ideas and forces will only make the correct physiological reaction if the catalyst is correct—and that catalyst is the moral side—the attitude of people who give that particular service. It is not enough to have a courageous plan about hospital construction; you have to have the human element.

Those people who are aging; there are no two alike in the world. They are individuals.

No matter how good an operating plant, no matter how good a medical care plant is or how good the social services are, in their application they are no better than the people who handle them. That means you, and it means me. You have to have that cornerstone of ethics.

It seems that the pension systems in vogue among the industries of the country, voluntary insurance system, the possibility of developing crafts characteristic of local communities, the constructive work being done by the United States Public Health Service, the activities of the Veterans Administration, the various State hospital systems, the private hospitals in the various communities, and old age and retirement systems—should all be studied with a view to approaching the integrated solution of the problems of the aging.

We must have an integrated program.

The Veterans Administration is vitally concerned with the problems of the aging. In 1940, 20 years after the first World War, there were approximately 16,000 members in the domiciliary homes of the Veterans Administration. The total number of veterans was approximately 4,000,000. There are now approximately 18,500,000 veterans. It is estimated that there will be required approximately 75,000 domiciliary homes 20 years hence, provided the same legal basis for eligibility exists then as exists now. There are at present 112,000 beds in Veterans Administration hospitals.

Despite the fact that 75 per cent of the patients presently receiving hospital treatment are veterans of World War II, the average age of the veteran patient is 55 years. Twenty years hence the average age of the veterans entitled to hospital, domiciliary and out-patients care will place them definitely among the aging segment of the general population.

The Veterans Administration is studying this problem with the greatest of interest, in order to meet its obligation and in order to make its contribution to the total problem incidental to the aging population. On the other hand, the findings of the New York State Joint Legislative Committee on Problems of the Aging will assist in pointing to a practical solution to some of the veterans' problems relative to its segment of the aging population.

We try to get the man back on the job or have him transferred to another job if the job he has is such that he can't go back to it. We are trying to solve part of the problem before it happens with the younger group of our veteran patients, and I may say that we are having a fair degree of success.

Considering the intrinsic human values, such as the love of home with all its family association and its connotation for the future of the state, it is imperative that we pause before we embark upon an expansive and costly plan of constructing public institutions to house the growing aging segment of our population, as a substitute for the traditional home, which, after all, is the foundation of our way of life.

The aged worker is not a psychiatric case or an orthopedic case or a geriatric case; he is a man or woman with individuality and dignity and rights and duties, and it is our business to see to it that we do not blame our industrial people because they can't continue a man when he is no longer able to continue a job that he has been doing all his life in the physical field. But we have a challenge to see if he cannot be transferred to a job less strenuous mentally or physically, where he can continue working efficiently.

Environmental Health and Aging Population *

By M. Allen Pond, F.A.P.H.A.

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CHANGE in the age composition of a population is always the result of the simultaneous action of complex factors. For example, during the past half-century, when the sharpest recorded changes in life expectancy and average age at death occurred, the American people have enjoyed progressively higher standards of living and better nutrition. They have become better educated. Transportation has improved. The nation has become more urbanized. Advances in the medical sciences have made possible the prevention of some diseases, the cure of others, and better management of most. Not the least important factor has been the establishment of environmental barriers against the spread of disease.

On the debit side of the ledger there have been two world wars. Increased mechanization of the factory and home have increased accident hazards. New and deadly materials have been discovered and come into wide use. The tempo of life, both urban and rural, has increased.

We have had, then, a variety of forces—mostly beneficial—working upon the population. The net result has been that the average unit in the population has been made to live longer. However, as the average length of life has been extended, so too has the time over which the individual is exposed to the favorable and unfavorable conditions that influence his function and development.[1]

It so happens that the principal recognized hazards to health in the early part of life are primarily exogenous, while those that are significant in later life seem to be largely endogenous. This may explain in part why the engineer, by establishing environmental barriers against the spread of communicable disease, has contributed directly to increased longevity. It suggests, also, that the physical environment may not be a direct etiological factor in organic disease. However, as Frank points out, the problem of aging is not purely a biological one, but has large cultural, social and psychological implications.[2]

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Health in an Aging Population

It is our purpose here to examine some of the health problems associated with an aging population and to speculate on the significance of the physical environment in relation thereto. As a by-product, it may be possible to hazard a prediction as to the role of the engineer in chronic disease prevention and control.

The subject is so complex and intangible that discussion of it must appear discursive, and no obvious point of departure suggests itself. As a baseline, it is important to recognize that the objectives in environmental health are (1) to establish physical barriers to prevent the spread of disease, and (2) to provide surroundings that will help maintain vital resistance and promote positive health and a sense of well-being. The engineer is concerned primarily with inanimate matter and directs his attention not to people but to the physical environment in and with which they must live. He is equipped to prevent but not to cure.

The keys to successful public health practice are to be found in the understanding of the etiological and epidemiological characteristics of diseases of community-wide importance. For instance, it was impossible to develop effective environmental health programs until there was reasonably precise knowledge about the causes and mode of spread of typhoid fever, the dysenteries, yellow fever, malaria, and cholera, to name a few communicable diseases that have been controlled by sanitation measures.

There is an analogy between our position at present relative to the prevention of chronic disease and the situation that existed before the germ theory of disease was enunciated. Then, blood-letting and bed rest were advocated but used only *after* the illness appeared. Now in our chronic disease programs early diagnosis is emphasized. Yet, in general, treatment for most of the organic diseases is largely palliative and destined to postpone rather than prevent death from the diagnosed cause of illness.

Until more light is shed on the cause or mechanism of those diseases most frequently attacking older adults, efficiency in preventive programs will be difficult. Environmental health measures, if they are to play any role in chronic disease control, must either await the accumulation of essential knowledge, or

they may be directed at raising the standard of living with the knowledge that such activities usually benefit the public health.

In spite of this generally pessimistic note about the present role of environmental health workers in the attack on health problems associated with the aging population, it is possible to comment positively, or at least to discuss hopefully, certain aspects of the subject.

Environmental Cancer—For example, in the field of cancer prevention there are certain definite signs that environmental controls may be expected to be useful. Even though there remains a vast ignorance as to the carcinogenic properties of the environment, there is an increasing literature on environmental cancer, almost all of which is industrial in origin.[3] As the use of known cancer producing materials becomes more widespread and as more becomes known about the carcinogenic spectrum, it is likely that greater attention will be paid to non-industrial environments.

Of the few recognized carcinogens occurring in the natural environment, solar radiation and radium are among the best established.

It is the artificial environment of our industrial society that has created more serious carcinogenic potentialities. Soot and certain waste products from the fractionation and distillation of coal and petroleum, as well as the wastes from the smelting and processing of certain metals may produce cancer. Fully 90 per cent of the known environmental carcinogens never existed in dangerous concentrations until industrial processes brought workers into constant and close contact with them.[4]

It is indulging in pure speculation to attempt to prophesy the role that the engineer may play in cancer control. Industrial hygiene engineers already are concerning themselves with the protection of workers against excessive exposure to known carcinogens. It may be too early to train large numbers of engineers in cancer control, but there should be no delay in interesting at least a few in this field.

Heart Disease—Undoubtedly the potential death toll from diseases of the heart and circulatory system has been reduced by communicable disease control and treatment of recognized heart ailments. Engineering control of health hazards associated with environmental defects has helped prevent the spread of infections known to be precursors of heart disease. For practical purposes, however, little has been done to develop a physical environment in which those with heart afflictions may be protected against unnecessary additional cardiac damage.

Glickman and his coworkers, reporting on the effects of sudden environmental temperature changes on cardiac patients, note few differences between the response of those with cardiac ailments and those in the control group.[5] They conclude that the differences may as well have been related to the aging process.

These observations may be used to illustrate an administrative problem. From the engineering standpoint it is interesting that there were differences; but until their practical significance is assessed, there is little reason to reconsider air conditioning, ventilation or heating standards. In other words, the mere revelation of hitherto unknown facts cannot without interpretation be used as a basis for changing standards or practices.

It is impossible to resist a temptation to draw an analogy between an important engineering research finding a quarter of a century ago and the role of the physical environment in heart disease. Talbot demonstrated that relatively mild stresses applied repeatedly caused failure in railroad rails resistant to much greater stresses applied a few times or continuously.[6] Is it fair to assume that the stresses inherent in frequent, literally thousands of stair ascents may ultimately produce cardiac failure in persons with mild or unrecognized heart disease?

Mental Health—The potential of the physical environment to produce mental health problems remains to be defined. Certain characteristics of dwellings and working places are known to cause tensions, but there is insufficient epidemiological evidence upon which to base activities aimed at controlling environmental hazards to mental health. It is likely that the physical environment *per se* seldom produces mental illness, although it may serve as a contributory factor by increasing the hazard of breakdown in persons on the threshold of mental illness.

Studies of the livability of low-rent dwellings have shown that inadequate storage space and unsatisfactory room layouts, among other factors, make housekeeping difficult and unpleasant.[7] If we accept the premise that longevity implies more prolonged exposure to the continuing hazards of living, such harassments as these may be especially significant for older people. Recommendations for the design of housing for elderly persons take these points into account.[8-11] However, research is needed to substantiate or refute the group judgments underlying such recommendations.

Housing—A thorough knowledge of population statistics is basic for the planning of housing.[11] Designers and builders of houses have not yet shown that they appreciate that changes in the age composition of the population are paralleled by changes in family composition and size. At both ends of the adult span

of life, single-person families are more numerous than in the age group from 25 to 64. Except in large cities, little has been done to provide housing for one- and two-person families, particularly for those in the twilight years of life. Even in the best planned modern housing developments attention is rarely paid to design for elderly tenants.

There is wide agreement among students of the subject that housing for elderly people needs special consideration as to location, design, and equipment.[8-11] In general, all new housing projects should contain provisions for persons of all age groups, and the able-bodied elderly should be housed with the rest of the community.

Older persons are ordinarily housed more safely in single-story units than in dwellings containing stairs. It is not so widely realized that special attention should be paid to provision for warmth, layout for efficient and easy housekeeping, and accident prevention. It is desirable also to provide communal facilities and easy access to such neighborhood facilities as stores, churches, theaters, and public transportation. Furthermore, the question of elastic design (i.e., provision for easy modification of dwelling size to take care of changing family needs) has hardly been explored.

If housing plays any role in determining the health status of a community, it is obviously related to the health of old persons and the infirm.

Accidents—Death rates from accidents traditionally have been highest in the age group 65 and over. In 1947 the accidental death rate for persons in this age group was 286.8 per 100,000, of which fatal falls accounted for 59 per cent and motor vehicle mishaps represented 17 per cent.[12] The accidental death rate for persons 45 to 64 years old was 68.5 per 100,000. The number of permanent disabilities produced by accidents is significantly larger than the number of deaths.

More than 3 out of 4 fatal home accidents among persons 65 years of age or older are caused by falls, and in 1947 accounted for more than 15,000 deaths. These accidents occurred in various parts of the house, although the bedroom was the most frequent site.

The causes of accidents are manifold. In older persons especially, physical deficiencies and poor judgment are frequently cited as contributory causes. However, structural or mechanical defects that predispose to accidents should not be overlooked by the health official concerned with accident prevention. In the design, construction, and maintenance of shelter for the aged and infirm, special attention should be given to the elimination of accident hazards.

Atmospheric Pollution—Although the epidemiological bases for a large scale attack on air pollution are insecure, experience in London, England, and Donora, Pa., during the late fall of 1948 focuses attention on the potential hazard presented by smog (i.e., a combination of smoke and fog).

Acute mass disasters from atmospheric pollution are spectacular events because of the resulting number of deaths and disabled persons encountered. However, such catastrophes occur rather infrequently and result from unusually massive exposures. In point of fact, they are of lesser importance than more widespread and less obvious injuries to health occasioned by the prolonged action of lower concentrations of atmospheric impurities on larger population groups.[13] Nevertheless, Whipple many years ago pointed out that epidemics in the ultimate may serve as life savers. The London and Donora incidents may well become the incentives to basic work in this field.

In London, deaths from all causes during the week of the widely publicized intense fog of November, 1948, rose sharply in comparison with previous weeks and with the same week in previous years.[14] Death rates from bronchitis and pneumonia were more than double those for the same causes during each of several preceding weeks. Possibly the most significant public health aspect of this particular London fog is revealed by analysis of the age grouping of fatal cases of bronchitis and pneumonia. For both diseases, the greatest excesses in mortality rates occurred among persons 45 years of age and older, the peak being in the age group 65 and over. Among persons under 45, there were no significant differences between either the crude or the respiratory disease death rates for preceding weeks and those for the foggy week.

At Donora, all of the fatalities which were attributable to the smog incident occurred among persons over 52, the mean average and median ages being 65.[15] The Public Health Service investigation of the situation revealed also that there was a significantly higher incidence of serious cases among persons in the older age groups. Similar crises had occurred previously in the community, probably being associated with adverse atmospheric conditions. An interesting sidelight of the inquiry was the revelation that there appeared to be a positive correlation between the severity of the affliction and certain aspects of housing quality.

Roth and Swenson, in an unpublished study of the irritant aspects of atmospheric pollution, point out that irritation appears to increase with age and that susceptibilities vary widely and are greatest for persons whose eyes or nasal passages are inflamed.[16] In their reference to the implications of age, they show that college students require a concentration of about four times the strength of the irritant (e.g., formaldehyde vapor) needed to produce equivalent irritation in

persons over 50. Furthermore, susceptibility appears to increase with age even in older persons.

As a result of these isolated experiences, is it fair to assume that older people are especially susceptible to the hazards of atmospheric pollution? Is it likely that older persons, who may have less efficient or more worn out respiratory or circulatory systems than younger members of the community, when exposed to abnormal atmospheric conditions may be seriously embarrassed? What specific air pollutants are most significant in producing excess morbidity and mortality? Answers to questions such as these will be important in planning and operating community-wide projects for the control of air pollution, and will also play a role in increasing life expectancy.

Care of the Chronically Ill—The increase in recognized chronic disease has created a need to plan for and provide a variety of facilities for care of the chronically ill. Therein lies a fertile field for engineering study and progress in the design, construction, equipment, and maintenance of hospitals, infirmaries, nursing homes, and outpatient centers.

Hope recently has outlined some of the environmental sanitation problems in the national hospital survey and construction program.[17] As he points out, it is one of the few activities in which the engineer is identified with the care and treatment of the ill and infirm. With rare exceptions, there is little evidence that sanitary engineers involved in hospital design, construction, and maintenance have concerned themselves yet with much beyond their traditional interest in water supply, plumbing, and waste disposal. In the field of radiation therapy alone, there appears to be abundant need for public health engineering skill in the design and maintenance of treatment rooms and equipment. Furthermore, increased use of radioactive materials in medical research and patient care will pose a variety of new problems in radiation protection and hospital waste disposal.

Even casual observation of relatively modern plants for the care of the chronically ill reveals the need for substantial extension of knowledge concerning the thermal environment, illumination, noise, and materials of construction as they relate to elderly persons and the infirm. Standards are based insecurely on group judgment supported largely by limited physiological research on young, healthy adults. In spite of the inherent difficulties of carrying out controlled laboratory studies on persons past middle age, serious consideration should be given to necessary physiological and psychological research on elderly persons. Without the basic data which can be obtained only through such research, it is unlikely that there will be significant improvements in the physical standards for shelter for the aged and infirm.

Discussion

It is clear that planning an environmental health program for the aging population is not only complex but at present must be based largely on speculation. Intuitively we are led to believe that the physical environment will ultimately be demonstrated to be significant in the etiology of organic disease. Factual bases for such an assumption are inadequate.

The immediate problem, from the engineer's standpoint, seems to be one of gathering and analyzing data concerning the relationships between the environment and the health of older people. Little is known of the physiological and psychological responses of the aged and chronically diseased to sharp changes in th environment. The implications of micro-changes are virtually unknown.

In spite of the lack of factual bases for action, sound judgment dictates that the solution of health problems among the aging population will involve preventive as well as curative measures, and that the preventive program will include environmental controls as well as improvements in personal hygiene. Present knowledge supports the belief that the physical environment contributes to the causes of cancer and accidents; further, it points up a relationship between environment and the course of mental illness and of diseases of the heart and circulatory system. Is it unreasonable to expect that knowledge to be gained in the future will bear out these facts?

This discussion would be incomplete without mention of the public health significance of the continuing application of basic sanitation measures. Although many of the diseases normally resulting from an insanitary environment have been brought under control, eternal vigilance will be necessary to preserve the gains already made. It would be patently absurd not to maintain existing barriers against environmental hazards to health. Measures to prevent the spread of enteric and insect- and rodent-borne diseases are as important for the aged as for the young. For this reason alone, health agencies must promote widespread application of existing sanitation knowledge to prevent preventable diseases. Such action will raise the standard of living and bring measurable health benefits to all segments of the population.

It has already been mentioned that increased longevity also increases the period of time during which the human organism may be exposed to environmental hazards. Despite the success which has attended engineering efforts to improve and protect water, milk, and food supplies, and to control disease-carrying insects and rodents, there remain a large number of unsolved sanitation problems. Food-borne disease seems to be on the increase.[18] New problems are appearing in

water supply.[19] The radiological health field is in its infancy, and the surface has only been scratched in the hygiene of housing.[20]

There is acute need to realign official and voluntary forces to strengthen sanitation activities throughout the Nation. Serious personnel shortages exist, and many existing sanitation workers are inadequately trained. Most are poorly paid. There are literally thousands of conflicting ordinances, codes, and regulations in effect which serve to impede uniform and coordinated action. Although progress is being made, sanitation activities continue too frequently to be carried on as isolated programs comparatively insulated from other components of the public health effort.

For all these reasons it is encouraging to note that plans are being laid by the National Sanitation Foundation, in cooperation with numerous official and voluntary agencies, to launch a nationwide sanitation program. For the first time on a broad scale, attention is being given to the development of community interests in all aspects of environmental health, without which progress in the future will be painfully slow. It has been comparatively easy to apply a few successful control measures to protect water and milk supplies, or to eliminate insect- or rodent-breeding places. It is more difficult to control widespread hazards that result from human frailties.

As we enter into the era when chronic disease becomes a major public health problem, it is likely to be vital that everyone—not just the waterworks official or milk-plant operator or restaurateur—be concerned with environmental barriers against disease. The whole realm of sanitation practice in all likelihood will change dramatically during the next quarter century. A safe and healthful environment is now and will become increasingly important to the aging population.

It is important, therefore, that sanitation personnel be prepared to assume new responsibilities and deal with new problems. Public interest is likely to promote professional awakening. A nation-wide sanitation program will stimulate both.

References

[1] Boone, B. B., and Ciocco, A. Cardiometric Studies on Children. I. Stethographic Patterns of Heart Sounds Observed in 1,482 Children. *Milbank Mem. Fund Quart.*, 17:323 (Oct.), 1939.

[2] Frank, L. K. Foreword to *Problems of Aging* by E. V. Cowdrey. Baltimore: Williams & Wilkins, 1939.

[3] Hueper, W. C. Environmental and Occupational Cancer. Suppl. 209. *Pub. Health Rep.*, 1948.

[4] Hueper, W. C. Environmental Cancer. Bethesda: Natl. Cancer Inst., 1949, 19 pp.

[5] Glickman, N., Inouye, T., Keeton, R. W., Callen, I. R., Hick, F. K., and Fahnestock, M. K. Physiologic Adjustments of Normal Subjects and Cardiac Patients to Sudden Change in Environment. Presented at 55th Annual Meeting of American Society of Heating and Ventilating Engineers, Chicago, Jan., 1949. Preprinted from A.S.H.V.E. Journal Section, Heating, Piping and Air Conditioning.

[6] Talbot, A. N. Progress Reports Nos. 1–5 of Committee on Stresses in Railroad Track. *Proc. Am. Ry. Eng. Assn.* Vols. 19, 21, 24, 26, 31. 1918, –20, –23, –25, –29.

[7] Livability Problems of 1,000 Families. Fed. Public Housing Auth., Washington, *Bull. 28.* Oct. 1, 1945.

[8] Anon. *Old People's Welfare.* The Natl. Council of Social Service, Inc. London, 1947, 72 pp.

[9] Anon. *The Care and Treatment of the Elderly and Infirm.* British Med. Assn. London, 1947, 28 pp.

[10] Matthews, Olive. *Housing for Old and Single People.* Inst. of Housing, Inc. Birmingham, 1938, 15 pp.

[11] Lansing, C. F. *Studies of Community Planning in Terms of the Span of Life.* New York City Housing Auth. 1937, 43 pp.

[12] *Accident Facts.* 1949 Ed. Natl. Safety Council. Chicago, 96 pp.

[13] Editorial. Industrial Pollution of Human Environment. *J.A.M.A.*, 140:1342 (Aug. 27), 1949.

[14] Logan, W. P. D. Fog and Mortality. *Lancet*, 256:78 (Jan. 8), 1949.

[15] Schrenk, H. H., Heimann, H., Clayton, G. D., Gafafer, W. M., and Wexler, H. Air Pollution in Donora, Pennsylvania. *Pub. Health Bull.* 306. Washington, 1949, 173 pp.

[16] Roth, H. P., and Swenson, E. A. Physiological Studies of Irritant Aspects of Atmospheric Pollution. Univ. of Southern Calif. School of Med., Los Angeles (Oct. 15), 1947, 48 pp. (unpublished).

[17] Hope, M. C. The Hospital Survey and Construction Program: Environmental Sanitation. *A.J.P.H.*, 39:893 (July), 1949.

[18] Summary of Disease Outbreaks from Water, Milk and Milk Products, Other Foods and Undetermined Vehicles. Div. of Sanitation, P.H.S., Mar., 1949.

[19] Borts, I. H. Water-Borne Diseases. *A.J.P.H.*, 39:974 (Aug.), 1949.

[20] Johnson, R. J. The Housing Act of 1949 and Health Department Programs. *Pub. Health Rep.*, Vol. 64, No. 43 (Oct. 28), 1949.

Geriatrics—A New Frontier

By Senator Thomas C. Desmond

Chairman, New York State Joint Legislative Committee on Problems of the Aging

THE TOWNSPEOPLE in a small, New England community had gathered once again to honor their oldest neighbor and friend, Jim Burroughs. As they pressed around him to offer their good wishes on this, his 96th birthday, the question came up as it had so many times before: "Jim, what's the secret of your long life and good health?"

Jim paused and thought for a moment. "You know," he said, "every year you've asked me that I've probably told you something different. This year I'm going to tell you the truth. The reason I've lived so long is because I never died."

Jim Burroughs' explanation was much more reasonable than the hundreds of longevity secrets offered by the elderly. These range from sleeping late mornings and smoking a pipe after lunch to rising early and shunning tobacco.

Scientists scoff at the suggestion that any of these countless schemes offered by the oldsters as the keys to longevity have any real value. They tell us that our hope lies not in an elixir of youth, not in any stay-young-and-be-happy prescription, but in the work of a new breed of scientists called geriatricians.

You will be hearing more and more in years to come about geriatrics. It is a new branch of medicine which aims not merely to stretch out the years of life but to make them brimful of vigor.

Geriatrics (the word is derived from two Greek words, geras, meaning old age, and iatrikos-e-on, belonging to medicine) is the medical aspect of aging. Just as the pediatrician specializes in the health of children, the geriatrician specializes in the health and well-being of the elderly.

"The aim of geriatrics," says Dr. C. Ward Crampton, Chairman of the Geriatric Committee of the New York City Health Department, "is to retard, modify, defeat, postpone, and neutralize the progressive deterioration and disabilities associated with aging."

At Cornell and Columbia Universities, in Indiana and Illinois, in Baltimore and Boston, researchers are intensifying their efforts to find the answer to the age-old question, "What makes people grow old?"

Medical societies are beginning to set up geriatric committees. A Geriatric Bureau has been established in New York City's Health Department. Medical specialists have organized the American Geriatrics Society. The American Pharmaceutical Manufacturers' Association, in cooperation with the American Medical Association, has launched a foundation to study degenerative diseases. Homes for the aged and chronically ill are adding clinics for the oldsters.

Activity in the medical field of aging is booming like stocks in a bull market. Why the accelerated interest?

With startling rapidity the population structure of our Nation is changing toward an ever-increasing proportion of the elderly. If present trends continue, by 1980 some 40.4 per cent of the population will be 45 years of age or more.

One of our top scientists has estimated that 30 per cent of persons who have reached 65 owe their survival to advances in public health and medicine since they were born. Once people died young. Now they have an even chance to live to be happy oldsters. We are at a turning point in medical research. From now on the emphasis will be on chronic illness and degenerative diseases.

Public health agencies have largely subdued the infectious diseases and plagues. Only 50 years ago the greatest killers were tuberculosis and pneumonia. Today these diseases have been pushed down to relative unimportance. Rearing their heads defiantly instead are heart disease, cancer, and cerebral hemorrhage. These are among the chief cripplers of the oldsters.

While we have given people bonus years of life, not much has been done to make these years vigorous, and free of fear of the merciless onslaughts of time. Unless something is done to prevent it, one-half of the children born this year will ultimately die of degenerative diseases of the circulatory system and kidneys.

The Age Fighters

A small band of geriatricians, armed with the conviction that many of our middle-aged people are being consigned to old age long before their time, are searching for clues which might lead to longer and better living.

Theories on what causes trouble in later years are numerous. Some geriatricians believe that it is the failure of the various systems of organs to work together properly; others suspect that clumping of cells

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in the blood vessels may be the cause of decline in the aging; still others regard chemical processes and nutritive factors as the fields of study promising the greatest rewards.

Ill-supported in their important work and toiling in relative obscurity, the age-fighters are hammering at different fronts, but driving toward a common goal: more life in more years of life.

The key to perpetual youth may never be found, but in their quest the researchers expect to turn up the answers to many puzzlers: Why does the heart weaken after middle age? Why do arteries harden and joints become knotted and stiff? Why does the hairline recede and the waistline bulge? In short, what can be done to put off the dreaded period of the Great Decline?

Geriatricians already confidently predict that by 1960 life expectancy will climb to 70 years, and they see no reason why man's life span cannot be boosted eventually to 100 years. They point out that a dog is fully grown at two and has a life expectancy of 12 years; a cat at 2½ years is fully grown and has a life expectancy of 10 years; at four a horse is fully grown and has a life expectancy of 25. Accordingly, if man is physically mature at 25, he should have a normal life span of 150 years.

The Russian scientist, Alexander A. Bogomolets, developed ACS (antireticular cytotoxic serum) which he thought might prolong human life to a century and a half. Groups in Texas and California have taken up the study of ACS, and are investigating intensively its potential benefits.

At Cornell University Professor Clive M. McCay has been conducting a series of brilliant experiments with dogs and white rats which offer startling new clues for prolonged vitality. He has found that life can be extended and youthful characteristics maintained by control of a single factor: food.

The geriatricians will be the first to tell you, however, that you are wishing for the moon if you expect to have the elixir of youth handed to you on a silver platter. On the other hand, we are assured that on the basis of what is now known, we can not only extend the average life 10 more years, but insert the extra decade in the prime of life.

Prepare in Youth for Age

The time to prepare for age is in youth. Your 30th birthday is not too soon to decide whether at 60 you will be as young and vigorous as the man of 40, or whether you will present the common picture of the average man of 80, old, weak, and miserable. You must seek and earn health as your years advance; it will not be thrust upon you.

The only hope you have of avoiding old age is to die young. If you expect to continue living, you have two alternatives: you can shut your eyes to disagreeable facts and hope to escape them (which you can't), or you can anticipate the problems of age while your mind is still vigorous and make plans to meet them. If you have elderly parents or relatives, chances are that you have already seen or soon will see insidious, degenerative diseases of the mind and body at work. Old age is peculiarly the field of chronic disease, which causes a million deaths annually. Virtually every family feels its tragic, lingering sting.

Geriatricians tell us that to avoid many of the pitfalls of the later years of life we should cushion ourselves early against the shock of old age. Don't make the mistake of Mrs. Emily Camp, a 60 year old widow, who carefully camouflaged her snow-white hair with jet-black dyes, hid her wrinkles under layers of make-up, and wore the gay-colored, youthful clothes of a Hollywood starlet. She tried to look and act forty, and almost had herself believing that she was. One day while she was standing in a crowded bus, however, Mrs. Camp received a light tap on the shoulder from a pink-checked teen-ager who had politely risen to offer her a seat. Mrs. Camp forced a smile and nodded appreciatively, but she slid down heavily as though she had experienced her first taste of death. She had never faced the fact that she was growing elderly, and that others could see it.

In industry each year thousands of older workers, untrained and unprepared for retirement, are turned out to become burdens on their offspring and sink into stupor and inactivity. Industry brands them "too old," and it comes as a crushing blow. Dr. Theodore G. Klumpp, noted scientist and business executive, declares that "Any biological organism that has been accustomed to a set routine for 40 or 50 years can't suddenly be shaken from its orbit without untoward consequences." The age-fighters tell us that leisure without useful activity can be a trap. You can't retire from life, but you can retire to new interests: that small business you wanted to start; the book you always thought of writing; the summer camp you planned at the lake; the flower garden you pictured in your back yard. Your third and fourth and fifth decades are not too soon to cultivate the hobbies and activities that will serve you a lifetime. Retirement should be welcomed as the beginning of a new career; it should not be dreaded as the end of life.

The present hope of geriatrics is not just to tack on to your twilight of life a few more years to be endured in senility and chronic illness. The chief aim is to conserve your vigor, brain and skills so that you can maintain your active participation in society.

Dr. Nathan W. Shock, who is heading the Geriatric Unit of the United States Public Health Service at Baltimore City Hospitals, says: "We are not interested in finding ways to allow people to live longer

than they already do. What we are interested in is finding ways to help them to live out their normal life spans as vigorous, useful citizens."

At Welfare Island, where New York City's taxpayers have put up the money to build a hospital and to defray the operating costs of laboratories for the purpose of studying chronic diseases, Dr. J. Murray Steele, who is in charge of the work, expresses a similar view. "The philosophy of the project," Dr. Steele explains, "is not primarily to increase the life span of the aged individual, but to increase his 'span of health', so his last years will be spent in 'reasonable comfort and happiness', and he will not become a burden to the community."

Geriatrics applies to every year of life, for every year has its effect on the succeeding ones. But it is often around the age of forty that the signs of wear and tear during life begin to become readily detectable. Forty is certainly not "old age". It is merely the beginning of senescence, the normal process of aging. The two most critical decades for you from the medical viewpoint are the years between 40 and 60, when warning signals are beginning to appear, but while there is still enough "youth" left with which to work.

Mrs. George Fiske, an alert, intelligent housewife of 40, startled the members of her bridge club by announcing that she had made an appointment for her first comprehensive health examination in preparation for her later years. "Have you gone out of your mind?" chuckled her friends. "Why there's obviously nothing wrong with you. Why don't you enjoy life. You're just looking for trouble."

That's precisely what Mrs. Fiske intended. She was looking for trouble, trying to ferret it out before it could do much damage.

The apparently healthy, "youthful" geriatric patient like Mrs. Fiske is the age-fighter's delight, but, unfortunately, as rare as a string of lakes in a desert.

If you wait until you have been floored by heart trouble, arthritis or some other insidious degenerative disorder, you have waited too long. Dr. Edward J. Stieglitz, pioneer age fighter, and Chief of Staff of Suburban Hospital in Bethesda, Maryland, tells us that the subtle, stealthy signs of depreciation are seldom obvious. They don't jump up at you and ring a bell. High blood pressure may exist for 20 or 30 years before it moves in for the kill. Long before diabetes becomes crippling there is a period in which the victim's ability to utilize sugar is but moderately impaired.

Most of the patients who come to the clinician in later life are looking for a cure after the damage has been done. They gambled on being among the lucky few whom nature does not treat harshly; and they lost.

People do not age at the same rate or in the same way. Even in the same person organs deteriorate at different rates. We are told that a 60 year old man may have a 70 year old heart, 50 year old kidneys, a 40 year old liver; and he may be trying to live like a 30 year old. Another specialist in aging compares the later years of life to a foot race. If the stop signal were suddenly given, every participant would be at a different point.

Then too, we are told that there are many kinds of aging: anatomical, physiological, psychological, biological, hereditary and statistical. Probably the least important of these is your age measured merely by the number of birthdays you have had.

The geriatrician will take you at 40 or 60 or 80, and he will do the best with which he has to work. In every case he emphasizes that the treatment must be individualized. He has to know medicine, but he must also know the man.

The basic step in "de-aging" is the complete health examination, sometimes called the "health inventory." The geriatrician wants to know what your condition is and how it got that way. He wants to "measure" your health, for he knows that health is only relative. He wants to know something about your forebears, for a 60 year old man whose parents died at 40 is potentially far different from a 60 year old whose parents and ancestors averaged 90 at death. He is interested in the accidents and the illnesses of your youth, for they may have left scars which crop up again in maturity. He wants to know about the stresses you have undergone, mental and physical, during any period of life. He wants to know something about your daily routine and habits: what you eat, how well you sleep, what narcotics or stimulants you use, and how often.

Chances are your personal medical history is sketchy and inaccurate, and that it is incomplete is certain.

Health Report

Doctors have long advocated the health report card or "health passport" which would be a birth-to-death summary of your physical condition and background, so that any physician who treats you will have at his disposal comprehensive knowledge of your medical biography.

Medical societies in various states have already proposed that state health departments establish for each person born a continuing health record, to be issued with the birth certificate and used by the individual throughout life.

No law compels you to do so, but the medical men tell us that you will have a great head start over the familiar geriatric cripplers if you will keep a complete

health and medical record yourself as accurately and as faithfully as you can.

As one age-fighter has said, "We seldom see anything but the XYZ of life. Equally important to us are the ABC's, through Q and R and S. With the blank spaces filled in, the doctor could prolong life, ease suffering, and occasionally even snatch his patient from a menacing doom."

Fortunately, the disabilities of aging come slowly and in varying degrees, so that there is an opportunity for the patient to adjust himself to them if he wishes.

The greatest dangers to watch for as you grow old are malnutrition and physical and mental unfitness, which are present to some degree in almost every person over 60 years of age. They are at the core of many of the degenerative disabilities of later years, and they often begin in youth and middle life.

Dr. Joseph T. Freeman, of Doctor's Hospital, Philadelphia, recommends a diet for the aging that is "relatively high in protein, average in carbohydrate, and low in fat."

Dr. Crampton tells us more specifically how a 60-year-old should modify his eating habits compared with a 30-year-old. He indicates that compared with recommended standard requirements for the younger person, the sexagenarian should consume: 10 per cent more protein, Vitamin E, calcium, iron, and phosphorus; 15 per cent more iodine; and from 20 per cent to 25 per cent more Vitamin A, thiamin, niacin, riboflavin, folic acid, Vitamins C and D; and 20 per cent to 25 per cent less fats and carbohydrates.

The significant conclusions of the hunger-fighters and age-fighters on diet for the elderly can be summed up in these five major points:

1. **Shed unhealthy, excess fat and hold your beltline down.**
2. **Drink your tea and coffee if you like it, but don't neglect milk. If you have given it up go back to it. Get a pint to a quart a day.**
3. **Forget the toast and tea fad of Grandmother's day. Get an optimum diet, rich in vitamins and proteins.**
4. **Have your weight checked periodically. Ask your doctor to plan a diet to fit your individual needs if necessary, and obtain his recommendations on vitamin and mineral supplements.**
5. **Don't spare the fruits and fruit juices, and don't spurn leafy vegetables as being "weeds". They will help you keep in trim.**

At his geriatric clinic in Boston, one of the first such clinics in the world, Dr. Robert T. Monroe has found that much that passes for senility turns out to be merely physical or mental unfitness. This is true of much feebleness, frailty, unsteadiness, awkwardness, undue fatigue, and shortness of breath.

He has found that regular exercise and play (such as simple games and dancing to restore the sense of timing and coordination) have beneficial effects on patients with high blood pressure, hypertensive heart disease, arthritis, tremors, and hemiplegia. "Here," says Dr. Monroe, "is a field of rehabilitation as exciting and rewarding as that with war casualties."

Dr. Monroe's observations have been further verified at the Hodson Community Center in New York City, where outings, games, meetings and crafts are provided for oldsters. The expected average life span of the old folks who find companionship at the Center and participate in its recreational programs has been extended 10 years. From an age group in which mental disturbances and senility take a huge toll, there has not been a single case of a referral to a mental institution of an oldster at the Hodson Center!

The man who keeps up his associations as he grows older, retains an interest in what is going on about him, and develops hobbies and useful activities to take up his idle time will remain young, no matter how white his hair.

Obviously, the handful of geriatricians in the country cannot take care of a vast army of old timers whose needs range from mere sympathetic understanding to treatment of severe heart disease. But you can look for help to any physician who is geriatric-minded. The point to remember is that the usual health examination today is for the purpose of detecting any ailments you might have. The kind of "anti-aging," pre-disease examination you must seek is one of prognostic value; one that will not only measure your health, but help you to know what it will be five or 10 or 15 years from now. If you are an avid tennis enthusiast at 30, you want to know what pitfalls to avoid, what to do so that you will still be playing a good game 10 years hence. If you're a top bowler in your league at 40 you don't want to be sitting on the sidelines at 45. No matter how old you are, you want to free yourself of anxiety over premature disability and prolonged invalidism in the years to come.

Through "stress tests," the geriatrician can give you some indication of what your future health status might be. He does this by placing upon the organs a load corresponding to the wear and stress they will undergo in another decade or two. Commonly used stress tests are reaction of blood pressure to cold water wrist submersion; the electrocardiogram before and after measured step climbing; and the comparison of the horizontal and standing blood pressure. In this way he can find weak spots in your body. Following analysis of your detailed and searching "history," a careful examination of your body, and a frank discussion of your anxieties, emotional conflicts, and adjustments, the geriatrician can give you

guidance in nutrition, exercise, recreation, posture, mental outlook, and proper environment to suit your condition. If he finds that your heart is weak or your liver is bad, his method is one of support. He tries to build up all the other organs to their full efficiency to buoy up the stragglers; to reduce the load they have to carry. He can gauge your limit, and say "Keep within your limit and you will be safe."

You acquire confidence after your health inventory, for now you know what you are, and what you can and should not do. You have been relieved of many of the bugaboos of age. You go out to face a brighter world with a spring in your step and a smile on your face.

You go back for periodic check-ups, and thus keep your health and vigor at or near their maximum. Just as in youth you insure yourself for economic security in later years, you have insured yourself for physical and mental security.

Geriatrics promises less but delivers more than the quick cure-alls and youth-restorers we read about and hear about so often. The frontiers of knowledge in geriatrics are constantly being extended, and further dramatic advances are inevitable.

There is no route to earthly immortality, but there is a road to a longer and happier life if you will keep looking ahead, and seek the proper guidance along the way.

Need There Be Death?

By Dr. Paul A. Zahl

Associate Director of the Haskins Laboratories, New York City

With his emergence from total animalism into a state of high subjectivity, man has suddenly (that is, within the last 5,000 years) turned the tables on nature. No longer do species and evolutionary considerations compel his activities; the psychological growth of the individual in relation to his fellows is the keynote (still unrecognized by many) of the Coming World. How eminently frustrating, then, when thoughtful man—ever obsessed by the will to live—knows that he has but a few decades of creative existence before he must succumb to evolution's most uncharitable and sardonic ruling.

But must he yield forever to nature's disinterest in individual survival? Is it an absolute cyclicity with which men go down into extinction every generation, to be replaced by a new crop of germ-cell bearing tyros? Well, there is still the reasonable hope that if scientific aspiration and technological progress can be prevented from withering in the dust of crumbling social institutions, then individual wisdom and experience may some day be permitted to gather cumulative strength, instead of ebbing back to zero with each aged generation. . . .

When our neolithic ancestors buried weapons and travel accouterments with their dead, they were premising an existence beyond the grave. In the millennia after those dawn days, the human creature came to see himself as a dual entity composed of mortal body and immortal soul; the phenomenon of human life was even construed by some as a spiritual test trip between two eternities. In beliefs ranging from nirvanaistic forceverness to complete corporeal resurrection, we have never ceased hoping, dreaming, praying that death is not the end. Hence, when the biologist ponders the mysteries of life's transcience, he is acting in the tradition of all men.

Biological Questions

Only a few years ago the biologist would have defined death as an irreversible cessation of metabolic activity. But today, far more than the philosopher, he has had to revise his conception of mortality. Cannot the viruses, dried to a state of zero metabolism, be preserved indefinitely, thereby virtually negating death? Do not experiments in which microbes are frozen into suspended animation, to be revitalized at will, change our ideas of biological time, and the meaning of death?

In order to reveal the basis and extent of these emendations, it is relevant perhaps to begin with an inspection of life and death among man's evolutionary forebears.

The first inhabitants of our planet were not subject to death. As single cells, they grew until reaching a fixed size limit, then divided in two, leaving no parent—and no corpse.

In the course of evolutionary time, organisms came to consist of many cells, the vast majority of which—relegated to subserve supportive and nutritive functions—were shorn of their original capacity to reproduce the whole organism. Further division of labor occurred; and as millions of years rolled on, the cellular constituency of advancing organisms became highly diverse and astronomically large. There were tissues which served to digest food for the entire organism; others specialized to deliver nutriment to every cranny of the body; still others assigned for integration and courier detail, for locomotion, excretion, protection. But ever secluded and sheltered within each organism were the precious germinal cells, waiting but to pass on the species, ere the body died.

Motivation for the epical developments which comprise what we know as organic evolution, lay in the fact that multicellular animals had long since abandoned sunlight as the source of primary energy, and so were impelled to sharpen their efficiency in the capture and devouring of their evolutionary collaterals. The whole "aim" and "purpose" of the outer body was to nurture and protect its wards—the reproductive cells—and to deposit them, when ripe, for fusion with those of the opposite sex.

In life's two-billion year reaction chain, no value was assigned to post-reproductive maintenance of the individual organism. The diversity and survival-fitness of evolving species were enhanced by this generation-to-generation scheme, this life-death-life-death pattern, since in the mixing of mutated genes during fertilization, offspring differing from either parent were produced. Only those individuals whose constitutions enabled them to cope with endless geological and environmental shifts on the planet, survived to pass their valuable new gene combinations into the main stream of the species' germ plasm. Thus, survival of the evolving species, not of the single being,

[1] Reprinted from *The American Scholar*, spring issue, 1949.

was the preeminent goal of animal evolution. The institution of death arose as a result of this null value placed on the individual once it had passed on the family torch.

Senescence and death are by no means universal biological phenomena; they are but the price paid for high specialization and for an advanced evolutionary position. Perennial organisms, for example, are in fact not subject to senescence, and never wear down to natural expiration. This condition prevails, presumably, because the body tissues of such organisms have not been specialized to the point where they have wholly lost their reproductive capacity. A single mangrove sprout may spread to a continuous net over many square miles of brackish swampland, its indefinite increase being limited only by competing vegetation or other environmental restrictions. Perennialism applies, in addition, not only to such notable examples of non-aging as the giant sequoias, but to the teeming bacteria, fungi and algae; and also to many of the lower multicellular animals which grow and bud very much like plants. Among organisms of this class, life can be stopped (as it is most often) only by accident, attack by preying organisms, or severe environmental adversity.

The life-span of those higher organisms whose body cells have lost their species-reproduction capacity, always begins with the activation of a previously dormant egg cell, and continues from birth to death in a series of intergrading growth stages. No known consciousness of self exists in the embryo, which is parasitic on the mother (as in mammals), or dependent on a store of yolk which the mother has provided for embryo nourishment (as in the egg-laying forms). Birth is usually associated with a release from this dependency, although in many animals, especially the mammals, a post-parturiency relationship persists for a considerable time.

Life's course after birth includes a progressive self-awareness, varying widely from species to species, and ostensibly reaching its highest expression in man. Concomitant with this "subjective" development, the organism becomes sexually mature, and sets out to repeat the life-cycle pattern of its parent-predecessors, employing perhaps half its total lifetime in reproductive activities aimed at species perpetuation. The body then progresses without choice through tissue degeneration into death.

Gene-determined Life Span

The span allotted from birth to the onset of senescence of the body super-structure is gene-determined, and subject to wide species variation. A tiny animal called the rotifer completes its entire cycle within a few days, during this period having passed on its undying germ cells. The mouse does not age and die until one to two years have elapsed; some reptiles live to exceed a hundred and fifty years; and the elephant's longevity is proverbial. Moreover, there is no apparent relationship between the size of an organism and its life expectancy. A man is smaller than a cow, yet lives much longer. The parrot's normal span may approach the human three-score-and-ten.

Of course not all, indeed very few such death-destined individuals realize their full life-potential, which for most mammals is calculated to be about six times the period from birth to maturity. The nature of the competitive biological milieu is such that mishap, nutritional deficiency, or invasion by predatory microbes usually terminates life long before true old age has set in. In man, these factors have been considerably minimized, making the "sere and yellow leaf" stage all the more conspicuous. Perhaps half of civilized man's total personal activities—accident avoidance, food consumption, rest, hygiene, medical therapy, etc.—are aimed at deferring death.

The non-perennial organism which ages and finally dies when the life-potential has dissipated itself, may well be compared to a clock which stops ticking once the spring tension fails. But spring tension alone does not determine the life-span, for the *rate* of a clock's ticking obviously fixes the speed at which its spring energy is spent. This applies analogously to the organism.

Since the speed of "ticking" within the body is broadly conditioned by the temperature at which it occurs, thermal changes may alter the life-span. Fruit flies maintained from birth at 30 degrees centigrade go into senescence within 21 days; at 10 degrees centigrade they do not succumb to old age and natural death until almost 200 days have elapsed. Moreover, temperature affects not only the length of the life-cycle; it changes markedly the organism's subjective sense of time. Insects, for example, when fed at a set hour each day become conditioned and will anticipate feeding by arriving punctually at the trough. If the temperature of the environment is raised, they come too early; if lowered, too late.

Immediately one wonders why the Eskimo and, say, the desert Bedouin do not show high discrepancy in their time senses, or indeed why the former does not vastly outlive the latter. The answer is clearly that mammals possess an efficient internal regulating system which, irrespective of external temperature, maintains the inside fires burning at a constant rate. Insects, again, lacking themostats—like all other animals, except mammals and birds—tend to adopt the temperature of the air around them. It is interesting to note that when something goes wrong with the human thermostat, as in fever, the time sense is completely upset, and events race crazily.

We have said that the rate of metabolic "ticking" determines the length of time during which a given

life-potential is expended, and that this rate is to a considerable degree fixed by the temperature at which the body chemistry functions. Improving on the experiment with the fruit flies, could we not reduce the internal temperature of higher animals to a point where the life-span could be increased indefinitely, or at least suspended? Happily or unhappily, this is not possible at the present state of the biological art. The delicately balanced organ and tissue relationships within the mammalian body are such that a drop in internal temperature of only a few degrees is quickly fatal.

But among the non-mammalian species some suggestive experiments have been performed—spectacularly successful among very low species, disappointing among creatures even as high as the insects. The research and interpretation of Basile Luyet explains why. If protoplasm is frozen by ordinary means, there develop tiny water crystals which, sharp and angular, cause irreparable damage to fragile structural arrangements within the cell. On the other hand, if freezing is accomplished so rapidly and to so low a temperature that ice crystals do not have a chance to form, protoplasm assumes a vitreous or non-crystalline condition.

This vitreous state is achieved by rapid immersion of the material into liquid nitrogen (195 degrees below zero centigrade) or some similar low-temperature fluid. Essential to the procedure is that the transition from normal temperature to that of vitrification be instantaneous; and that in thawing, the change be equally rapid. Present techniques do not allow such lightning thermal shifts in any but microscopic organisms, undoubtedly because of the longer time required for heat transference in large masses of cellular material. Thus, only the viruses, bacteria, protozoa, and some of the smallest multicellular animals have been successfully vitrified, and thereby transmuted into a state of passive immortality. The platform demonstrator who re-vivifies a "frozen" fish would find with a little dissection that only the outer scales were actually frozen.

Of profound significance is the possibility of vitrifying spermatozoa, and perhaps even ova, for perpetual storage. This has actually been accomplished in the case of spermatozoa, although the technique is not developed to the point where it has practical application. We may expect that in the not too distant future, vitrified sperm banks will be employed in animal husbandry. The implications of their use in human euthenics are breathtaking. . . .

The Coiled Spring

More directly cogent than thermal manipulation to the problems of aging and death is the plausibility of somehow altering the spring which lies coiled to a predetermined tension within every individual of every non-perennial species. The tortoise drives ahead for more than a century; the human being for three-score-years-and-ten; the rotifer for only eight days. Is it not possible to identify the factors that preordain the shortness of individual existence, and perhaps to control them?

This question, asked so early in the Atomic Era, still seems unfortunately to connote fantasy. Obviously, we cannot yet supply a complete or even a satisfactory answer. On the other hand, we may infer from the absence of inevitable death among the lower organisms that there is nothing in the fundamental nature of protoplasm that demands a wearing-out. A man is protoplasm; a sequoia is protoplasm. One has a death-terminated life-cycle; the other does not. A man is a mammal; so is a mouse. Yet one lives thirty times longer than the other.

Many crude attempts have been made to probe the human aspects of such gerontic enigmas. The elixir of life has prayerfully been sought in glandular therapy, connective tissue extract treatment, reduction of bacterial toxins within the body, nutritional manipulation, and so on—but vainly, for such gropings have been based on the shaky premise that senility is due to the break-up of a single tissue or physiological system. Current physiological intelligence indicates that true aging derives not from the wearing-out of a single body unit, but rather from an over-all deterioration genetically intrinsic to the physiological organization of each species.

One would expect a more fruitful approach to the problem of man's mortality to lie in a further quest for fundamental knowledge of the nature of organ and system relationships within the body, and of the subtle genetic means by which they are influenced. Modern gerontologists are just beginning to look into such aspects of biochemistry as molecular degradation and synthesis, membrane permeability, energy, exchange, dynamics of gene determinism—to list them all would constitute the outline of a physiology textbook. It does not require a seer's perception to realize that this class of phenomena will have to be elucidated far more fully before effective thought can be devoted to the challenge of obviating that deep-seated rusting which leads so inexorably to senescence and death. Perhaps in this inaugural age of science, man will begin to supplant his traditional but fading dream of life-after-death with a new and vigorous search for biological, and so psychological, immortality.

To those who would worry about the staggering implications of literal immortality, may one add, in genuflection, that there will be time enough to deal with that greatest of all challenges: the patterning of values, motivations and reproductive mores in a society whose citizens are assured perpetual life.

A Psychiatrist Looks at the Aging

By Dr. G. M. Davidson

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Needless to say that a long life without health is not only an individual but a national tragedy. Therefore, no effort is too costly to remedy the situation. The problem of aging is very complex, has many aspects and issues inclusive of the psychiatric.

My presentation is limited to an approach of basic evaluation of the aging process.

To begin with, I would like to point out certain fallacies of thought which in my opinion handicap progress. Due to our traditional materialistic education we are looking for a cause and effect relationship in any problem we may be interested in. This attitude, however, has proven inadequate in its application toward problems pertaining to human nature. In fact, biology has definitely established that what may be considered "the cause" of a condition is often not the cause at all, and that causes are multiple. To illustrate, there is an organic brain disease known as Korsakoff disease of which a most characteristic sign is a certain type of amnesia. The latter was always considered due to the pathology of the brain of such subjects. However, I was able to show that amnesia could be lifted in some cases by means of sodium amytal and that in such instances it was possible to ascertain that amnesia is essentially psychogenetic in origin; the organic implication belonging to other factors in the problem as a whole.

Alice in Wonderland

Another difficulty in our approach toward problems related to manifestation of human nature is our ignorance regarding the body-mind relationship. We are still under the spell of the "old" dualism, which makes, to quote von Hornbostel, "sound and sight, inner and outer, body and soul, God and the world to fall apart." Perhaps the difficulty will be best illustrated if I should quote to you from Alice in Wonderland. As you recall, Alice was very much annoyed with the sudden vanishing and reappearing cat, and asked him to stop the practice. The cat complied vanishing this time slowly beginning with the tail and ending with the grin which remained for some time after the rest were gone. "Well I have often seen a cat without a grin," thought Alice, "but a grin without a cat; it is the most curious thing I ever saw in all my life." However, it is not only Alice that might be surprised by such a phenomenon. Many educated people including some medical men still identify the mind with the brain and cannot "see" the mind without the brain. In other words they insist that the grin and the cat can be only seen together. The latter "logic" is definitely not logical clinically. For instance we know from experiment that a visual image may outlast the stimulus that provoked the image; we know that mental growth continues after physical growth ceases; we know that a mental reaction which may be ushered in by a physical cause may continue after the physical cause subsides. It should, therefore, be the ambition of the psychiatrist to be able to reach ultimately conclusions of physical changes in the organisms on the basis of psychological symptoms. This falls in line with the experience of Alice in Wonderland. If so, how can we scientifically outline the quoted allegory?

It is this way: We identify the individual in space and time as the "total personality" which means to regard him as a whole inclusive of his past and his environment. The total personality is composed of a multitude of parts which are trained by experience to work in harmony for the benefit of the totality. Depending upon the harmony and unity achieved and the compensatory ability for incurred damages, there may be all degrees of functioning up to a point of maximum efficiency. Disharmony or unrepaired damage may result in clumsiness in its mind expression, failure in more pronounced states, and disaster in severe expression. In search to measure the totality in action I applied Sherrington's view on the coordinated neurological mechanism which he called the final common path. My studies have convinced me that there is a common final path of the total personality which I identified with affectivity (according to a standard dictionary affectivity means to aspire; to aim; bent of mind; used synonymously with emotionality). It is in harmony with the view that the mental and the physical are separate of one and the same, the totality, which may be measured by different methods. Affectivity is regarded as the evolutionary outcome of the original irritability of the cell which in turn may be identified as the "mental component" of the cell. Affectivity is the measure of the bodily power to absorb and reflect stimuli. This approach suggests that the release of personality disorders is caused by many factors among which I distinguish:

Factors in Personality Disorders

1. Factors belonging to the evolution and integration of the total personality and expressed in disorder of the total affectivity and its constituents (such as social, sexual, etc. impulses), a disorder which is considered in turn the biological background of what is known as "mental conflict;"

2. Factors belonging to the maintenance of equilibrium and rooted in the system of defense of the total personality (physically—impairment of homeostasis; mentally—impairment of mechanism, such as the mechanism of repression, compensation, etc.); and

3. Precipitating and aggravating factors (emotional, traumatic, etc.) which overcharge our capacity to react, or participate in dissolution of the total personality.

With the foregoing in mind and with emphasis on the fact that psychopathology may give clues of changes in the organism, I tried to isolate certain phenomena which could be applicable in a longitudinal way, to manifestations of aging. Now comes the question, What do we mean by aging and when does aging begin? In answer, some see aging as beginning with conception and terminating in death, which view, while correct in a philosophical sense, is incorrect clinically since it confuses at some phases of life growth with decline. Another opinion is that aging begins some time about middle age. This is also incorrect for the reason that chronological age does not coincide with the physiological and the psychological age. And when does middle age set in? That is another question. I would think that aging is a phase in the life process of the individual which starts some time after maturity (according to a standard dictionary, maturity is a process brought about by completion and development for any function appropriate to its kind). According to my investigation aging begins at about the end of the third and the beginning of the fourth decade of the life of the individual and is manifested by a set of psychological phenomena. It is at this time that the individual may cast a glance into the future and the unknown. He develops insecurity to which he reacts with an anxiety state; the idea of death may cross his mind with all the disquiet that it may cause. Other symptoms may follow. The mentioned phenomena may be mild in their expression or more severe, depending upon the original emotional constellation of the individual.

For those who are very concrete in their attitude, or for those who are burdened with problem of cause and effect relationship, the foregoing conclusion and the following discussion will be difficult to accept. However, as far as I am concerned, I believe that the mentioned symptoms and the similar ones which may be observed at middle life or advanced age are essentially of the same origin. I mean to say that certain mental manifestations associated with involution of the individual (change of life), can be observed in the agitated and depressed type of senile psychosis known as agitated depression, as well as those similar symptoms which occur in agitated depression at any age, and differ only in their strength of expression, which is due essentially to the psychology and physiology of the respective age. For instance, the emotional state of involutional melancholia, in addition to the aspect of anxiety, has an admixture of remorse and nostalgia. The nuclear motive of these mental states is the fear of death and of the unknown (in so many instances the fear of life), which in turn is the result of other psychodynamics of the total personality. This may be applied also to other mental states with due consideration to the individuality of the case.

If this view is correct then there is hope that the individual may be spared these incapacitating states.

It has been established that in the mentioned neuroses and psychoses, the subjects are of a certain make-up which is marked by traits of oversensitivity, scrupulosity, overorderliness, stinginess, etc. The traits are considered as "reaction formations" due to faulty early socialization, and thus may be avoided by proper education.

Cerebral Arteriosclerosis

Another point that I would like to discuss is the question of cerebral arteriosclerosis which we encounter in persons of advanced age. We do not know exactly what cerebral arteriosclerosis is due to. But we do know that the process is selective. It used to be said that a man is as old as his arteries. This is not quite true; however, it may be said that arteriosclerosis may be related among other things, to the individual's ability to disperse cholesterol. This would refer to hormonal and dietary factors, as well as to the function of the reticuloendothelial system (belongs to the system of defense of the personality).

Diagnosis of cerebral arteriosclerosis is often difficult unless there are pronounced focal symptoms, and other organic conditions are excluded. However, the diagnosis of early cerebral arteriosclerosis may be made on mental lines. A particular irritability and emotional instability may be an early sign. These emotional states are undoubtedly an unconscious reaction to his failures due to aging. Depressive states may be rooted in involutional changes which may go on in the same period. Acute vascular conditions may be suspected from the manifestations of acute disturbances in orientation and memory. The more severe disturbances of memory or language are due to impairment of the symbolic formulation of thought, which has an emotional as well as neurological aspect.

As far as cerebral arteriosclerotic dementias are concerned, we have no adequate tests to measure them. In some respects they are similar to other dementias, such as senile ones, which we shall discuss presently. Generally speaking, studies of the brains of cerebral arteriosclerosis subjects do not produce definite evidence to account for the clinical manifestations. I believe that the studies on the subject do not reveal any factors which could be considered solely due to aging. It refers rather to factors working upon the life process in general. Therefore, one may hope also here that better knowledge of the nature of arteriosclerosis will help in prevention of the difficulties which arise from this acquired condition.

Senility

I want to discuss briefly still another point which is a pathological appendix of aging, and which is spoken of as senility. The latter in its height of expression is known as senile psychosis. I have already mentioned one type of such psychosis, the agitated and depressed type. There are other types, such as: the paranoid type, the confused type, the type of simple deterioration, etc. Approaches from the angle of the final common path we identify the situation with dissolution of affectivity (interestingly enough the French psychologist Ribot studying at the turn of the century the senile states and emphasizing the loss of memory discussed very ably the progressive changes in emotionality). In examining the various types of senile psychoses we come to the conclusions that the respective type of reaction is rooted in the potentialities of the personality of the individual. For instance a person with a poor system of defense will show simple deterioration. A well equipped person will develop trends which in turn may help him to be better preserved. In the confused states we may have a toxic factor, etc. Regarding intelligence in the senile cases I wish to repeat that we have no adequate tests to measure it. It is to be noted that intelligence seems to improve after treatment of the subject with vitamins B and C. Concerning memory, I like to say that a loss of the latter may occur at any time during life. It ought to be noted that memory is only important as an instrument of adjustment. To function properly there must be integration of new with old memories. This integration is weakened in the aged for the reason of dissolution of emotionality. It is the emotional link which is essential for integration of new with old memories (compare with our "loss" of memory for infantile experiences).

Studies of senile brains do not produce satisfactory evidence to explain the clinical manifestations. In fact, there is no correlation between the findings of the brain and clinical phenomena. Therefore, one may assume, at the present state of our knowledge, that there are no specific causes for the process of aging. The causes are multiple. It is the people themselves, their mode of life with all the traumatic influences that are responsible for the pathological states of the aging. The release of the condition being in harmony with the outlined three groups of factors responsible for the release of any personality disorder, as discussed.

Conclusions

In summing up I would like to emphasize the following psychiatric observation:

1. We are ill-prepared in meeting our aging. In fact we meet aging grudgingly and react to its perception with anxiety which is an alarm signal of the system of defense, and in pronounced instances with morbidity.
2. Normal aging is marked by a decline in function which is taken care of by the system of defense of the personality—in both its physical and mental aspects—as seen from measurement of biological time and mental manifestations.
3. In pathological aging there is an abnormal weakening of the system of defense, which reaches its height of expression in dissolution of affectivity, conditions which require most urgent study. (The workings of it is seen in the various types of senile psychoses with all its "negative" compensations.)
4. The system of defense of the personality may be vulnerable on more than one score. There may be hereditary and constitutional factors responsible, yet unknown. We do know, however, that infectious, traumatic and emotional factors play an important role. Therefore one may conclude that proper education, proper application of physical and mental hygiene guided by a sound philosophy of life which shall provide the individual with social, economic, sexual and emotional security will help him and society to avoid the calamities of aging as observed in our times.
5. Finally it must be pointed out that the road of of achievement of normal aging **for all** is a long and thorny one. Our knowledge of the problem is very meager. The time is short and only a vigorous research program may help. For research two elements are needed: ideas and financial backing. Fortunately there is abundance of both in this country. Therefore, we may look with confidence in the future. But we have to go to work right away.

Family Care for the Aged

By Miss Hester B. Crutcher

Director of Social Work, New York State Mental Hygiene Department

Since 1933 the State of New York has developed a program of placing patients in homes other than their own for care. This method of care is used for the patient for whom it will have definite therapeutic value. In this instance, the family care home serves somewhat the same purpose as a convalescent home might for patients who had been treated in a general hospital. This offers the patient the opportunity of making his community adjustment gradually and without the pressure he would feel from his own family to work or to assume other responsibilities which he may not feel equal to doing.

In the family care home the social worker from the hospital encourages the patient to do what he feels able to do and gradually to assume the responsibilities of community life. The family caretakers are given instructions as to what the patients' needs are and how these needs should be met. They give him support and encouragement so that he will make progress and yet not feel that any pressure is put upon him to assume the responsibilities he carried before his illness.

Therapeutic family care has been used for elderly patients as it is felt that with this support they can find a niche for themselves in the community and eventually make a permanent adjustment with the help of old age assistance or other community agencies interested in helping the aged.

Foster family care is also used for patients, many of whom are aged, who have profited all they can from hospital-treatment but who do not need the various highly specialized services of the hospital. Those patients are often confused, forgetful and unable to take adequate care of themselves but they are not dangerous to themselves or others. They need the careful supervision of the hospital social service and the protection offered by an understanding family. With this they can enjoy varying degrees of freedom in community living and they are much happier than they are in the institution.

Family care in the State of New York has developed slowly. During the war the securing of families interested in this project was difficult because in many families both husband and wife worked or perhaps they opened their homes to daughters and children whose husbands were in service—thus they had no space for patients. Since the war the housing shortage has continued to hinder the development of this program. We should also mention the fact that the shortage of both psychiatric and social service staff during the war was an added factor preventing the development of family care. In spite of this relatively slow development it has been shown that with adequate psychiatric social service supervision, and adequate medical personnel to select patients, that family care offers a valuable source of exit from our institutions which can be increasingly used both for the benefit of the patient and the community.

We feel that the development of family care might be one way of decreasing the necessity for new buildings; we know that it is less expensive than hospital care and that the satisfaction to the individuals who enjoy the benefit of family care is something that cannot be measured.

At the present time there are 2,000 patients placed in foster homes by the institutions of the department. Of the 1,284 placed by various State hospitals, 743 are over 60 years of age and 84 of the State school patients are over 60. Incidentally, in this group of patients past 60 there are 27 men and 36 women who are past 80 years of age.

From the above figures it will be noted that already the State has used family care quite extensively for elderly patients. We believe that foster home care for elderly patients is a resource which has shown its value and which should be more extensively developed.

*You Can't Retire On Your Money Alone**

By Senator Thomas C. Desmond

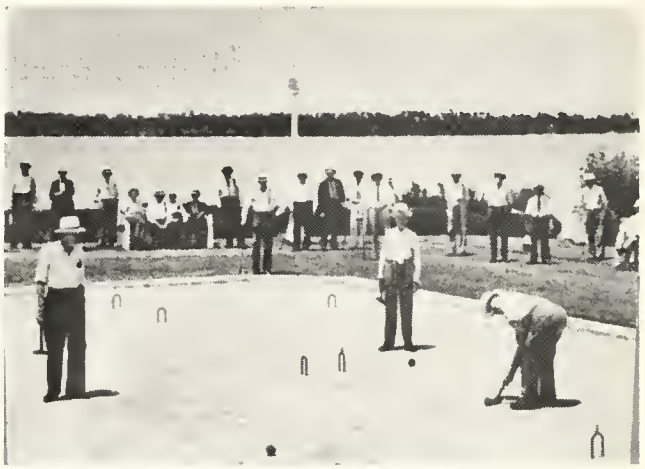
Chairman, New York State Joint Legislative Committee on Problems of the Aging

You have seen them; once they were dynamic executives or vigorous professional men; now, they aimlessly putter about the garden or gloomily rock themselves on some hotel porch in a futile effort to find peace of mind in retirement. Many succumb. The doctor's certificate may read "coronary thrombosis" or "cardiac failure" but the physician knows the real cause is "retirement shock," inability to adjust oneself to retirement.

They are the victims of the myth that all one needs for successful retirement is ample annuities, a bulging investment portfolio, or an adequate pension. Financial preparation for retirement, an expression of high resolution and character, is the foundation on which a retirement structure must be built; but it is only one part of a livable edifice.

Physicians today warn us to erase from our minds the phantasy of retirement as the period of The Grand Loaf. Activity is a biologic duty. It is violation of this fundamental precept that makes retirement, as currently envisaged by many people, as dangerous as toying with a high-voltage wire. Functions and living tissues that are not used decline and atrophy. Nature tends to eliminate those which have relinquished their functional usefulness.

Dr. Edward J. Steiglitz of Washington, D. C., one of the world's leading specialists dealing with the aged, points out that while we cannot halt deterioration or aging of muscular and nervous systems, its speed can be altered; aging can be hastened or slowed down. Inactivity speeds up degeneration.



Olders find croquet fun, but also need constructive activity.

Two of the world's greatest living conductors, Arturo Toscanini and Serge Koussevitzky, are 82 and 74 respectively. Verdi wrote his greatest opera "Otello" when he was 74, and "Falstaff" when he was 80. Between the ages of 70 and 83, Commodore Vanderbilt added about $100,000,000 to his fortune. Titian, at 98, painted his masterpiece of the "Battle of Lepanto." Kant, at 74, wrote his "Anthropology," "Metaphysics of Ethics," and "Strife of the Faculties." Bernard Baruch, at 76, represented the country on the Atomic Energy Commission. Root revamped the setup of the World Court at 84. Edison designed, built and operated chemical plants after he was 67.—(Excerpt from "Need 65 Be Time to Retire?" in *The Management Review.*)

Writing is retirement career for many.

* Reprinted from the March, 1950 issue of Trusts and Estates.

Dr. Theodore G. Klumpp, president of the Winthrop Chemical Co., says, "Any biological organism that has been accustomed to a set routine for 40 or 50 years can't suddenly be shaken from its orbit without untoward consequences. Dr. Lydia G. Giberson of the Metropolitan Life Insurance Company speaks of the "lethal" cessation of activity.

Famed physiologist A. J. Carlson of the University

Psychiatrists warn that idle retirement is likely to aggravate our personality defects, to evoke deep irritations, and make us childish and petulant to such an extent as to transform a fine citizen into a liability. Retirement unwisely planned tends to bring forth weaknesses of childhood that have been consciously or unconsciously repressed through an active life. The mental experts find that the man who wishes to

"Thirty-nine days until I have to retire! I've looked forward to this all these years—till now!"

of Chicago and the late Dr. Alexis Carrel, one of the greatest scientists of our era, have both warned against the "rocking chair" phantasy. "When we are in idle retirement," says Dr. Carlson, "we are contributing to biological parasitism and degeneration of human society as well as wasting valuable human resources." Dr. Carrel pointed out that leisure is even more dangerous for the old then for the young, that inaction impoverishes the content of time. "To those whose forces are declining appropriate work should be given, but not rest," he advised.

"rest" or "live the life of Reilly" is either indulging in a phantasy or is simply running away from life, due to past failures, inadequately rewarded.

Our mental hospitals are flooded with elderly who are not insane but simply confused, harmlessly childish or depressed, senile largely because they permitted their minds to rust away.

The Best Rule to Follow

Science therefore calls for viewing retirement in a new light, in which it must be:

(a) fitted to the individual's needs,

(b) in which activity must not cease, and

(c) in which it must be conceived not as a "drawing back," but rather as a new turn in life's road, filled with new challenges, new opportunities.

When Should You Retire? Since some of us are old at 45, while others are young at 80, no general rule can be given as to when we should retire. Since one's chronological age is unimportant compared with one's physiological or mental age, New York State Health Commissioner Herman E. Hilleboe says, "a fixed age for retirement is absurd."

The best rule to follow is to retire when you can afford to, want to, or have to, due to inability to continue, and then be certain you don't merely vegetate but retire *to* something.

Examples of Successful Retirement

We can learn much from those who have retired successfully. When Dr. Frank P. Graves, former New York State Commissioner of Education, noted educator and holder of 40 honorary degrees, retired, he decided to go back to school and become a lawyer, something he had always wanted to be. In his 80s, Dr. Graves found a new, satisfying career. Mr. Bernard Baruch has found in retirement a busy, vital, rich career advising governments and stimulating much needed health research. Freed of administrative details and responsibilities, three of General Electric Company's top scientists, Drs. Willis R. Whitney, 82; Irving Langmuir, 67; and William D. Coolidge, 76, all officially "retired" from the company, have returned to their laboratories to find new challenges and satisfactions in working, perhaps at a more leisurely pace than previously, in the new fields of radar, television and atomic energy. Note that all these men are useful and needed.

Synthesizing the findings of science with the personal experiences of the successfully retired, there are five basic principles for making retirement a golden era of satisfaction and happiness:

1. Start planning the non-fiscal aspects of retirement when you initiate your fiscal program for retirement. Begin in your 30s and 40s to work on your plan.
2. Don't stop working abruptly; slow down gradually.
3. Make *useful activity* the core of your retirement plans.
4. Develop now an interest outside your business or profession that you can ride as a hobby when you retire.
5. Devote part of your retirement to civic or charitable service.

Successful retirement is one of the most difficult achievements of a lifetime, as hard as the climb to the top in business or finance or law. It requires careful thought. Too many persons begin in their 30s and 40s to invest in annuities or to build up investments for retirement, but neglect until the day they retire planning what they are going to do with their retirement years. Allow yourself at least 10 years, if possible, to develop and test your plan.

Don't Stop—Slow Down

Above all, don't stop working until other interests are ready to absorb and keep alive your mental energies. This slowing down process may consist of easing off the number of hours you work at the office; taking longer or more frequent vacations; gradually shifting responsibilities to younger associates; or cutting down on activities that drain your energies, such as business travelling, sales promotion work, supervision of personnel. This slow-down will also enable you to give your program a pre-retirement trial.

The core of successful retirement is useful activity. But what constitutes "useful" activity? Again, the answer depends on the individual. A retired sales manager found that operating a small gift shop was useful, pleasurable, and kept him sufficiently active to suit his needs. Another retired "big business" executive organized a small woodworking plant in his garage to produce hand carved trays that sell successfully by mail. This man had always been an organizer and reveled in his ability to weld together a small organization that makes a profit without much effort on his part. A third "retiree" when advised at age 82 by his physician to "take things easy," moved his real estate business from his office to his home, where he still works at it part-time. These men are all still productive and the years sit lightly on their shoulders.

And Get a Hobby-Horse

All of us, to grow old gracefully, need to develop—as early as we can—interests outside of business. Age is no excuse. Dr. Noland D. C. Lewis, noted psychiatrist, points out that a man of 65 can learn more easily than a boy of 12. If you don't like to play golf, skip it. If you despise gardening, avoid it. But keep an open mind about hobbies. In retirement you need leisure time activity to supplement your useful work.

Many a businessman who sneered at such activities as painting, photography, writing, sculpturing or carving has found such hobbies a "blue chip" investment for contentment in retirement. In many communities you will find handicraft schools or Y.M.C.A. hobby clubs where businessmen are preparing for their retirement.

One of the basic emotional needs for successful retirement is to feel needed. And certainly one field in which our senior citizens—men and women—are needed is that of civic and charitable work in every community. Many of our philanthropic and educational organizations are staffed by well-meaning amateur administrators; they need help in modernizing their work, they need counsel. Some agencies need investment counsel; others need aid in giving financial counselling to families in trouble. Many need help in soliciting funds from industry and financial organizations.

Our health associations, family welfare agencies, local groups combatting juvenile delinquency, the Red Cross, the Boy Scouts of America, and church organizations, urgently need part-time volunteer aid that our retired executives and professional people can give. We need more businessmen of ability on our boards of education, on our hospital boards of directors. Work with such groups will be enormously rewarding, absorbing and useful. It will give zest to your retirement years.

Selling the American System

Many of our businessmen earn their livelihood selling products, services or ideas. In retirement they can use their talents to render a patriotic service of utmost importance by "selling" the people of their respective communities on the American system and the achievements of American initiative; on the role of capital in producing new standards of living; and on the simple economic facts of American life. Many retired American businessmen will find this role of "salesman emeritus" to be enormously satisfying and challenging. And it is a job that needs to be done.

Underlying the activity program for retirement years there must be a solid bedrock of financial security. This is needed to make the retirement program feasible, to erase the possibility of financial stress and to provide an emotional stability that stems from the knowledge that the later years are provided for. One who is not a financial expert should consult one of the host of experienced fiscal advisers, such as trust officers, who are skilled in portfolio planning for retirement. The stakes are too high to depend on amateur counsel, tips from well-meaning friends, or intuition. Retirement can be an era of achievement as well as calm, of usefulness as well as restfulness, which will keep one youthful in spirit.

If you would avoid the boredom of unplanned retirement, the restlessness of useless activity in your later years, the dulling of mental powers in idle leisure, start now to avoid the hazards of the mental "bends" that come with sudden, unplanned retirement.

Let me grow lovely, growing old.
So many fine things do.
Laces and ivory and gold
And silks need not be new.

And there is healing in old trees,
Old trees a glamour hold;
Why may not I, as well as these,
Grow lovely, growing old?

Author Unknown

State Aid for Recreation Centers

By Harry Levine

Administrator, Special Services for the Aged, New York City Department of Welfare

I SHOULD like to pay tribute to the splendid achievements of the Desmond Committee. In the very brief period in which it has functioned, it has made a most important contribution to the field of old age. Through its published material and its ability to reach the community it is making the leaders in many fields and the community, itself, aware of the problem and the possibilities of a concrete practical program. It is making a lasting contribution to the 16 million Americans past 60.

Since time immemorial, man has counted longevity amongst the blessings, particularly when few achieved it. Now that we have achieved the three score and ten years for the many, those who have achieved it doubt it's blessing and with good reason. There are, however, some blessings. Today, the man of 60 or 65 is a much different person from the man of 60 or 65 of the 1800's or 1900's. He is a much younger person. He is much healthier, stronger and more dynamic. When the average life expectancy was 35 in 1800, a person of 40 was comparatively old; when we achieved an average life expectancy of 45 in 1900, a person of 50 was a comparatively old person. Now that we live to almost 70, a person of 40 or 50 is comparatively young.

In a shorter lifetime, he worked as many hours as he now does in a longer lifetime. He works under conditions much more favorably to his health in terms of sanitation, heat, light and transportation. In the past, if he managed to reach 65 he was a tired old person. Today, a 65 year old person has an interest in and a zest for living, a need to be active and to participate—and why not, for at 55 he has a life expectancy of close to 20 years; at 60, at least 16 years; at 65, 13 years. Even at 70, he still expects to live for 10 more years. If you add 5 or 10 years of unemployment, that is the lot of many people. Before they reach 60 or 65, you have another lifetime to account for. Actually that lifetime cannot be accounted for. It is generally wasted. It makes little contribution to the family and to the community and much less to the older person. It is difficult to accept the fact that the lifetime of millions of people in the United States is wasted, but what is even more difficult to accept is that from these millions—with little to do, with no positive interest, unwanted, feeling themselves a burden—deterioration and illness becomes their daily experience and for many, many thousands mental hospitals become an unnecessary and undeserved inhuman and bitter ending.

I just had occasion to check the figures of Brooklyn State Hospital. As of October 1, 1949, they had 1,165 men and women patients over 60, 71 were 85 to 89, 28 were 90 to 94, 3 were 95 to 99 and 1 was even over 100. It is difficult to contemplate that an individual may enter at the age of 60 and live for 40 years in a mental hospital. Kings County has 1,800 patients who are past 60 and they send more than 100 patients a week over 60 to other State hospitals. The Manhattan State Hospital advises that of their 4,000 patients, 1,971 are over 60 years of age. There are 153 on convalescent status. Dr. Travis writes that it is amongst the latter group that people should avail themselves of our day center activities. I am very deeply concerned with the 153 convalescent patients, but I am even more concerned with the people who may get into mental hospitals—particularly when we are advised that 75 per cent of those already in mental hospitals could have remained in the community with a little help, and even now, most of them do not belong there. Old age homes care for approximately 1 per cent of our older people. I am interested in the more than 90 per cent. The lack of information and lack of understanding of our older people not only makes possible the fact that over 60 per cent of all new admissions to mental hospitals in New York State are people over 60, but it makes possible the consignment of most of our older people to our economic, social and cultural scrap heap.

When a man or woman stops working in his or her regular occupation; when there is no longer a family to raise; when an older person must learn to live alone after the death of a lifetime partner; unless there is a place where they are needed, where they could continue to make a contribution; where they could continue to be active, they begin to lose their feelings of adequacy and worthwhileness. Time begins to hang heavy on their persons and their personalities, particularly during the working hours between 9:00 A.M. to 5:00 P.M., when everyone else around them is occupied and functioning. I believe it is then that deterioration sets in and illness becomes confused with age and eventually part of it. There must be a place in the community for the older person—a place that

can maintain a feeling of usefulness and adequacy and belonging for the countless numbers who need it and want it.

Day Centers Needed

When we begin to analyze what really can be done for the older person, not in the near future, but now, we feel more and more that the development of a well planned integrated system of day centers for older people is one of the realistic practical programs that can be developed today. When Dr. Charles Kidd analyzed the problem, he pointed out that a smaller population of older workers will be in the labor force in 1960 than in 1948, despite the recognition that there will be a tremendous increase in the number of older people. There is a steady marked decline of older people in the labor force. For example, in 1890, 70 per cent of men 65 and over were in the labor force. By 1940, this figure declined to 42 per cent and will decline to 36 per cent by 1950; and by 1960, he predicts it may be as low as 30 per cent. It becomes even more apparent when Dr. Ewan Clague points out that among persons 65 to 74 one-half are not affected by chronic disability and impairment. Only 5 out of every 100 persons were classified as invalids, and there is a growing difference between ability to work, work itself and the life span.

The day center can be a substitute for the loss of the work day; the day center can be instrumental in prolonging the period of usefulness; it can extend the feeling of acceptance and belonging in the older person; it can give meaning to the latter part of life by developing a dynamic program for the older person.

It is generally accepted that each individual ages at his own speed or pace and in the same individual different functions age at different rates. It is, therefore, the content age rather than the birthday or chronological age that becomes important in working with older people. We hope that in these day centers medical findings will be utilized to help the older person to a realization of the remaining strengths available to him and to plan for its utilization. We also are aware that people have many areas of competency that a busy work life has not permitted of development. We hope, through a testing process, to uncover these areas and combine those areas of competency with the strengths remaining to the individual.

The day center program has for its objectives:

1. The promoting of the social and emotional adjustment of the older person through activity.
2. To make possible for the older person the maximum use of the capacities least impaired and of capacities least used.
3. To promote community usefulness by having the older person fit to participate in voluntary programs in the community.

With a case work, group work and personal counselling program, the older person can maintain a period of well being for a much longer time than is presently the case. We believe, through the various activities developed at the centers, that it is possible:

1. To lessen the need for mental hospitals. We haven't had a single admission to a mental hospital from our centers in the six years of its existence.
2. To lessen the need for clinics and general hospitals. Our people stop going to clinics after a period at the center.
3. To cut the period of illness from a matter of years to a matter of months. Their illness is usually of short duration—a matter of weeks or at most months.

I do hope that the committee will see fit to recommend the appropriation of at least one million dollars to extend this program throughout the State. I believe the appropriation will, in turn, save many millions for the taxpayers in the State.

OUR NEW OLDSTERS

"Noting the interest you are taking in the conditions of the 'oldsters,' *of which I shall soon be a member,* I am writing to you for information."

Letter to Senator Desmond from *80-year old* Mr. W. H. Singer, of Olean, New York, Jan. 29, 1950, inquiring whether he can take a job without impairing his old age assistance benefits.

Financing Old Age

By Dr. Henry W. Steinhaus

Research Assistant to the President of the Equitable Life Assurance Society

Some 60 years ago, on June 22, 1889, to be specific, the first Social Insurance Pension System in the world became law in Germany. During these 60 years the extension of life has intensified the problem of livelihood after retirement but no satisfactory basis has been developed for financing old age pensions on a national scale.

There are two principal methods of financing a national pension system. One involves a pay-as-you-go system under which pensions are paid out of current revenues. The other involves complete funding under which capital is accumulated during the working years of a generation, sufficient to pay pensions after retirement without additional financing. Between these two extremes are various other methods under which some reserves are accumulated to pay part of the pensions but ultimately requiring subsidies.

Pay-as-you-go vs. Funded System

The original Social Security Act of 1935 employed the method of funding. When the act was amended in 1939, a pay-as-you-go system was substituted, modified somewhat by a small contingency reserve. However, this reserve actually rose to $12 billion due to the inflation of wages on which contributions are based, and it looks as if the pay-as-you-go system had turned itself into a funded system under which the scheduled tax rates would be entirely sufficient to maintain the present structure of benefits.

If inflationary developments of the relatively mild character of the last few years are sufficient to turn one type of funding into the other, there would seem to exist most serious objections to the adoption of a fully funded system. Nevertheless, H. R. 6000 again has proposed funding of pensions. Reserves would accumulate which would reach even without any further inflationary development nearly $100 billion over the next 30–40 years.

There is obviously no guaranty under either system of financing that the old age pensions will accomplish what they were supposed to do, namely, to establish at least a minimum of financial security for our aging population. Current pensions average $25 monthly, and while they may be raised to an average of some $44 next year, there is obviously no guaranty that the purchasing power of these $44 will be maintained. If our deficit spending and easy money policy continues, the chances are that the purchasing power of the pensions will steadily decline and that adjustments in benefits will always lag by several years. At the same time payrolls and contributions would be higher than anticipated.

In 1935, opponents of the funded system compared the proposed $47 billion reserve to our then national debt of some $30 billions and wondered what the Government would use for investments. This objection was taken care of quite neatly, and even a $100 billion reserve could apparently be handled. However, in order to create this reserve, we must withdraw from current income billions of dollars annually.

These withdrawals would be in addition to any required by supplementary private pensions. Since the Government has the taxing power, it could always pay the promised pensions, Congress willing, whether or not the reserves existed. Private pensions, however, have obviously no security behind them except the funds already deposited. If the pension movement spreads and millions of our citizens obtain a supplementary pension guaranteed to provide $100 a month including Social Insurance pensions, the annual charge would be prohibitive. On a funded basis it costs about 6 per cent of payroll to provide private pensions to supplement those proposed under H.R. 6000, or $6 billion annually for a $100 billion payroll. This amount added to the taxes proposed for the Social Insurance pension represents a sizable proportion of our national capacity to save.

The withdrawal of funds of such magnitude would probably cause a decline in consumption, because price rises necessitated by increased employer costs will cause deferment of spending by a population whose income is also reduced by direct contributions for Federal and private pensions. If the Government attempts to replace this deficiency by additional deficit spending, an inflationary cycle would be set in motion and deflate the purchasing power of the pensions.

We cannot increase our standard of living by printing money and distributing it. I think the public understands this by now. We cannot create old age security by putting away current earnings without actually reducing our standard of living accordingly. This the public does not understand yet. In either

ease, the economy will adjust itself automatically by inflation. Attempts to provide artificially more financial security than there is have perhaps the pleasant illusion of a chain letter that benefits the first few recipients of income, but the outcome is a rude awakening of those who expect a benefit later on.

Three Point Programs

It is not conceivable that there would be a single answer to all these problems, but there are a few things that can be done. First of all, we must attempt to stabilize the span of retired life by encouraging deferment of retirement. Fortunately, the generations living under the favorable health conditions of today appear to bring into their old age an improved vitality. This improvement in vitality may permit a deferment of retirement for those able to maintain employment.

Second, the Federal Government should abstain entirely from withdrawing purchasing power by means of payroll taxation for the purpose of building up additional old age reserves. The reserve of $12 billion by itself would be sufficient to pay the pensions proposed under H.R. 6000 for the next six years, without requiring additional contributions. If payroll taxes are held at low levels, a greater number of individuals will be able to provide a competence for their old age, and thereby minimize the national problem.

Third, we should explore non-monetary financing of old age security. Up to this point we only reviewed the problem of providing a pension payable in cash, and it was the accumulation of money of declining purchasing power which caused all the difficulties. One of the biggest items on the budget for the aged is the cost of living quarters. Only too often exorbitant rents eat up much of the money grants and leave little for comfort. Ownership of living quarters effectively provides an inflation-proof roof over the head. The European pattern of living of the aged has emerged as centered around living quarters, either in large settlements or in individual homes and apartments of income-producing types.

There are many problems involved in furthering non-monetary financing of old age. An equitable method must be found to transfer ownership from generation to generation. The taxation of such dwellings must be handled in such a way as to avoid undue burdens on both the aged and the community.

There are other items in the budget of the aged which may lend themselves to non-monetary storage. In my opinion, the greatest hope for old age security lies in our success in exploring and activating non-monetary methods of financing old age security.

Trends in Old Age Assistance

By Miss Jane M. Hoey

Director, Bureau of Public Assistance, United States Social Security Administration

As an introduction to the subject of trends in old age assistance perhaps it would be desirable to state some basic assumptions underlying the need for and objective of an old age assistance program.

Man is a nation's greatest asset, whatever his age—not just when he is young—and whatever his race, nationality, religion, physical or mental capacity, personality, or social or economic status. The family, whatever its composition or age of its members, is the basic unit of our civilization and needs to be developed and preserved whatever the cost. There is no substitute for the family nor for the care and affection which most members of a family give to each other.

The Nation has an obligation to man, always to respect his dignity, his integrity, and rights as a human being, and to help him develop all his capacities to be productive, and to support himself and his dependents, and to contribute materially, culturally and spiritually to his own growth and development for the benefit of society. The Nation, through its various governmental units and private agencies, has an obligation to make possible normal family life through such measures as will protect health and develop wholesome surroundings in which man can live; to establish and maintain a decent standard of living; to provide such services as education, health, and welfare as are necessary to promote public welfare; and to encourage private institutions and agencies in giving services which are helpful to man and families as these services are needed and desired. It is because of our failure to live up to our theoretical assumptions in practice, and because of the facts of change in our population and the varying needs of groups such as the aging, that we must reconsider our plans, our attitudes, and our programs.

When the Social Security Act was passed in 1935 it was in the middle of a depression and millions of workers of all age groups were unemployed. There was a generally accepted idea at that time that older workers should retire and thus leave jobs available for younger workers. During the long period of the depression, large numbers of older workers who were unemployed used up their savings and other resources and at 65 were almost completely destitute. Therefore, a long-range plan for meeting need caused by certain common standards, unemployment and old age, was developed under the Social Security Act. Provision was made for unemployment insurance, State administered, and old age insurance, later changed to old age and survivors' insurance, a Federal plan financed through contributions of employees and employers. However, no provision under the Social Security Act was made for large numbers of workers, chiefly those in agriculture and domestic servants. Also there were many who were then aged and in need and who could never be covered by the insurance programs. So for this latter group the Social Security Act provided grants-in-aid to states to help them give more adequate financial aid and other services to their needy aged living in their own homes or in private institutions or boarding homes. Because this needy group was so numerous and because it took so long for persons to qualify under the old age insurance program, many persons, aged and others, assumed that the only program for care of the aged with which the Federal and State governments were concerned was old age assistance. For this reason and because for a long time there have been individuals and groups advocating "pensions for the aged," some state legislatures have tried through the old age assistance program to guarantee a minimum income to the needy aged and have liberally interpreted need. Because old age insurance benefits are inadequate to meet the average need, many beneficiaries of old age insurance are also eligible for supplementary old age assistance, and 10 per cent are in receipt of it.

H.R. 6000

If changes in the Social Security Act, such as are proposed in H.R. 6000 are enacted, this may change drastically the trend in old age assistance in the future. It may also change community attitudes toward the need for a flat pension. An Old Age and Survivors Insurance program for all employed persons and with benefits adequate in amount to meet average need, supplemented by an old age assistance program for the needy aged, would seem to be a desirable objective toward which we have made real progress, but which needs extension and strengthening as indicated by present congressional action.

Old age assistance is a program of financial aid and other services to men and women who are at least 65 years old and who do not have enough income and re-

sources to secure the necessities of life—food, shelter, clothing, medical care, etc. The program was intended to supplement insufficient incomes of individual people; and to supplement other plans and programs that provide income after 65. These programs have not been developed as anticipated, and old age assistance has grown beyond its intended scope and responsibilities. To understand past trends and to plan for the properly limited function of old age assistance in the future we must look, in passing, at some other pertinent developments in the United States.

As most of our programs and plans for old age security are oriented toward age 65, that age has become unfortunately synonymous with old, retired, disabled, and sometimes useless. Unless community attitudes and our programs are redirected toward a worker's ability to maintain himself as long as he is able and wishes to do so, many of our citizens over 65 will be sentenced to a life of inactivity. To avoid this sentence, we must overcome these confusing and misleading concepts and attitudes they reflect. We must assert our conviction that people over 65, like those of 20 and 40, have the right and the responsibility to use fully their capacities for work, play and participation in community affairs. For ethical, social and economic reasons we cannot afford to retire workers automatically on their sixty-fifth birthday.

Although we should modify our fixation on age 65 as the benchmark for retirement, we must keep in mind that the rate of people who reach that age is growing more rapidly than the population as a whole. In 1880, persons 65 and over constituted 3.4 per cent of the population; in 1940, 5.7 per cent; in 1960, 9.2 per cent; in 1975, 11.3 per cent. In 1948 there were 11 million persons 65 and over; in 1960 there will be 15 millions.

Resources of the Older Worker

We are all too familiar with the truth of the statement that *employment opportunities* of older workers deteriorate. It has been confirmed recently by a study of the United States Employment Service conducted in six areas in the spring of 1949 at the height of the recent recession. In a period of declining employment, marginal workers and particularly men over 45 and women over 35 are among the first to be laid off. This is especially true of unskilled workers. Unemployed men over 45 and women over 35 take longer than those in younger age groups to find new employment. If not re-employed in their former regular occupation, they are nearly always required to accept employment at lower skill and pay levels. Such employment policies are hardly in line with the unequivocal statement of economists that our economy cannot get along without the older worker, if it is to be an expanding economy of the type they forecast.

The majority of retired workers are not likely to maintain themselves *from savings of their own.* One example may be enough to show this:

In November 1949, it cost a family of four in Detroit $280 a month to maintain itself at a modest standard of living. Two hundred sixty dollars per month is the average wage of the Detroit automobile worker, if he works 11 out of 12 months. Thirty-six dollars is the monthly premium for a private annuity that assures him an income at the age of 60 of $100 if he starts buying it at the age of 30 and pays for 360 months. This is, of course, impossible for most factory and farm workers.[1]

Private pension plans are estimated to cover about four million workers, many of whom are also entitled to Old Age and Survivors Insurance benefits. The essential purpose of these plans is to remove those workers from the employment rolls who are past a specified age, usually 65.

Union welfare funds were established as early as 1867, when the Brotherhood of Locomotive Engineers developed a death and accident benefit plan. Their recent spectacular expansion is due in part to the lack of provision for sickness and disability insurance under Old Age and Survivors Insurance. Today these union plans according to Harry Becker of the United States Automobile Workers, protect nearly four million workers, about five times the number in 1945.

Old Age and Survivors Insurance, in 1935, when the Social Security Act was passed, was expected to be the major source of economic security for the retired worker. Because of the program's limited coverage and inadequate benefits, this intent of Congress has been realized only in part. Out of 57,000,000 workers in civilian employment in June 1949, some 22,000,000 were in jobs that provided no credits under the Old Age and Survivors Insurance program. The number of beneficiaries aged 65 and older was then about 1,800,000; the number had almost tripled since 1945, but was still 836,000 fewer than the number of old age assistance recipients, now 2.6 million in June 1949. The average monthly old age insurance benefit was about $26.

If H. R. 6000 becomes law, its liberalizations for Old Age and Survivors Insurance would be felt gradually in old age assistance, as the program matures; but we could not look to an immediate realignment of responsibilities between the programs.

As previously indicated, the vigorous efforts of the

[1] Summarized from "Supplementary Security Programs under Collective Bargaining" Harry Becker, *Public Welfare* November 1949, Vol. 7, Number 11, p. 208.

so-called *pension movements* make it hazardous to predict that the future will assign to Old Age and Survivors Insurance its major role and to old age assistance its minor place among Social Security programs. In fact, these movements are a direct threat to Old Age and Survivors Insurance. They exert strong political pressure to expand old age assistance into a non-contributory pension program for all persons aged 65 and older, their cost to be met from current taxation. The success of these efforts is obvious in Louisiana, Washington, California, and Colorado, as is their impact on governmental expenses and taxation. For instance, Louisiana in 1949 has the highest per capita state tax revenue in the country, $85.59 as compared with $79.75 in Washington, $72.47 in California, and $70.60 in Colorado.[2] The rise and fall of the movement in California may not be an omen of future developments. However, California's experience illustrates what happens when old age assistance is promoted with little considerations of the requirements of other needy people in the State or of the other types of public services which need financing, such as education and health. Through these efforts has been created an imbalance in program planning and adequate consideration to all interests has not been given in some states. On the other hand, these pension movements have made positive contributions by drawing attention to the needs of the aged and securing more adequate assistance in a number of states, and by strengthening the conviction throughout the country that old age assistance comes to people as a right and not as a gratuity.

Grants-in-aid for Old Age Assistance

As a way of decentralizing operation and in order to leave with the states full responsibility for administration of old age assistance and other public assistance and service programs, the Federal Government established under the Social Security Act grants-in-aid to the states. The conditions for state receipt of such funds are stated in the act, including the maximum amounts of Federal funds available to match state funds. In the fiscal year of 1950 the Federal Government will expend over one billion dollars for public assistance to 4½ million needy persons and the state governments will spend about an equal amount. For old age assistance the Federal share in 1950 will be about $850,000,000. As of October 1949, the number of recipients is about 2,700,000.

The imbalance in provisions as between programs under the Social Security Act can best be illustrated by the amounts granted to states under the Social Security Act since the beginning of these programs in February 1936 through October 1949. The total amount in round figures for public health service grants, the three programs under the Children's Bureau—crippled children, maternal and child health, and child welfare services; the administration of employment security; and the three public assistance programs—old age assistance, aid to dependent children, and aid to the blind—was seven billion dollars, almost five billion of which went for old age assistance and one billion for aid to dependent children. The Federal agency matches state funds up to certain maximums and the higher income states generally make higher appropriations.

In the Nation as a whole, old age assistance programs have developed gradually toward more adequate payments and coverage, toward more equitable treatment of individuals, and more efficient operation.

Old age assistance laws have existed in the United States since 1915, when the first one, later found unconstitutional, was passed in Alaska. Montana followed in 1923, Nevada and Wisconsin in 1925. By 1935, there were 32 states that had enacted legislation and paid old age assistance under these laws. Ten of these states began payments only in 1934 in anticipation of the Social Security Act.

Recipient Rates and Amounts of Assistance

In December 1935, 42 states had submitted plans for the administration of old age assistance to the Social Security Board. All states and territories had an approved plan by December 1938. Since then the number of recipients has grown from 1,779,292 to 2,700,000 in October 1949. Almost one out of every four persons, aged 65 or over, is now on the old age assistance rolls. The number of beneficiaries of this program is greater than in any other public program except those for veterans. In October 1949 the average assistance payment was $44.37 as compared with $29.75 in July 1945. This average payment today buys only 11 per cent more consumer goods and services than in 1945. The cost to the Federal Government has more than doubled since 1945.

Assistance recipient rates and amounts of assistance still vary widely among the states. In June 1949, 810 out of 1,000 aged persons were on the assistance rolls in Louisiana, 601 in Oklahoma, 103 in New York, 66 in New Jersey, and 109 in Pennsylvania. In June 1949, the average monthly payment in California was $70.55 and Mississippi $18.80. In New York it was $52.74. This range between average payments is obviously much greater than the range between the cost of living in these states. If we want to appreciate what the individual payment may mean to indi-

[2] State tax collections in 1949 exclusive of unemployment insurance tax. Bureau of the Census.

vidual men and women who must live on it, we cannot think only in terms of national averages.

Perhaps the most significant development in the shifting pattern of state recipient rates has been that of the development of a rather clear-cut relationship between the per capita income of the states and the proportion of aged persons on assistance.

States with a low per capita income have now, in general, the high recipient rates. This situation is quite different from the situation in 1940. In that year, Nevada and New York, states with a high per capita income, had recipient rates of 334 and 128 per 1,000 aged 65 and older; and Arkansas and Mississippi, states with a very low per capita income, had rates of 185 and 193; today the figures are respectively 220 and 103 for Nevada and New York, and 403 and 480 for Arkansas and Mississippi. In eight states, most of which rank low in per capita income, more than 400 per 1,000 are receiving aid. Five states, four of which rank high in per capita income, had a rate below 100 per 1,000.

If we relate this pattern to the pattern of distribution of old age and insurance benefits, it becomes clear that in the agricultural states the old age assistance program carries an extra burden of needy persons out of proportion to that of industrial states. Eleven (except West Virginia) of the twelve states (Mississippi, Arkansas, South Carolina, Alabama, Kentucky, North Carolina, Tennessee, Georgia, Louisiana, Oklahoma, New Mexico, West Virginia) that had the lowest per capita income in 1947 rank high in the relative number of old age assistance recipients and low in the proportion receiving Old Age and Survivors Insurance benefits in June 1949. In that month, 14 states had more beneficiaries of Old Age and Survivors Insurance than recipients of old age assistance. Nine of these states, largely industrial, had per capita incomes above the national average in 1946–1948. The 14 states are Connecticut, Delaware, District of Columbia, Indiana, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Virginia. Increased Federal financial participation has been an important factor in enabling states to raise assistance payments.

Following the enactment of the 1948 amendments, most states reported increases in average payments. Many of these resulted from raising the money amounts assigned to individual items in the state's assistance standards, from adding items to the standards, or from raising maximums. From June 1948 to June 1949 the average increase was $5 or more in 15 states, and from $4 to $4.99 in eight states. Among the states that increased payments by smaller amounts, the largest single group included those in which state funds were inadequate and cuts in payments to recipients would have been made had there been no additional Federal funds. Some of the states with smaller increases also added relatively large numbers of recipients to their assitsance rolls.

In New York State, recipients benefited from the 1948 amendments by an average monthly increase of $3.30. Since the New York provisions for financing the program require that the localities meet 20 per cent of the total payments, the localities had to appropriate additional funds to meet their share of the increase since assistance rolls have continued to expand.

Services Determining Eligibility

From statistical case records we know that the ways by which assistance is provided is improving in many places. Applicants receive aid with less delay. In 1946, for instance, only 31 states made the first payment less than a month after the receipt of the request for aid. In 1948, 39 states managed to do so. This administrative progress, although only two or three weeks, may seem a very long waiting period to the needy applicant. More and more recipients are left free to spend their assistance payment according to their own choice and judgment as required in the Social Security Act. In our review of state practice for 1947–48, which was limited to one or a few counties in each state, serious questions were raised in four states only about a violation of the requirement that assistance be paid without direction on the spending by the agency. However, practices which do not restrict outright the recipient's use of the money, but are not in accord with the principle of unrestricted cash payments, are unfortunately still found in several states. It is difficult for some workers to draw the fine line between counseling on appropriate uses for money and instructions on how to spend it. The opportunity for a hearing before the state agency is available to dissatisfied claimants in all states. The promptness and ease with which this opportunity is given varies considerably.

While average assistance payments still differ widely among the states, distinct progress has been made within a good many states toward the equitable determination according to uniform state-wide standards of assistance.

Medical Care

While the public assistance program is primarily concerned with money for maintenance when medical care is not available from other sources, it must be provided by the assistance agency. The provision of medical care or of money for its purchase has steadily increased. In 11 states maximums on assistance payments may be exceeded for that purpose. In Louisiana it may be raised to $90 for that purpose; in Montana it may be increased to $90 for nursing care, and

to $100 for hospitalization. In addition to amounts made available to recipients to pay for medical care, most agencies—among them New York—that provide such care, pay vendors directly for some medical services. Such vendor payments are most likely to be made when large bills for hospitalization or other expensive treatment are incurred. Four states meet the entire cost of medical care through vendor payments. Federal financial participation is not available for the expense of vendor payments and for expenses that exceed the Federal maximum. Under H. R. 6000 vendor payments may be made but the maximum on individual payments for old age assistance is $50 per month for assistance and medical care. This would be entirely inadequate. Providing $6 per month on the average for each old age assistance recipient would be a much more adequate amount.

Other Services

Throughout the country, many public assistance workers give additional services, such as counseling to and referrals of claimants to other social agencies. These services are so closely integrated with the workers' activities in determining eligibility that their statistical enumeration and identification in case records is not often feasible.

We can identify those services that are provided by special staffs, such as homemaker services, as given in New York City, through which people are helped to stay in their own homes when their ability to manage them is failing. In several states (Illinois, Texas, and Michigan) state and local staffs develop ways of making sheltered care available to aged recipients. In many large and small communities and probably in all states, top administrative staffs cooperate in commodity planning for health and welfare services.

Legislative Trends

Trends toward liberalization and expansion of the assistance programs continued in legislation enacted in 1949, a year when nearly all legislatures were in session. The trend, generally, was toward increasing the amount of assistance paid to needy people and to making more needy people eligible for aid by repealing restrictive conditions of eligibility. Little legislation was enacted which restricted the scope of the assistance programs. This is interesting because many legislatures had previously appointed committees to study the operation of the public welfare department specifically, or as part of a larger study of state government. One reason given was to see whether the assistance rolls could be reduced.

In previous legislative sessions there have always been some areas of public assistance administration in some states that have suffered set-backs, although legislation as a whole was constructive. In 1947, legislation affecting the responsibility of relatives to support their kin, and the recovery from estates of recipients for assistance granted, restricted the states' programs in some instances. These same areas were singled out for attention in 1949.

Some Liberalizations

For instance: In 1949 eleven states amended their laws with reference to minimums and maximums on old age assistance payments. Eight states raised the maximum, two established or changed the minimum; Connecticut deleted its maximum altogether. Five states liberalized residence provisions, including one that repealed the residence requirement. Some repealed the clauses requiring the recovery of assistance granted from the estate or resources of a recipient. Arizona modified its citizenship requirement and tempered the provision that made acceptance of employment a condition of eligibility. Massachusetts provided an additional item in its assistance standards, namely, $4 for leisure time activities, and the state is to reimburse the locality for this amount of money in full, notwithstanding any other provisions concerning reimbursement. Eight states passed legislation affecting persons in institutions or needing institutional care. This reflects the continued interest of legislatures in this area and the discussions in Congress that considered a relaxation of provisions in titles I and X which prohibit Federal financial participation in payments to inmates of public institutions.

Restrictive Legislation

The outstanding concern of legislatures with the problem of dependency arising from desertion of parents is also noticeable in provisions affecting adult children who refuse to support their parents. Seven states this year enacted statutes providing for interstate cooperation in obtaining support from deserting relatives. Several other states passed other provisions to strengthen the responsibility of public agencies to secure support from relatives.

If property was transferred for other than fair consideration within a specified period, this was made a bar to eligibility in several states.

The right to recover from resources of recipients of assistance paid was written into some laws, as well as penalties for any fraudulent action in connection with the receipt of assistance.

Miscellaneous Provisions

There was also considerable activity in providing for changes in state organizational patterns in some

states, and in others for a modification in the division of fiscal responsibilities between state and counties. Some of the latter should prove to be of considerable help to those counties that have found it hard, if not impossible, to raise their share of money for assistance expenditures.

Conclusion

The increasing interest in and understanding of the problems of an aging population hopefully make themselves felt in many ways. An Old Age and Survivors Insurance program expanded to cover all employed persons, including agricultural workers, would in the not too distant future reverse the trends toward an expanding old age assistance program, and restrict the latter to the function of meeting the needs of a relatively small number of needy people who for some exceptional reason are not entitled to Old Age and Survivors Insurance benefits or find them inadequate.

The social insurances should be the basic form of security against need when people cannot work and support themselves.

A basic minimum guaranteed to workers through their own and their employers' contributions would maintain in this country the mobility of labor, a right which is important for us to maintain.

If these developments come to pass, both programs can assume their respective major and minor functions in a comprehensive plan of the American community for its older citizens.

Such a plan should be based on the following facts: Chronological age per se does not establish a barrier to continued economic self-maintenance, employment, rehabilitation, or to physical and mental health. Although disabling conditions accompany the aging process in many cases, aging itself must not be treated as a disability. The community as a whole depends increasingly on the contribution of aging persons, and they must be urged to participate in planning and working with the younger people. Although it may be necessary to do so for an interim period, we are not interested in setting up special welfare services for the aged, but we are interested in establishing for all people who want them social and economic resources, built up in balance within our total economy.

*Older Persons Have Special Housing Needs**

By Hertha Kraus

Associate Professor of Social Economy, Bryn Mawr College

A RAPIDLY expanding literature on the aging population agrees substantially on the facts presented in the box on this page. Where and how do these people live now?

Case studies and experience have shown that living in their own home, even with insufficient care, is preferred by most elderly people. There is infinite reluctance to move into institutions, or to share the home of near relatives, unless forced by dire economic need, serious physical incapacity, or utter lack of suitable housing. In a New York City study of more than three thousand inquiries concerning aged, 87.5 per cent related to living arrangements—where, how, with whom to live!

It may be assumed that within the census group of 24 per cent, living with children or close relatives, many aged would have preferred independent homes if available. Increasingly, in the wake of a changing culture pattern of family life, this arrangement is also the preferred choice of the younger family. Urban and apartment living, simplified housekeeping, and fewer children have combined to reduce the usefulness of the resident grandparent within the family cycle of the younger generation, except for emergencies.

Needs of Chronically Ill

The need for more adequate care for the chronically ill, including more adequate housing, has been studied widely in recent years. Occasionally it has been dramatized when serious incapacity affects a comparatively small group whose tragic handicap is war-related, for instance in the case of the paraplegics. Legislation enacted in 1948 (HR 4244) has authorized the Veterans Administration to pay 50 per cent of the cost (not exceeding $10,000) of a suitable housing unit for any veteran entitled to compensation for permanent and total service-connected disability "due to spinal cord disease or injury with paralysis of the legs and lower part of the body." Eligible veterans may obtain model plans and specifications of suitable housing units without cost. The paraplegics' plight is an extreme illustration of the plight of an infinitely larger and steadily increasing group of the population, which, despite considerable handicap, may live and desire to live in their own homes—not in institutions and commercial nursing homes—if suitable homes can be found with adequate equipment and a chance for housekeeping and attendant care as needed.

It is well known that a substantial part of the chronically disabled group are identical with the aged population; others are somewhat younger. In the case of disabled children and adolescents, suitable arrangements involve the entire family home to which these young people belong. They do not, in the main, represent a peculiar housing problem. It is among the middle aged and elderly living alone, or with a spouse or close relative (possibly away from home for most of the day as the main wage earner) that a demand for **adapted living arrangements** has arisen that requires attention. They represent a substantial group.

In 1933, Mary C. Jarrett found that many chronic patients in hospitals and in their own homes need only attendant care but actually receive hospital and skilled nursing care, at high cost, because more suitable facilities are lacking. In turn, they deprive others of urgently needed qualified hospital service, of which there was and remains a serious shortage. Many patients must be kept in hospitals beyond the point of need for hospitalization; at the time of possible discharge, they and their relatives, assisted by case workers, are frustrated by the utter lack of provisions suitable for living within personal limitations. Plans for additional hospitals for the chronically ill, for public, voluntary, and commercial nursing homes—all urgently needed in most communities—will only meet a small fraction of the problem, which in the main requires the facilities of family homes, not of institutional care.

Mentally Ill

Realistic attention should also be given to the very frequent incident of failing mental powers among the aging. According to expert opinion, our overcrowded mental institutions today are forced to house large numbers of elderly patients who do *not* require the treatment facilities nor the type of custodial care provided in them.

In planning for dwelling units suitable in design for the handicapped, it should be remembered that the frequency of chronic disabling illness is consid-

* Reprinted from Journal of Housing, Jan. 1950.

FACTS ON OLDER PERSONS IN POPULATION OF THE UNITED STATES*

NUMBER OF PERSONS 65 AND OVER	In the year 1900—3 million In the year 1946—10.5 million In the year 1975—17 to 20 million (estimate)
MARRIAGES	Marriages with both man and wife surviving have 39-year average span. Last child of above couple marries, on the average, at end of 28 years of couple's married life—leaving one-fourth of couple's married life as two-person family. Of men 65 and over, 64 per cent are married with spouse present—only 34 per cent of women in same age group.
LIFE SPAN	Average wife usually lives 13 years after husband's death. Average husband, in family where wife dies prematurely, survives six years.
EMPLOYMENT	About 50 per cent of men continue in gainful employment beyond age of 65; about 8 per cent of women. At age of 75, percentages drop to 17 and 2. In December 1946, of 10.5 million persons 65 and over, 3.6 employed (including 900,000 wives of earners)—3.9 million benefited from social insurance, old age assistance, institutional care, etc.
INCOME	Of 2.5 million husband-wife families, where head 65 and over, 9.1 per cent had incomes less than $500; 28.5 per cent, $500-$1500; 20.3 per cent, $1500-$2500. In 1946, old age and survivors benefits averaged $25.80 per month, per person; grants from old age assistance, $35.31.
HOUSING	Private homes of their own—68.8 per cent (about half of them, one- and two-person households) Shared home of relative—21.9 per cent Shared home of non-relative—over 5 per cent In institutions—4 per cent.

erably greater among low-income groups than among the more comfortable.

Housing for those seriously handicapped by physical or mental disabilities should be seen as an integral part of a housing program for an aging population. The requirements are identical, although slightly different in degree, not in character of need. The transition from full to impaired capacity may be slow and hardly noticeable; it may also be sudden. It must be assumed that the majority of all aged persons suffer from one or several impairments, whether actually diagnosed as such or not. Dwelling units planned for the aged and suitable for them in design and supplemental facilities should not be reserved rigidly for people of a specified chronological age. They should also be available, as an important community resource, for those of younger age groups who require the same provisions because of actual disability. Of all persons suffering from invalidity, 50 per cent are in the age groups over 55; their integration should not offer a serious problem.

In developing different patterns for senior dwellings, special attention should also be paid to the problem of the aging farmer ready to retire but with no place to go. It has been estimated that about 12 per cent of all farm operators—over 800,000—are now in this age group; at the same time there is considerable demand for farms by young families eager for independent operation. In addition to sound opportunities for reinvestment after selling his farm, the elderly farmer and his wife want a suitable and comfortable dwelling near familiar surroundings, perhaps in a suburban cluster around the county seat. They may also become interested in busy and congenial communities in a more favorable climate, deliberately planned for meeting the increasingly effective demand of senior householders.

Experience to Date

In this country, the development of non-institutional housing for aged has not yet gone beyond a few units, valuable as illustrative samples and pioneering ventures. Until very recently, the housing needs of the aged were considered only in general, as part of every cross section of the population, none of which should be overlooked. For the last 10 years, however, there has been growing recognition of a widespread, serious, and utterly unmet need of very considerable scope. In early postwar Congressional hearings on the housing bill that became law last year, the representative of the American Public Welfare Association testified that the housing need of the aged is among the most serious. The housing platform of the American Association of Social Workers also demands special attention to such housing.

Local housing authorities, too, are beginning to pay some attention to the need. As a widespread policy, most public housing projects have excluded elderly people living alone, even couples, in order to give preference to families with children. A noticeable exception is the New York City Housing Authority.

Their Fort Greene Houses, built with State funds, includes apartments built for the aged. Another unique public housing project for the aged is a small colony, Roosevelt Park, Millville, New Jersey—a development of 18 bungalows.

The State of Washington has been the first to encourage cooperative housing for small groups of elderly people, as a design for living peculiarly suitable for those of independent spirit and eager for congenial associations combined with low-cost living. Each project is sponsored locally by some civic association. Units of older persons have been helped to set up cooperative households in dwellings adapted for this purpose. Most of the residents are recipients of old age assistance grants, with the Washington State Department of Public Assistance encouraging the venture, but not financing it.

Starting in New York City, but later moved to Newark, New Jersey, a similiar cooperative housing project was developed for aged, mostly refugees from central Europe. The Cooperative Residence Club, Inc., has established a unit for approximately 55 residents (also an additional summer unit in New England), financed and operated as a nonprofit cooperative association.

Among the best known humanitarian developments are two New York City apartment houses for aged, providing sheltered living—Tompkins Square House, containing 60 units of one or two rooms, operated by the Community Service Society of New York, and an expanding apartment project operated since 1939 by the Home for Aged Infirm Hebrews.

Finally, two small "villages" for aged, developed under private auspices, may be mentioned—the colony of the Motion Picture Country House Association in San Fernando Valley, California and the new venture of The Loyal Order of Moose, developing the fraternity's City of the Aged at Moosehaven (near Jacksonville), Florida, expected to become at some time also a research center for gerontology.

Experience Abroad

Foreign countries have paid considerably more attention to the peculiar housing needs of the aged, living on restricted means, although the provisions are not yet adequate in any country. Municipal housing projects with simple housekeeping facilities for aged women have been a common resource in many European countries since the middle ages. A modern version of the same plan was developed in Cologne, Germany, in 1926 when the city established a unit of 800 housekeeping apartments for aged individuals and couples of limited income, grouped around a park. Rentals included nursing and housekeeping aid, also complete laundry service for all tenants.

England, Denmark, Sweden, and Holland, among others, have developed extensive dwelling units for aged as part of their public housing programs. England has for many years allocated 1 per cent of public housing to the aged. In that country, the report of the Survey Committee on the Problems of Aging, sponsored by the Nuffield Foundation, which has made a nationwide study covering numerous aspects of needs and services, suggests "as the most intelligent guess" that a minimum of 5 per cent dwelling units specifically suited to the needs of the aged should be available throughout Britain. The report emphasizes that meeting this figure will require a quota of building and remodeling in most areas substantially beyond the 5 per cent average. England's National Assistance Law of 1947 also includes definite provisions for the expansion of senior housing facilities, in the main in the form of public hostels. All plans reflect a realistic appreciation of their needs and the very sound observation that larger housing units, scattered through the communities, will become available for families with children when aged individuals and couples will be offered new small units designed for them. Building these small units will obviously be less expensive than the development of an equivalent number of dwellings for growing families, which often must include new school projects.

In addition to expanding non-institutional housing, Great Britain is also engaged in building small public homes, allowing for a maximum of freedom and privacy despite institutional management. Voluntary agencies are also encouraged and assisted to contribute within the next few years a sizable number of small hostels for aged residents.

Among a wide range of Swedish projects, homes for "pensioners" and the Flower Courts of the Flower Foundation have become well known as representing an enlightened social housing policy.

In 1938, the International Federation for Housing and Town Planning studied the various housing projects for aged in 13 different countries and published a summary of interesting information on senior housing in Belgium, Denmark, France, Germany, Great Britain, Holland, Italy, Latvia, Norway, Roumania, Sweden, Switzerland, United States.

Next Steps

It is of great importance that the housing market should begin to respond with definite plans to the housing demand of a 10 million, plus, population group of adults, steadily increasing in actual numbers and in proportion to the total population. Community planning for most of their needed facilities has barely begun.

Clusters of senior dwellings—remodeled older hous-

ing or newly built—must soon form an integral part of all public and private housing developments, to be scattered over many different neighborhoods and to be offered on every price level. Such units may be developed in cottage and bungalow courts, as part of multiple dwellings and mixed with apartments of other sizes, or as solid wings of apartment houses. They may expand to entire suburban neighborhoods or even individual communities, especially in southern climates.

Architects and builders should also be encouraged to give increasing attention to a pattern for which we may assume effective demand. **Single family dwellings could be planned with the attachment of small housekeeping units with a separate entrance, offering considerable privacy.** Such combination units would have the following advantages. They may be part of a wise and practical retirement plan: the housekeeping annex may serve as an income-producing unit, or as a suitable home for adult children, single or married, while the senior family will live in the larger home during the expansive part of the family cycle. On retirement, the senior family, or widowed parent, may move into the annex, now using the main house as an income-producing unit. Such combination would provide some economic security developed over a period of years. It would add to emotional security by continuing family and neighborhood contacts despite advancing years and shrinking income. It would give access to essential housekeeping and nursing aid, as necessary, to be provided by the younger family in the main dwelling, presumably close relatives. It would allow mutual aid to flow both ways, for instance during periods of illness or absence of the younger family when grandparent aid may again become important. At the same time residents in the housekeeping annex would not affect the family pattern of either the younger or the older family unit and would not force two or three generations into a common rhythm, thus protecting the privacy and living arrangements of each group.

Design

Good design for all types of units, in single and multiple dwellings, remodeled and new, will be essential. It should be worked out jointly by architects, homemakers, physicians, social workers, and nurses. American studies of such design should cover the best layout and equipment for individual units, within the limits of economic planning, and the equally important layout and equipment for essential group facilities (service centers) that must supplement individual units. Some of the design developed abroad may be found very suggestive indeed, since it aims at widely identical, common human needs.

Good design for a housing program for the aged must be guided by the following essential requirements.

It must provide an adequate number of small dwellings suitable for one to two persons, at low and middle price levels. All dwellings must be easy to manage and require only a minimum of housekeeping effort. They must also be carefully freed from common hazards likely to injure persons of slowed reactions, impaired vision and hearing, and decreasing mobility.

A certain proportion—possibly 20 per cent—must be planned specifically for persons actually incapacitated, so as to accommodate the seriously infirm, including those of the middle aged group. Their design must be adapted to the needs of individuals who may require help in bathing, toileting, dressing; who may have to grope their way or may be tied to wheel chairs. Such conditions will affect the measurements of individual rooms, doors, stairways, elevators, ramps, porches.

Good design will reduce the exceedingly high home accident rate among elderly people; the elderly die from accidents that younger people survive easily. A special study of fatal accidents of the 65 and over group in New York State in 1947 has shown that four out of five home accident fatalities were caused by falls. Burns and poisonous gases ranked second and third as the greatest killers. Inadequate housing often proves disastrous when advancing age brings weaker vision and hearing, and poorer coordination.

Group Services

Finally, senior dwellings must be planned in **clusters large enough to allow for the economic development of group services** by which each individual unit may be reached as needed and which must be seen as an essential supplement of each unit. Group services will center on housekeeping, attendant, and nursing aid. There must also be recreational facilities, provided in- and out-of-doors, suitable in layout and program for seniors of mature interests and limited mobility.

The physical base for such group services must be included in the basic design of each housing development but their operation should not necessarily be a function of the landlord. Group services may be sponsored by nonprofit agencies, by churches, by cooperative associations, by public or private community agencies. For the middle and higher income levels, some of the facilities may be managed commercially, in the form of service occupations.

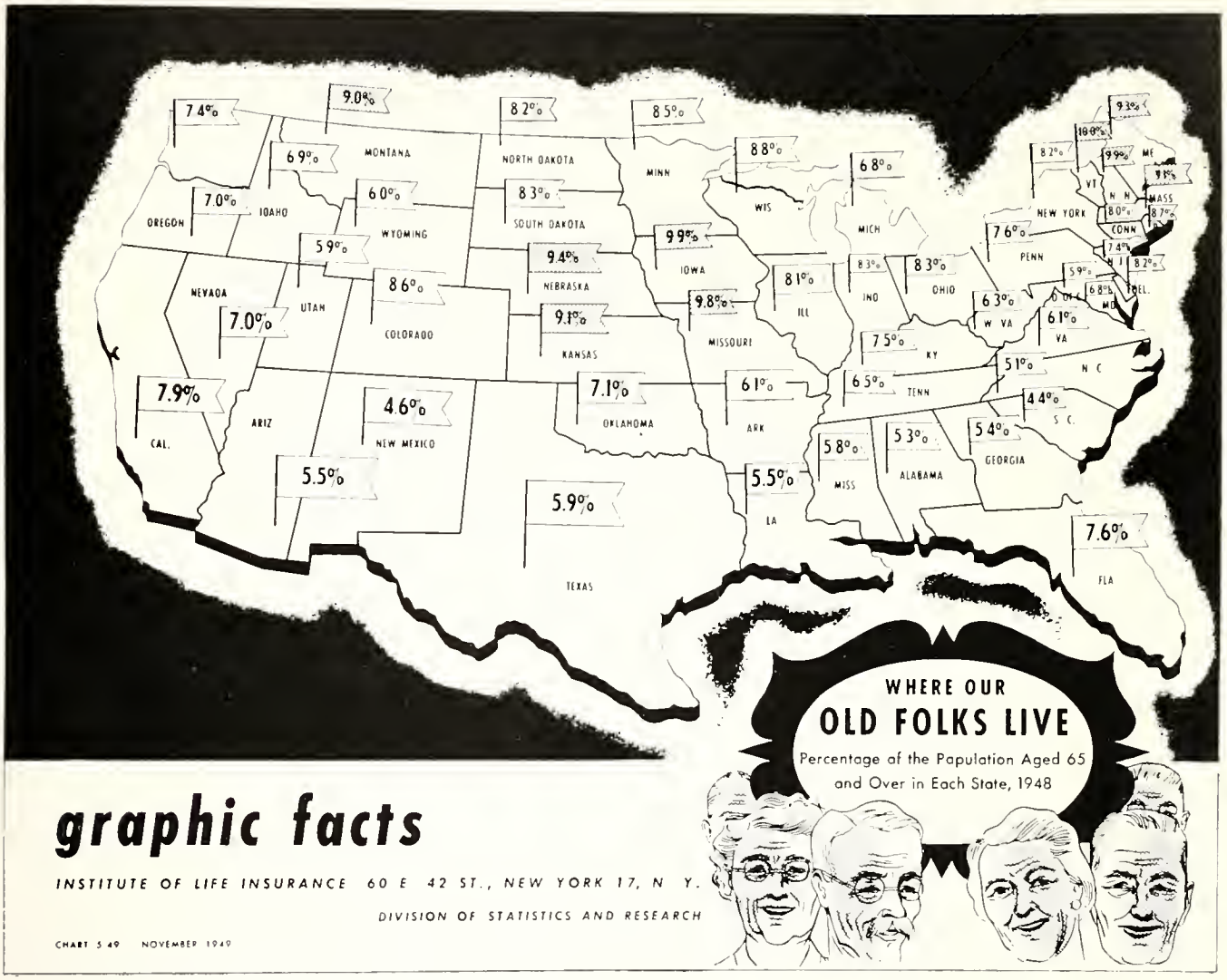
A typical service center for senior dwellings would

offer one or several social rooms adjacent to outdoor living space. It would also provide a housekeeper service operated by a small staff of visiting housekeepers and practical nurses for part-time care in the residents' own homes, except for disabling illness of very extended duration or requiring institutional service. In units planned for a sizable number of senior dwellings, a local infirmary under the care of the central housekeeping and nursing service may become desirable.

All services must be directed and coordinated by a qualified resident hostess, a strong human link between the individual elderly residents (and their absent families) and each of the technical and personal aids available for meeting typical needs.

A financial program for more adequate senior housing throughout the country may well relate to the substantial funds which, under a nationwide contributory old age and survivors insurance plan, are set aside year by year for providing more old age security for the people. In contrast to most countries, United States legislation confines the investment of the accumulated moneys under the Federal Insurance Contributions Act to investment in Treasury notes. The Old Age and Survivors Insurance Trust Fund now has total assets of well over $8 billion, growing by approximately $1 billion every year. The Treasury notes yield revenue ranging from 1⅞ per cent to a maximum of 3 per cent. While there can be no question of the safety of such an investment, its social validity may well be doubted. **It would seem very appropriate to allocate a limited fraction of the annual investment of this fund to investment in housing, with preference given to such housing projects—public, cooperative, and other acceptable forms—which would yield a sizable number of low and medium cost units suitable for senior residents.** In foreign countries social insurance funds have long been used as a major lever in a progressive, socially directed housing policy.

Sumptuous old age home of the United Brotherhood of Carpenters and Joiners of America at Lakeland, Fla., cares for 300.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DIVISION OF STATISTICS AND RESEARCH
CHART 5 49 NOVEMBER 1949

Educational Needs of the Older Adult in Rural New York State

By Mrs. Henrietta Rabe

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The following paper is a field report made to Dr. R. J. Pulling, Chief of the Bureau of Adult Education of the New York State Education Department. Our Committee believes this report uncovers attitudes and has educational implications of utmost importance in the development of programs for older persons living in rural areas.

This report is based on a study of eight widely scattered villages in New York State having a population of 2500 or less. In contrast to the city, where public and private agencies are a chief source of information on the older adult, getting the picture rural-wise necessitated speaking with individuals such as the principal of the central district school; the librarian; directors of homes for the aged, both public and private; the local historian; clergymen; officers of local clubs and organizations, including the Grange and the New York State Farm Bureau Federation; as well as to shopkeepers, particularly those shops where people are inclined to "visit." Typical of such shops are the feed store, the barbershop, the drugstore, the garage, and the tavern.

No study of this type would be complete without getting the point of view of the older person himself. Therefore, a number of older persons were interviewed in each of the villages studied.

In making this study no attempt was made to get a comprehensive picture of the total needs of the older person on such problems as employment, health or housing. Education assumes these needs to be necessary concerns of other agencies. However, some consideration had to be given to economic and social factors, because of their direct relationship to needs that can be served through education.

The value of this study is not as it relates directly to the communities studied, but rather as it relates to the larger picture rural-wise. In order to serve this larger purpose, consideration also was given to certain population characteristics of rural New York State.

Some Pertinent Population Characteristics of Rural New York State

1. The older adult makes up a larger proportion of the rural farm and rural non-farm regions than of the urban population. One out of every twenty persons in urban areas is in the older bracket (45 and over), but in farm regions the ratio is one out of ten.

2. The rural non-farming population includes the highest percentage of widows in New York State. Many such widows come from urban centers as well as from farms, concentrating in villages and non-farm residences.

3. One of the significant changes in the population of New York State in the past decade is in the number of persons living in rural areas who do not farm. This has resulted in part from the fact that many folks, on retirement, return to a rural community, where, in many cases, they lived earlier in life.

Economic Status of the Older Adult

Figures are not available to contrast the proportionate number of dependent adults in rural farming and rural non-farming regions with those in urban regions. The following facts are significant, however, with respect to the rural scene: (1) the home farmer in most cases continues to operate his farm beyond the usual age of retirement; (2) the farm laborer in normal times finds his employment dependent upon physiological capacity rather than chronological age; and (3) the non-farming group, including the manual laborer, the skilled craftsman, the store worker, etc., seems to be less discriminated against than city workers because of age.

Few farmers today give up their farms after reaching the customary retirement age. When the farmer finds himself less able to operate his place, he continues to maintain it as his homestead and either rents the farm out on shares, permits a married child to operate it, or cuts his farming down to a minimum.

In normal times the farm laborer in his fifties and sixties who is known in the community does not find

"These beautiful May days don't appeal to me as much as they did once—can't play hooky from anything!"

that his age is a bar to employment. In the case of the aged single farm worker, it is not uncommon for him to be employed for room, board, and a little spending money in return for working conditions which are commensurate with his physical capacity, namely, lighter work, a slower pace, and short working hours.

Most villages have a number of more or less retired people, but the men frequently find odd jobs available locally. There seems to be a ready willingness on the part of local merchants to give work to older men when they are considered a part of the community. Another explanation for this is that the older person generally is willing to accept a lower wage than the younger worker in the community who, for the most part, commutes to the nearest city for employment.

Comparatively few aged people in rural regions are to be found in homes for the aged. County welfare departments make it a practice, wherever possible, to place applicants in boarding homes. In the communities studied, about 90 per cent of the residents of the county homes are men, mostly without families, who are considered difficult to place in boarding homes. A large percentage of these men listed their former occupation as manual and farm laborer.

No attempt was made, for purpose of this study, to get a break-down of the number of people receiving old age assistance in the different communities. However, there may be some value in giving this picture for at least one of the communities.

In a village having a population of about two thousand there are 53 people 65 years of age and over who are receiving old age assistance. This figure includes 21 people who are in nursing homes, 11 in boarding homes, 16 who maintain their own homes, and 5 who live with relatives.

Social Status of the Older Adult

The older person in rural regions continues in the mainstream of community activities along with other age groups, ofttimes maintaining positions of leadership. For example, in the communities studied the board of trustees of the library and the school board were composed largely of men and women in their seventies and eighties. In one community the president of the school board is a man seventy-six years of age. In another, the president of the board of directors of the library is ninety years of age.

In church groups as well as in such organizations as the Grange, the Masons, Odd Fellows, Eastern Star, Rebekah, Garden Club, and Historical Society, the officers are largely from the older member group. The Home Bureau and farm cooperatives, with their women's auxiliaries, are other groups in which many older people participate.

Club activities such as the above loom very large in the social life of rural dwellers. The average adult belongs to at least one organization in addition to church affiliation. The Central District School is another center of activity for many adults.

With respect to family relationships, even in rural life, there seems to be a consistent pattern of preference on the part of aged parents to live apart from their married children. Only out of necessity does the parent give up his home to live with a married child. It was repeatedly stated by school principals, by clergymen, as well as by individuals, that even in the rural community, the strong family tie of the past has undergone a change.

Prevailing Attitudes of Rural Dwellers

The expressions of rural dwellers and those closely concerned with rural issues not only help to point up existing needs but give some indication of the obstacles in the way of initiating a program of education in the interest of the older adult. For this reason some characteristic expressions are being included in this report.

1. The question "How do older people in the community spend their time?" brought forth such responses as:

Protestant minister: "Our most active church members are the older people—particularly the older women."

Librarian: "A lot of older men and women come to the library regularly, not always to read, but as another place to go, and to chat."

School principal:

(A) "They remain active in their clubs. We have about thirty clubs in this town, including civic, church and fraternal groups. Many of the officers of the clubs are old folks."

(B) "About twenty per cent of the adults attending our evening classes are fifty years of age and over."

(C) "Lots of older people attend our special programs here in school, even the basketball games."

Director, private home for the aged: "Our ladies enjoy sewing, reading, and bridge playing. On Sunday most of them go to one church or another. Some of them are active in the Woman's Club."

Director, county home for the aged: "Nothing. You couldn't get those people interested in anything."

Garage owner: "A few of the men come around regularly. They like to sit around and play cards."

Tavern owner: "They come in every day for a glass or two of beer and sit around."

Retired railroad worker: "I listen to the radio a lot. At night I visit at my neighbor's and watch the television."

Retired school teacher: "I read a lot and belong to the Garden Club and Historical Society. We have a study group in the Garden Club."

Former city dweller: "I do all sorts of odd jobs around town. A man's got to keep busy."

Farmer, age seventy: "There are plenty of chores for an old farmer. And I belong to the Masons and Grange. Rarely miss a meeting."

2. In an attempt to discover the existing social pattern for "talking things over" in the rural community, the question was asked, "What has taken the place of the 'cracker-barrel' discussion groups?"

Protestant minister: "Nothing—unless perhaps the meeting room at the fire-house. No matter when you go by, you'll find a few men sitting around there talking things over."

School principal: "My guess is that the radio has taken its place, but that doen't allow them to express themselves, nor does it have the same social value."

Town Historian: "With automobiles, they're able to get around more to club meetings."

Medical doctor, age 74: "People don't talk politics over as much as they used to."

Catholic priest: "The railroad shack (gate house) is a meeting place for a number of the older men in the village. Once in a while I join them."

3. In answer to the question, "Do you feel that there is a need for educational activities designed especially for the older person?" the following were typical responses:

School principal:

(A) "Possibly, but it would be difficult to reach some of the older people who probably need it most. Many old folks are reluctant to start new things."

(B) "If we did have special programs for the older folks here in the central school it would be all right for those in the village, but how about those outside of the village where transportation would be a problem?"

(C) "If they're interested in such activities, why don't more of them attend our evening classes now?"

Officer—New York State Farm Bureau: "With the growing interest of the adults in the activities of the central district school in my own community, I would be inclined to think that the older adults would respond to a program planned for them. As I see it, they do have real needs that could be served by the school. I wish there was some way that the school could help the older person who finds it necessary to supplement his income, which is a serious problem for many widows and spinsters."

Catholic priest: "I think it would be a very good thing to provide such activities for the older folks, and certainly well worth trying. I approve of the idea whole-heartedly."

Director of Youth Center: "I don't see why the older folks couldn't use the center same as the young folks do. We could give them space here if the school were to furnish leaders for their activities. They certainly could use the place before the kids get there. That would make it a real community center."

Librarian: "It would be easy to form a discussion group from among those older folks who come to the library."

Welfare officer: "Our recipients of old age assistance who live in boarding homes are old and I do not believe they are interested in outside activities. Those living in their own homes have home duties and are not people that would be interested in any sort of activities."

President—Garden Club: "Yes, I do. I know it would be a good thing for people like the couple next door. They keep entirely to themselves. He has a heart condition, and when he goes, she'll be lost."

Officer—New York State Grange:

(A) "The farmer is conservative and doesn't take quickly to new ideas such as that, but I believe that once he is sold on its value, he'll go in for it wholeheartedly."

(B) "Because of mechanization, even the older farmer is able to get his work done and still have time for other things."

Protestant Minister:

(A) "Yes, I do, not only for those that are able to get around but for the home-bound. Many of my older church members are finding it difficult to get out, and I know how important it is for them to keep up contacts with the outside."

(B) "It isn't only the old folks that need help, it's youth too, I plan to devote a series of sermons on the need for re-evaluating our attitude toward old age and on the 'Fourth Commandment'."

Implications for Education

Inasmuch as many rural dwellers continue to work beyond the customary age of retirement, it would seem that there is less need for recreation centers, as such, or for additional clubs of the "Golden Age" variety such as seem necessary in large communities.

Nevertheless, there are certain conditions that could be improved for the older adult through the provision of activities which are not commonly available in a small community. Such activities could reasonably be provided by the public school through its adult education program, and would bring benefit

not only to the individual, but to the larger social group. A description of such activities comprises the balance of this report.

1. The older adult needs to be kept flexible in his thinking and up-to-date with respect to technological and social change.

The rural community is very much influenced by its large proportion of older men and women who continue to function either as leaders in civic organizations and fraternal clubs or as members of such groups. As such, they either have a direct influence on others or are themselves subject to influence with respect to their attitudes, their thinking, and their voting. Our aging population will very significantly have an effect upon the Nation politically and economically; and in local matters the increasing proportion of older men and women will have a direct bearing on whether the community is to be a static or a dynamic one.

It is, therefore, of utmost importance that the older person be kept informed and helped to understand social issues and community problems. If this is not done, the older person who tends to be fixed in his thinking, translating the present through the past, might be resistant to change, even if it means social improvement. There is also the danger that this large unit of our population might be used politically for selfish purposes. Therefore, it is to the best interest of the individual as well as the community for the older person to be exposed to ideas that are different from his own and to the changes that are continually occurring in the social and political structure of the world.

As a solution to this need the public school can organize "old timer" discussion groups on a wide variety of topics, including issues of local, national, and world concern.

2. The older adult needs accurate information about and help in adjusting to the changes of aging.

To better understand what is involved in the process of aging—the limitations that come with age as well as the plus values—the older adult needs to become informed on such matters as the following:

(A) *Financial problems of older people*
Social security, old age assistance, employment opportunities for older workers, self-employment

(B) *Physiological aspects of aging*
Health education courses

(C) *Psychological aspects of aging*
Preventive mental hygiene

(D) *Nutritional needs*

(E) *Adjustments in family and other social relationships*
Grandparent education, living with other adults

(F) *Forming new concepts of successful living*
Working for satisfactions in later life in contrast to working for money

(G) *Agencies serving the aged*
Public health facilities, mental hygiene clinics, visiting nurses, recreation centers, employment centers, nursing and old age homes.

These and similar topics could be built around separate short-unit courses consisting of lectures and discussion groups. For such to be most effective, the individual must have a chance to discuss his own personal problems. Courses of this type would not only have value for the older person but for the middle aged person who is giving thought to successful retirement and old age.

3. The older adult needs to feel useful.

The desire to be useful and have social approval is present throughout all of normal life. The increased leisure that comes with a diminution of the activities of earlier life should make it possible for a person to attain new goals which bring added satisfaction to the individual and enrichment to the community. Yet many older men and women find themselves with little to do and think about because earlier in life they lacked the time or the opportunity to develop vital interests and skills other than that of their job. This is a particularly serious problem for many widowed and unmarried women.

Pastimes of a purely recreational nature, or custom-made fun, although an important aspect of living, will not over a long period of time be a satisfactory substitute for productive activity. The solution, rather, lies in the acquisition of skills that have inherent possibilities for creative expression, growth, and self-development and that can contribute something of value to the social group. The whole gamut of the arts and crafts as well as the pure and applied sciences offer rich interests for all age groups; but the added hours of leisure as life advances permits the older person to develop special skills in these areas, to read and plan, and to develop judgment and self-criticism.

From the point of view of the community, creative activity such as the above means raising the cultural level and adding a valuable local resource. Imagine any village enlivened by periodic art and craft exhibits, or having recurring musical activities performed by choral groups, string quartets, and small orchestras! Think of the value to the community in having a group of men and women who are studying local conservation needs with respect to water, soil, timber, wildlife, and other resources; or who are rendering a service to the field of professional science through the collection and recording of data on the

distribution and life histories of local animal and plant life!

Other than the personal satisfactions which creative activity affords, ofttimes it offers an opportunity for self-employment, and thus its value is increased, for some older men and women are seeking ways of supplementing their financial resources. Many a person has been able to find for himself a new source of income through creative interests—the painter; the textile designer; the lampshade decorator; the designer of greeting cards; the craftsman who makes jewelry, wood sculpture, pottery, metalwork, leather goods; the weaver; the woodworker who builds models of all sorts or who makes toys, furniture, and novelty items; the photographer; the animal fancier; the gardener who grows a new or special quality fruit, vegetable or flower.

The public school has the facilities and the personnel to provide training in a wide variety of creative activities that will do much to make up the last period of life one of activity and usefulness. The typical arts, crafts, and science courses offered in the evening adult education program may not be the answer. To be most effective, a program planned for the older adult might have to include a greater variety of subjects to fit many different interests, given at a time that corresponds with the older person's habits, and offered at a place suited to his convenience, with the work geared to his slower pace.

4. Many older adults need opportunities for developing social skills and finding new social relationships.

A problem common to many older people, regardless of where they live, is that of loneliness, some causes of which are mobility of married children, retirement, and loss of spouse and friends. This, again, is a great concern of many widowed persons; and according to statistics, 43 per cent of the married women of this country are widowed at age 65. The problem is also a serious one for many elderly couples who have moved to a rural community upon retirement. Lacking roots in the community the newcomer frequently does not possess the social skills and the know-how of making new social relationships.

The public school in providing programs for older adults will also help them develop social skills. The school is present in all communities, it is familiar to all and is accepted by all. By tradition it is accustomed to working with people of all types and backgrounds. It has facilities and equipment which frequently are not present elsewhere in the community. Therefore, the public school seems to be the logical center in the rural community for making available to the older person opportunities for meeting and mixing with others whom they otherwise might not have a chance to meet.

Through activities within the school the individual will be thrown in contact with people of like as well as different interests. This is a good social experience for the individual, and in addition, such exposure could very well result in a choice of new activities which might become an important part of his own living.

Thus the public school, in becoming a center of activity for the older men and women of the community, would help them to keep mentally pliable and alert, which is good mental hygiene, and in addition would provide concomitant social skills, important to many older people.

Summary

All of the activities suggested above and others of value can easily be defined as good adult education and are possible of attainment in any community which is large enough to maintain a public school. These activities could be made available within the school itself as well as to study groups that might be formed within such local organizations as the Grange, the Garden Club, Historical Society, Woman's Clubs, and church groups. A program such as this could be supported jointly by the community and state-aid.

The needs of the older person, as contained in this report, are not to be interpreted as applying exclusively to the residents of a small community. Definitely not! The need to feel useful, the need for social relationships are not needs of the aged alone any more so than the need to be mentally agile and up-to-date on social change are needs of only rural dwellers. Such needs are common to all adults, varying only in scope and satisfied in different ways at different stages of lifetime.

Our problem is to attempt to isolate the needs of the older adult that can be helped through learning activities; to evaluate such needs within the framework of the small community; and to recommend ways in which the public school can function in this area of service to the total community. These recommendations are based on the premise that the need for education is continuous throughout life and that it is the responsibility of public adult education to provide opportunities for such education wherever and for whomever the need exists.

Librarians and Our Senior Citizens

By Albert J. Abrams

Director, New York State Joint Legislative Committee on Problems of the Aging

WHAT should be the relationship of a library to the elderly of the community? What special services do our libraries render to our elderly? What types of books and magazines do the elderly prefer?

Interest in these questions is high among both gerontologists and librarians. The gerontologist is concerned with fitting the library into its proper niche in an over-all program for the elderly. The librarian is affected for if libraries are to be dynamic, vital agencies they must keep pace with shifting community needs, and serve the elderly as effectually as they serve other groups in the population.

The demographic factors which impel an examination of the role of our libraries in serving the elderly are these:

1. A spectacular increase in the number of our elderly, mounting from 1,100,000 in 1870 for 65-plus age group to nearly 12,000,000 in 1950.
2. The tremendous increase in the span of life, from roughly 48 in 1900 to 67 in 1948.
3. The fact that at age 65, the average person has a life expectancy of 12 years.
4. While the proportion of elderly in our communities is mounting sharply, the proportion will vary considerably according to types and locations of communities.

The socio-economic factors which call for librarians to examine their services to the elderly are these:

1. An amazing growth of retirement programs, now covering 10,500,000 workers.
2. The prevalence in industry of compulsory retirement at age 65 for men, age 60 for women.
3. Age barriers which prevent men 40 and over and women 35 and over from obtaining jobs.
4. Better educational background of the "new" old compared with the elderly of prior decades.

These trends add up to this: more and more of our elderly who are making up a larger proportion of our population have and will have more and more time for reading.

To gain an insight into the work being done and the work that should be done by libraries for our elderly, State Senator Thomas C. Desmond, Chairman of the New York State Joint Legislative Committee on Problems of the Aging, queried 150 librarians responsible for community libraries ranging from a one-room rural library at Haines Falls to the mammoth New York City Public Library system.

Their answers disclose that by and large our librarians are aware of the challenge that the increasing number of our elderly presents to our libraries, are alert to the opportunities that exist for helping our oldsters, and are eager to be of service to our senior citizens. The main handicap in serving the elderly appears to be not a deficit of zeal or will, but a deficit of finances to expand library services.

The Library and Other Community Agencies

The library is but one community agency capable of being geared to the needs of the elderly. The library must join with the schools, the recreation centers, and the "60-plus" clubs, for example, to meet the needs of the senior citizen for cultural, leisure-time activities. In some communities, the libraries will set the pace for other agencies; in others, it will for good reasons play a role minor to other agencies.

Whether the library is leader or follower, it is important that the library staff join with other groups in planning community programs for the elderly. The Desmond survey showed that the Rochester Public Library is in close contact with the Rochester Council of Social Agencies which is formulating a comprehensive program for the aged, and with neighborhood groups organized by the Council. In this way, both the council and the library are enabled to move forward together to serve the elderly. The Brooklyn Public Library works intimately with the Brooklyn Council for Social Planning and its Superintendent of Branch Libraries serves as a member of the Committee on Services to the Aging. Such close working relationships enable the library to keep in touch with new developments which may affect the library, to share in serving the elderly most effectively, and give other agencies the benefit of the library's experience with the elderly.

Relationship of the Library to the Elderly

Just as a philosophy of life or at the very least an attitude toward life enables one to adjust best to the daily vicissitudes of living, libraries need to

adopt some goal or rationale in attempting to serve the community and the various segments of the community. The Desmond survey indicates that librarians have an understanding of the difficulties of the aged, and the variability among them, needed to chart a sympathetic program for them.

"Growing old is a peculiar thing," says Librarian Helen A. Stratton of the Binghamton Public Library, "Its worst tragedy is that most elderly persons feel young and think young, but have not the outward appearance or quickness of youth. It does not hurt to be labelled a 'teen-ager' but it does hurt to be continually reminded that one is old."

The Acting Secretary of the City Library of Poughkeepsie, Miss Amy Ver Nooy, points out that the "aged of the future have had a different past from the aged of the present," and then asks, "Will their interests be the same as the interests of the aged of today? Have they not actively participated in a different world throughout their working lives?"

The need for making distinctions in various age groups even among the elderly is noted by Miss Lucy E. Francher of Swan Library, Albion, who says: "there seems to be a great difference between the 60–75-year-olds and those approaching 80. The first group can do considerable solid reading and are capable of following time-consuming interesting hobbies. The latter seem too feeble in physique and sometimes mentally to do more than read the lightest fiction and sometimes not even that. Whatever constructive work done should be for the 60–75 age group." However, librarians should not fall into a very common trap by confusing chronological age with physiological or mental age. The geriatricians emphasize that chronological age is of little significance, that some people are young at 80, others are old at 45; some at 75 have the heart, arteries, and alertness of a man of 35, others at 50 have a physiological and mental age of 80.

The gerontologist eager to see the elderly served may receive a temporary slight jolt when he awakens to the fact that libraries are created to serve all age groups, and that as librarians point out, it is dedicated to the entire community, not to any particular segment.

Librarian Alice H. Smith of the Arcade, N. Y., Free Library, bluntly says, "In my opinion, the elderly should be treated by the library exactly as the younger borrowers are treated." Director Isabel D. Clark of the White Plains Public Library informed the Desmond Survey: "The relationship of a library to the elderly of the community should be much the same as to all other groups, namely, to provide wholesome recreation and lifelong education to every citizen who needs it. Because a larger proportion of the elderly and the very young find it impossible to go their library it is important that means be provided to reach these people where they live."

Mrs. Marie B. Higgins, librarian of the Rensselaer Public Library, points out that the "important services a community library can offer elderly people are easy accessibility, absence of stairs, comfortable reading facilities, good lighting, and an adequate book selection, all items which in library service are needed by the public as a whole."

Sylvia C. Hilton, Librarian at the Scarsdale Public Library, comments, "I note a growing consciousness among libraries, churches and cities to the old as a different and separate group. In our library, if we had the space or facilities, we would answer any need for group activities with the emphasis on the interests, such as hobbies, rather than on age."

Esther Johnston, Chief of the Circulation Department of the New York Public Library, says, "the library best serves the older man or woman when it does not strive to set him or her apart from the younger members of the community."

The "equal treatment" concept received support from Librarian Sarah Corwin of the Newburgh Public Library who states, "the relationship of the library to the elderly of a community should be just about what it is to any of its borrowers: ready and willing to help wherever possible, but without emphasis on the oldster part." Alice L. Jewett, Chief Librarian of the Mount Vernon Public Library, elaborates on this viewpoint: "The relationship should be the same as to any other group in the community, a recognition of the existence of such a group, a conscious effort to supply their needs, and such special services as seem to be justified in view of the services provided by other local agencies."

Some librarians think their major contribution to the elderly can be "courtesy and comfort." Binhamton's Librarian, Helen A. Stratton, says, "In a library the elderly should be greeted cordially, helped to a certain extent (not too much) . . . and they must never be hurried." Mrs. Estelle Harrower, of the Amsterdam Free Library, says the library should be a place for the elderly to rest and relax as well as to take a book.

The relationship of the library to the elderly will depend largely on the librarian's concept of the total role of the library. If viewed as simply a place where a variety of books are available free of charge, the library will tend to be static, restricted; if viewed as an agency for bringing knowledge and enjoyment to all the people of the community, the library will be dynamic, its services varied. The gerontologist in his zeal to provide services to meet the needs of the elderly must keep a reign on his enthusiasm, for the library is dedicated to all the community, not to one segment. The library, on the other hand, in its

efforts to "play fair" with all groups must conscientiously seek to establish the needs of the elderly, and determine what it should do in justice to all to meet those needs.

Segregated Book Shelves Opposed

The Desmond Survey elicited the practically unanimous opinion of librarians against setting up special book shelves for the elderly. Thus Director F. L. Gates of the Syracuse Public Library says, "we do not approve of calling special attention in the library to these people on account of their age." Librarian Sara Corwin of Newburgh reports that at one time she did provide special shelves for oldsters but it was not successful, for the elderly do not want "to be considered different."

Mrs. Stephen Leechner of the Croton Free Library summed up the viewpoint of the librarians when she advised, "many people of 60 would be rather insulted or annoyed to be considered in the elderly group." To which Librarian Helen M. MacDonough of the Baldwin Public Library adds, "no one likes to be singled out as 'old'. For example, books on handicrafts and other home activities useful to retired persons as well as others are easily available in all libraries. They do not need to be especially grouped for the elderly. Such a grouping would be resented by some."

Librarian Anne F. Hammersley of the Hamburg Free Library says, "our library does not feel any of the readers are 'old.' We may take more care to find out what they want and to help them individually, but that is all."

Most gerontologists would probably agree with the librarians that segregation of the elderly in the library would not only be resented by the elderly but would tend to further isolate the oldsters physically and psychologically from the total population and thereby be harmful. However, it should be pointed out firmly that this does not mean no special effort should be made to serve the elderly. It does not mean for example that clubs and hobbies for the elderly should not be encouraged in the library. It does not mean that shut-in service for the elderly who are ill should not be provided. It simply means that shelves specially set aside for old folks are unwise, and that insofar as practical services should be based on function rather than age. Thus we see no reason why libraries cannot have special shelves for books on "Fun in Retirement."

Reading Preferences

Supporting the argument against special book shelves for the elderly is the conclusion of librarians, as reported to the Desmond survey, that our senior citizens have as wide a reading taste as many of our younger people. Librarian Francis R. St. John of the Brooklyn Public Library reports, "reading of older people cannot be typed. Their reading tastes stem from their backgrounds." Miss Thelma R. King of the Steele Memorial Library, Elmira, says, "By and large they keep the same reading interests they always had." At the Floyd Memorial Library, Greenport, Librarian Gladys K. Pemberton finds the "reading interest of people over sixty does not vary any noticeable extent from that of a person ten or twenty years younger. The usual reading interest of middle life carries over to the later years. Miss Helen Ludlow, of the Thrall Library in Middletown, says: "it is almost impossible to generalize about the reading tastes and habits of this group. Older people tend to read much the same kinds of books as they did in younger days."

Pointing out that for many the years between 60 and 70 are "the reading years," Librarian Mary L. McCabe, Corning Public Library, says many of these senior citizens have their own reading lists saved through the years, and that there are more older people with a fine appreciation of books than we sometimes realize.

Despite the agreement that the reading tastes of the elderly (the Desmond survey used 60 years and over as the dividing line because some arbitrary figure had to be used) could not be typed, the librarians nonetheless showed surprising uniformity in report that women over 60 like best light stories with happy endings, with a minimum of profanity or sex or realism. This was as true for elderly women who live in the cities as for those living in suburban and rural areas.

Other types ranking high on Grandma's "hit parade" of books are mysteries, light humorous nonfiction, religious fiction, and early 20th century light novels by authors like Grace Livingston Hill Lutz and Mary Waller. The books serve, the librarians reported, to take the elderly back to their youth, to escape life problems or simply to "pass time."

The elderly male rates westerns as tops, with the "whodunits" a close second. The older male likes books with plenty of action. As one librarian emphasized they prefer a minimum of "gooey romance," and will not be found dead with a novel by Faith Baldwin.

A substantial number of libraries indicated that the size of type frequently is the deciding factor in determining whether an older person will read a particular book. In fact, some attributed the popularity of westerns among the elderly males to the fact that these books often had uncrowded pages of clear type.

One interesting fact elicited by the Desmond survey was that books such as "Peace of Mind" apparently

is not as popnlar with the 60-plus age group as with the 40–50 age class. No reason was given for this preference.

There was a noticeable absence of statistical data on reading habits of the elderly.

However, the librarians seemed to be in general agreement that newspapers are preferred to magazines by the senior citizens, and that the "Reader's Digest," "Life," "Time," "Saturday Evening Post," "Colliers," "Ladies Home Journal" and "Women's Home Companion" were favorites among the magazines.

Some librarians, such as Miss Ludlow of Middletown reported "oldsters do not make much use of the magazine racks."

Many librarians reported they have what is known to them as an "old timers' morning club" consisting of elderly who come in to read the daily newspapers.

Clubs for Oldsters

Several librarians indicated their familiarity with the "Live Long and Like It" club for oldsters sponsored by the Cleveland, Ohio, Public Library, and some expressed the desire to form similar groups. Thus Mrs. Elizabeth F. Kelly of the Freeport Memorial Library says, "For the past year I have been giving considerable thought to what this library can do for the elderly people. I would like very much to form an organization for them."

In some communities, such clubs are already in operation sponsored by churches, Junior League organizations, recreation commissions and other local agencies. Librarian Lucy E. Franeher, Swan Library, Albion, reports she has given up the idea of forming a 69-plus club because "all the oldsters we know of belong to church groups, fraternal organizations, D. A. R. or a study club."

It is clear that whether "Golden Age" clubs should be organized at all or whether the library or some other group should sponsor "Golden Age" clubs should depend on local conditions.

At Mount Vernon, a recreation center for the elderly has been set up on library property in an old house adjacent to the library itself, by the Mount Vernon Chapter of the National Council of Jewish Women.

Some libraries which may not sponsor or organize such clubs may help by providing meeting spaee; others may have no meeting room facilities. Thus in the one-room library at Haines Falls, it is impossible to provide quarters for oldsters clubs. Others, such as the library at Kingston, reports, through Librarian Mary A. Schaeffer, that it is situated in the center of the city which spreads over a very large area, making it difficult for many of the oldsters to use it. Even some big city libraries, such as those in Rochester, report they do not have room or facilities for inviting oldsters clubs to meet there.

At Watertown, Librarian Helen M. Talbert notes that meeting rooms of the library are open to all groups in the city, and points out that many club women are in the 60-plus age bracket and make use of the meeting rooms. Elmira and Rome, N. Y., both report they have meeting rooms, but that no group of older persons has taken advantage of them. The Corinth Free Library expects to have meeting rooms available in the new building to be ereeted in the near future.

At Freeport Library, a group of older women meet in the library's High School Room two hours a week and discuss American and English literature. Interestingly enough this group started with a leader, but when the leader became ill, the oldsters were obtaining so much enjoyment from it that they have carried on by themselves.

At the Your Home Public Library, at Johnson City, club rooms are used by the Townsend Club and the industrially affiliated Endicott-Johnson Thirty Year Club.

The Rochester and New York Public Libraries cooperate with old age groups by sending out lecturers, book reviewers, and motion pictures to them. The New York Public Library sends through its branches cartons of books to recreation centers for the elderly. At stated periods the books are returned to the branches and a new collection issued.

The Brooklyn Public Library, on the other hand, which has an active and varied program dealing with the elderly, prefers to bring recreation clubs for the oldsters into the library for discussions of books of interest to them. Also, Elementary English Classes of the Adult Division of the Board of Education, composed mainly of older persons who have been in this country for many years, visit the libraries.

Shut-In Service

Shut-in service by libraries ranges from delivery of books to the housebound and the hospitalized to that of providing ceiling projectors for "Books on the Ceiling." It may involve operation of a "Bookmobile" or consist simply of selecting appropriate books for the ill to be picked up by friends or relatives.

The importance of shut-in service can be seen from the fact that according to a national survey one out of six persons at any given time is afflicted by chronic disease. Since the elderly are especially hard hit by chronic, degenerative diseases, shut-in service is particularly helpful to the older age groups.

Librarians may gain a new insight into the ability

of oldsters to gain benefits from reading, from the fact that at a state mental hospital a library of books has been set aside for the senile psychotics! Even these unfortunates, harmless but suffering from melancholia, forgetful and perhaps at times confused, confined to a state institution, find comfort and relaxation in books! We mention this merely to emphasize the need for not under-rating the capacity for our elderly to enjoy books.

The Desmond survey found that the Western Union Telegraph Company at one time provided an inexpensive delivery service for persons desiring books but this was discontinued.

On the other hand, at New Rochelle, Library Director Josephine H. Edwards reports that its shut-in service circulated during the 1948 calendar year 8,784 volumes. This consisted of monthly deliveries of carefully selected titles to people unable to come to the library or who have no one to send for their books. This library, interestingly enough, plans to cooperate with the local Visiting Nurse Association which is launching an active program for the elderly, and we can visualize in the future the visiting nurses bringing library books to the confined or directing the library to those who though confined need library services.

The Cornell Library Association at Ithaca reports it could probably arrange pickup and delivery to bedridden patients through friends of the library "if the need were indicated."

Unfortunately, the lack of personnel is handicapping shut-in service. The Fulton Public Library had to discontinue it because they "had no one to deliver the books." Miss Helen H. MacDonough of the Baldwin Public Library says the delivery service to bedridden oldsters would be desirable "if our staff were large enough to handle it."

Mrs. I. D. Clark, director of the White Plains Library, expands the concept of shut-in service significantly by pointing out that "mature and kindly volunteers who could deliver carefully selected books to house-bound folks and take time to talk with them or interest them in a hobby could add immeasurably to the happiness and contentment of this group of citizens. Such a plan would probably keep an appreciable number of possible inmates out of hospitals and institutions for the mentally disturbed."

It is probable that no large staff is needed to handle a shut-in service *supervised* by the library but *administered* by local civic or women's clubs, who would arrange for pickups and delivery service of books. Nurses and doctors would in many instances be glad to cooperate by encouraging bedridden oldsters to use the shut-in service.

Bookmobile service is approved by many libraries, if funds are available. In New York City older people who do not live near any branch library use the service provided by the bookmobiles. And at little Haines Falls, Librarian Era Zistel reports their bookmobile "makes the rounds during the summer; in the winter we provide no service, due to lack of funds." In Mount Vernon, bookmobile service was withdrawn, but was missed so keenly by two homes for old ladies at outlying sections of the city that arrangements have been made to send them a carton of about 40 books each month, partly of the library's choosing but largely the selection of the women themselves, reports Chief Librarian Alice L. Jewett.

Which brings us logically to the service rendered by libraries to the many elderly who are in old age homes, hospitals, nursing homes, boarding homes, and similar institutions. The geriatricians advise that as time goes on the variety of facilities for caring for oldsters will increase, so in seeking to reach the elderly, libraries will need to keep alert.

The Buffalo Public Library, reports Librarian Alexander Galt, conducts a branch library for patients at the Meyer Memorial Hospital, a county institution, but has no services in connection with any of the other hospitals. Mr. Galt says, "for many years we have hoped to have similar services in the other hospitals, but have never had the money to take care of this work; the same is true of old people's homes."

At Elmira, the library in cooperation with the Junior League provides books for two hospitals and one convalescent home. Through the Extension Division of the Rochester Public Library, books are sent to the Presbyterian Home, the Rochester Friendly Home, the Church Home, and the St. John's Home for the Aged. The Syracuse Public Library serves hospitals, nursing homes and homes for the aged. The Hempstead Library provides books for the elderly at the Nassau County Poor House. The New York Public Library cooperates with the United Hospitals Associations in furnishing books to hospitals.

Librarian Lucy E. Fancher of Swan Library, Albion, cites some of the headaches involved in shut-in service. She discussed with a Brownie leader the possibility of having her girls take books and return them for old people in convalescent homes. The proposal was viewed favorably. Then Miss Fancher communicated with the convalescent homes. One owner objected that it would be too much trouble to keep track of books. At another home, she ran into the fact that some of the elderly had cataracts which prevented their reading; others kept busy with other activities, ranging from crocheting to conducting an extensive correspondence; still others simply were not interested. However, at a third home she found a desire expressed for the service. But by this time, the Brownies had already been assigned to another activity.

As nursing and convalescent homes come under stricter supervision and their standards become higher, librarians will find that the directors of such institutions will come increasingly to welcome the service of the libraries.

At Port Jervis, Librarian Leona Edith Dugan tried sending books to the local hospital but the nurses felt they were too busy to collect and return them to the library and since none of the library staff had a car the service was discontinued. On the other hand, the library at Rome, N. Y., successfully operates a regular pickup service at the Oneida County Home.

It is not enough merely to offer such a service, to issue a statement to the press or post a bulletin in the library or even to send an announcement to the various institutions and homes. The service offer must be carried into the homes and institutions by the librarians, by nurses, doctors and relatives. If the library believes there is a real need for this type of delivery service in the community, it must sell the idea to the community.

In small communities especially, the added work of initiating and supervising this service would be slight, if the aid of civic and fraternal groups were enlisted to furnish transportation, and pickup service. Many fraternal groups have permanent committees to visit their sick, and these perhaps could be enlisted to bring with them not only flowers and good cheer, but also books.

Because so many of our elderly are immobilized through falls or chronic illness, the use of ceiling projectors became an important factor in enabling them to read, in providing them an opportunity to pass the time pleasurably. The Great Neck Library provides such projector service. The Hempstead Public Library reports that its ceiling projectors and microfilms are enthusiastically received by the elderly, stating that "patients in their 80's whether at home or in an institution have enjoyed reading our 'Books on the Ceiling.'"

At Gloversville, the library and Lions Club jointly operate the ceiling projector service, with the club informing the library as to persons entitled to use the machine, delivering and returning the machine, and the library responsible for record keeping and maintenance of the projector.

Miscellaneous Services

A miscellaneous number of library services available to all age groups are of especial interest to the elderly. Hobby exhibits often held their attention and interest. The Great Books Discussion groups and Book Review meetings frequently are a source of enjoyment to older people. Some libraries attempt to help oldsters who have difficulty reading by having a recording machine for them, or conducting record concerts. Some librarians make a special effort to obtain books for "tired eyes."

In some communities, the most practical service that could be rendered the elderly, the librarians say, would be to put the adult reading rooms on the ground floor, where the elderly could get to them without arduous climbing of steps.

Conclusions

Like Chief Librarian Francis R. St. John of the Brooklyn Public Library, "we feel that the elderly constitute a very important group in the community and one which has been rather neglected." As Senator Desmond says, "Librarians must face the fact that our people are living longer, are remaining vigorous and alert longer, and are having increased leisure time." Our communities and state must at the same time appreciate the fact that if library services are to be expanded to meet the needs of the elderly, financial assistance will be needed.

From the experiences and opinions of the librarians as expressed to the Desmond survey, we draw these fundamental conclusions, as basic precepts which might well govern libraries in serving the elderly of their community:

1. Libraries are dedicated to serve all the community. Therefore, it should examine the composition needs of the community and its patrons, and attempt to serve all in just proportion.
2. Communities differ not only in the proportion of their elderly but also in the educational backgrounds of their elderly. Therefore services of libraries to the oldsters would vary from community to community as local needs dictate.
3. The library should join with other community agencies in planning local programs for the elderly. The services the library renders to the oldsters should depend in part on the extent and character of services provided by other local agencies, to prevent unnecessary overlapping and duplication and omissions.
4. Library programs for the elderly need frequent auditing and review, for a program designed for the oldsters of 1950 may be outmoded by 1955. The library should keep pace with the changing backgrounds and needs of the elderly.
5. Librarians, educators, and other qualified authorities agree that education, which begins at our entrance into this world (if not sooner), should not end until we make our final exit. Thus the adult education programs of our communities should be geared not only to the young and to the middleaged but also to our oldsters.

6. Segregated book shelves for the elderly are unwise; activities should be set up on a functional rather than a chronological age basis, whenever possible. However, clubs for oldsters and hobby shows for oldsters serve an important function of bringing groups of elderly together, enlarging their social scope, revitalizing lives allowed to become shriveled up and narrow.
7. Libraries can best serve the elderly by:
   (a) bringing the elderly into the library by
      (1) making the library a hospitable, pleasant place to visit, with the library staff prepared to be especially kind and patient with oldsters who may be hard of hearing, inattentive, demanding, etc. because of peculiarities of the aging process.
      (2) organizing and directing clubs for oldsters if none exist in the community.
      (3) providing, if available, meeting space for clubs for the elderly.
      (4) arranging for "Great Books" discussion groups, Book Reviews, talks, and movies in the library, if facilities are available.
      (5) make available radio and recording rooms for those whose sight is impaired.
      (6) encourage hobby showings for the elderly.
      (7) keep needs of elderly in mind when ordering books.
   (b) bringing the library to the elderly by:
      (1) providing delivery service with the aid of volunteer groups, if possible, to the bedridden at home, or those unable to get to the library.
      (2) providing book service for public and private hospitals, old age homes, nursing and convalescent homes, and recreation clubs for elderly.
      (3) arranging for lectures, book reviews, and movies by library staff at meeting rooms of old age clubs.
      (4) providing "books on ceiling" projector service for the bedbound.

Librarians have an opportunity in many communities to lead the way to better community understanding of the needs and abilities of the elderly, to demonstrate that many of our elderly are capable of contributing a great deal to society, and to smash the common concept of the library as only a place where books are borrowed.

Let us remember that you can judge the cultural level of a community by the care and attention it gives its elderly.

It may take some patience and tolerance in dealing with some of our elderly; but then, these qualities are needed in dealing with some librarians, young or old, for we are all humans. However, few services of the librarian will yield such tremendous satisfaction as those arising from the knowledge that they are giving our neglected elderly new hope, new vistas, and new happiness, in their last years.

Canada And Its Aged

By Professor John S. Morgan

Associate Professor of Social Work, University of Toronto

THE GOVERNMENT of Canada has just appointed a special Committee of members of the Senate and the House of Commons to study the needs of the aged. This is symptomatic. The pressure of events is compelling the Canadian people to re-assess the provisions now made in Canada for its older citizens. This increased concern however, is due to a number of factors, some of which are typical of the situation in the United States, and some of which are peculiar to the Canadian scene.

As in the United States, the number of older citizens proportionately to the whole population has been rising during the first half of this century. For example in 1921 the age group over 60 represented 75.1 per 1000; in 1931 it was 83.9; in 1941 it was 102.1 per 1000;[1] and there is no doubt that the Census for 1951 will show a further substantial increase. Furthermore, as reported in a recent article prepared by the Bank of Nova Scotia,[2] the numbers in the upper half of the "working-age" group are also rising. "Even with no further reduction in mortality rates, the number of persons in Canada aged 45–64 will increase from about 2½ millions in 1949 to some 3½ millions in 1971, and they will then make up perhaps 40 per cent of those in the most active years of working life (20 to 64) as against 33⅓ per cent at present." So that, although the age structure of the Canadian nation is relatively that of a "young nation" as compared with all the Western European nations and is perhaps a little "younger" than that of the United States, the time has now arrived when the growing numbers of older citizens has become a matter of serious concern to the people of Canada.

Over-Emphasis on Youth

In Canada, as in the United States, the patterns of employment accepted by both labor and management have tended to put an overemphasis on youth. Since so much of Canadian industry until very recent years has been primary industry of a heavy type—such as logging, lumbering, mining, agriculture—the emphasis on comparative youth and physical strength has been even greater than in the United States. Employers in Canada have accepted without serious thought all of the myths about the difficulty of employing older workers which have been so thoroughly exposed by the New York State Joint Legislative Committee on Problems of the Aging in its two reports. There is, therefore, the same need in Canada as in the United States for research into the work capacities of older workers, and the same urgent need for public education on the necessity to revise accepted but now outdated employment practices.[3] The developing services of the National Employment Service in providing special counselling services for older workers has already been reported at length in *Never Too Old* and needs no elaboration here. It is being extended to the larger Employment Offices in the industrial parts of Canada.

Unlike the United States of America, Canada has no Social Security Act and no coherent set of plans or provisions for meeting the basic economic needs of dependent citizens. The main reason for this lies in the field of political science. Canada is a federal country but responsibility for health and welfare has been adjudged to lie with the Provinces, so that whenever a question of economic security legislation arises, Canada runs into a confused political discussion about jurisdictions in which the needs of people tend to get lost in the heat of the battle for Provincial rights. The last occasion on which an attempt was made to improve the system of economic assistance to aged persons was in 1945 when a Dominion-Provincial Conference was called to consider among other things a re-alignment of responsibilities for health and welfare between the Federal and Provincial legislatures. This Conference got involved in a fruitless discussion of powers of taxation and was abandoned before the proposals concerning the needs of the aged were seriously considered.

The main provision for economic aid to the aged in Canada is made in the Old Age Pensions Acts. The first Act was passed in 1927 when the Dominion Government was authorized to pay one-half of the net cost of pensions up to a maximum of $20 a month to British subjects of 70 years of age and over whose income did not exceed $365 a year, who had resided in Canada for 20 years and in the Province in which

[1] *The Canada Year Book 1948–49.* Ottawa: The Kings Printer, 1949.

[2] *Young and Old: The Changing Age Pattern.* The Bank of Nova Scotia Monthly Bulletin, February, 1950.

[3] See "Unemployment Among Older Workers 1945–49". The Canadian *Labour Gazette,* November, 1949. Ottawa: The Kings Printer, 1949.

application was made for five years or more. The Provincial Governments then passed Provincial Acts (British Columbia in 1927 being the first and the Province of Quebec in 1936 being the last, excluding Newfoundland which passed appropriate legislation in 1949 upon Confederation) which set up the administration and established these non-contributory means-test pensions within the minima laid down in the Dominion Act of 1927. In some Provinces, a share of the half not coming from federal funds was paid by municipalities, but this practice was soon discontinued.

This meagre provision has been extended and liberalized on several occasions. In 1931 the Federal Government's share was raised to 75 per cent of net pensions, in 1937 blind persons became eligible for pensions at age 40; in 1943 the maximum pension was raised to $25 a month; in 1944 the maximum permitted income was raised to $425. A major revision took place in 1947, liberalizing the conditions of the means test, including the blind at age 21, and raising the maximum monthly rate of pension to $30. In 1949 the maximum rate to which a 75 per cent Federal contribution can be claimed was raised to $40 a month. Since 1942 some provinces have paid supplemental allowances from provincial revenues; these have varied in amounts and from time to time, the present situation being that only three Provinces and the Yukon territory are paying supplemental allowances.

Excluding any provincial supplements, the position in March 1950, then, is that Old Age Pensions are payable to persons aged 70 or over when the annual income, including pension is not more than $600 for a single person or $1,080 for a married person, or $1,200 for a person married to a blind person. Administration is the responsibility of the various Provinces, Federal supervision being confined to audit of the accounts. With the exception of medical care provisions in some Provinces, there is little or no service to pensioners.

From the inception of the first Old Age Pension Act in 1927 to September 30, 1949, the Federal Government had spent $585,896,316.93. The annual cost of these pensions has been rising steadily, and will be substantially increased by the 1949 increase of maximum pension rate to $40 a month. It is this steadily rising charge on the budget which has influenced the Government to re-examine the whole situation.

The need for better provision can be even more clearly seen from the following table.

Since the Canadian Old Age Pension is only given after a fairly stringent means test, it is clear that nearly half of all Canadians over 70 years of age have been unable to provide for their old age, and by far the greater number of these have so little income that they qualify for the full pension.

Medical Care provisions are available to old age pensioners under the Provincial administrations in Ontario, Saskatchewan, Alberta, British Columbia and Nova Scotia. The typical arrangement is for the Provincial Government to make an agreement with the provincial Medical Association or the College of Physicians and Surgeons, that recipients of old age pensions may receive office care from their own physicians, with a limited list of permitted medicines, the administration of the scheme being in the hands of the medical society, which pays the physicians from a fund provided by the Province on a per capita per

Statistical Summary as at September 30, 1949

	Alberta	British Columbia	Manitoba	New Brunswick	Newfoundland	Nova Scotia
1. Number of Old Age Pensioners[1]	15,777	27,085	16,139	15,935	4,559	19,287
2. Number in receipt of Maximum Old Age Pension[2]	12,189	20,458	12,918	7,438	4,215 (max. $30 month)	6,590
3. Percentage of pensioners[3] to population 70 years of age or over	47.81	43.90	46.24	70.82	36.19	56.73

	Ontario	Prince Edward Island	Quebec	Saskatchewan	North West Territories	Yukon
1. Number of Old Age Pensioners[1]	80,731	2,853	66,674	16,230	19	83
2. Number in receipt of Maximum Old Age Pension[2]	65,304	1,085	52,876	11,384	19	75
3. Percentage of pensioners[3] to population 70 years of age or over	35.27	46.02	52.79	47.18	10.38	25.30

NOTES. 1 and 3 from the Quarterly return Old Age Pensions and Blind Pensions in Canada as at September 30th, 1949, published by the Old Age Pensions Division, Department of National Health and Welfare, Ottawa, 1949. Percentages based on estimated population as at June 1st, 1948, except Newfoundland, Yukon and Northwest Territories based on 1941 Census. 2 from a return furnished in the House of Commons, Nov. 3rd, 1949. (Report Col. 1394) All cases not reviewed under 1949 changes in pension rates.

day basis for each recipient of pension on the Provincial records. Hospital care, except in Saskatchewan and British Columbia, falls under the provisions for the care of indigents in the Public Hospitals Acts of most, if not all of the Provinces. Saskatchewan and British Columbia have contributory hospital insurance programs for the whole population of the Province. There has been little supervision of the kind of medical care given, and little or no research or action in the rapidly developing medical science of geriatrics.

The care of the aged in other ways than by means of pensions is more fragmentary and varies from Province to Province and municipality to municipality. It is very difficult to get at the real facts of the situation for the facts are hidden and little research has been done. It has been suggested that for some of those under 70 years of age, the Unemployment Insurance Fund is being used for economic support although the recipient and the Unemployment Insurance Commission are well aware that the recipient is only "able and willing to work" as a polite fiction to keep him within the statutory requirements of the Unemployment Insurance Act. The hospitals and mental hospitals of every Province contain large numbers of elderly people who are classed as chronically ill or mentally ill, but whose real need is geriatric care and rehabilitation.

The long tradition of municipal responsibility inherited from the old English Poor Law reaches into some of the Canadian Provinces more than others. Thus in most Canadian Provinces there are still municipal homes (or "poor houses") which shelter a number of elderly people who are there because their parishes or municipalities of residence can find no more suitable form of care for them. In Quebec Province, with the long standing tradition of the Roman Catholic Church, there are many old people in religious institutions, which receive support from the Province under the Quebec Public Charities Act. Ontario has recently made a valiant effort to encourage the conversion of the old municipal homes in the Province into more adequate homes for the aged, and in its recent Homes for the Aged Act has offered substantial financial assistance to municipalities to build new and more modern homes for the aged. These provisions and those of the other Provinces care for some of the aged who cannot, mostly for reasons of physical or mental health, be cared for in their own homes.

The need for better housing for older people is beginning to receive some attention in Canada. Here and there experiments are being tried which have much promise for the future. A block of flats for older people has been built in Burlington, Ontario, by the Canadian Legion, and is expected to operate on a self-sustaining basis now that the capital cost has been found. The family welfare agency in Montreal has converted a legacy into the Belvedere Apartments for older citizens in the center of the city. The development of well-established private agencies which have created homes for older people, such as the Sunset Lodge of the Salvation Army has been the subject of special attention in the city of Toronto. These are only examples of a number of experiments and extensions of existing services which are being developed to meet the growing need of places where an old person or an old couple can seek and find adequate shelter within their very modest means; but the supply falls far short of the need. Large numbers of older people, especially in the industrial towns and cities, still live in conditions of squalid discomfort.

Here and there in Canada there are experiments in recreation for older people and recreation agencies are giving this matter some but not enough attention. The activities of the Gordon House Settlement in Vancouver provide one example of a well planned programme of recreation activities for its older members. The Second Mile Club of Toronto, supported by the city council as well as by the Community Chest of the city, is an experiment in the development of a club for older people, in which they can not only get recreational activities but develop a new social life for themselves. Service clubs in a number of cities are beginning to interest themselves in the needs of the aged. These are all beginnings, but they are few in proportion to the need.

Canada Starts Old Age Work

Canada is just beginning on the long task of providing for its aged. Many plans are being aired. The Senate-Commons joint committee will be asked to consider various proposals for better economic aid; contributory insurance will be proposed, on the pattern of Old Age and Survivors Insurance in the United States or the Retirement Allowances of the British National Insurance Act: universal no-means test allowances (or "birthday pensions for all") of the kind recently suggested by Mr. Alton Linton, testifying on Bill H.R. 6000 before the Senate Committee on Finance, in the United States will be proposed: the needs of older citizens in terms of jobs, housing, medical care, and social services (such as those now provided under the British National Assistance Act) will be presented. There is much good-will, some anxiety, and not a little confusion. Constitutional problems, financial and administrative difficulties, political promises and counter proposal lie ahead. The studies of the New York State Joint Legislative Committee on Problems of the Aging cannot but be a valuable aid to careful examination of the facts and hopefully to the beginnings of wise solutions.

APPENDIX

RECOMMENDED LEGISLATION

STATE OF NEW YORK

No. 743 Int. 734

IN SENATE

January 23, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT

To create a counselling service for older workers in the labor department, and making an appropriation therefor

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Article twenty-four of the labor law and section eight hundred fifty to eight hundred fifty-five, both inclusive, comprising such article, as last renumbered by chapter three hundred seventy-seven of the laws of nineteen hundred forty-five, is hereby renumbered article twenty-five and sections nine hundred to nine hundred five, respectively, and such law is hereby amended by inserting therein a new article, to be article twenty-four-A, to read as follows:

ARTICLE 24-A

COUNSELLING SERVICE FOR OLDER WORKERS

§ 825. The industrial commissioner shall establish in the New York state employment service a counselling service for older workers. Such counselling service shall appraise the capabilities of the older workers, advise, guide and direct older workers to employment opportunities, encourage older workers to seek the work for which they are best suited, and give them confidence in their abilities and perform such other functions as the industrial commissioner shall deem desirable to counsel older workers successfully.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated to the state department of labor for the purposes of this act. The moneys appropriated by this act shall be payable from the state treasury on the audit and warrant of the comptroller on vouchers certified or approved in the manner provided by law.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK

Chapter 598, Laws of 1950

3rd Rdg. 388 Nos. 1629, 3354 Int. 1536

IN SENATE

February 8, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Internal Affairs—reported favorably from said committee, committed to the Committee of the Whole, ordered to a third reading, passed Senate and Assembly but not delivered to Governor, vote reconsidered, restored to third reading, amended and ordered reprinted retaining its place in the order of third reading

AN ACT

To amend the town law, in relation to the regulation of private sanatoriums, convalescent homes, homes for aged or indigent persons, day nurseries, hospitals, rest homes, and buildings used for similar purposes

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Paragraph numbered twenty of section one hundred thirty of the town law, as amended by chapter three hundred thirty-eight of the laws of nineteen hundred thirty-nine and renumbered by chapter one hundred twenty-six of the laws of nineteen hundred forty-four, is hereby amended to read as follows:

20. Hotels, inns, boarding houses, etc. Regulating hotels, inns, boarding houses, rooming houses, lodging houses, associations, clubs or any building or part of a building used in the business of renting rooms, individual or several, *and also private sanatoriums, convalescent homes, homes for aged or indigent persons, day nurseries, hospitals, rest homes or any building or part of a building used for similar purposes*, containing a total number of beds, cots or similar equipment providing sleeping accommodations for more than five persons; specifying the type of construction, the manner of their running and operation and prescribing regulations assuring proper sanitation [and], cleanliness *and fire protection.*

§ 2. This act shall take effect immediately.

This bill was adopted by the Legislature, and is now Chapter 598 of Laws of 1950.

STATE OF NEW YORK

No. 2286 Int. 2109

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Civil Service and Pensions

AN ACT

To amend the civil service law, in relation to the suspension of pensions

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Section thirty-two of the civil service law, as added by chapter seventy-eight of the laws of nineteen hundred thirty-two, is hereby amended to read as follows:

§ 32. When pension [and annuity] suspended. *1.* If any person subsequent to his retirement from the civil service of the state, or of any municipal corporation or political subdivision of the state shall accept any office, position or employment on and after July first, nineteen hundred thirty-two to which any salary or emolument is attached in the civil service of the state or of any municipal corporation or political subdivision of the state, except the office of inspector of election, jury duty, poll clerk or ballot clerk under the election law, or except the office of notary public or commissioner of deeds, or an elective public office, any pension [or annuity] awarded or allotted to him upon retirement, and payable by the state, by such municipal corporation or political subdivision, or out of any fund established by or pursuant to law, shall be suspended during such service or employment and while such person is receiving any salary or emolument therefor except reimbursement for traveling expenses.

2. The provisions of this section shall be suspended, until July first, nineteen hundred fifty-two, to the extent necessary to permit a retired member to continue as such and to earn not to exceed seven hundred fifty dollars per calendar year as compensation in any position in government service or public service, provided:

(a) His retirement allowance, computed without optional modification, does not exceed fifteen hundred dollars per year, and

(b) He duly executes and files with his retirement system a statement that he elects to have the provisions of this subdivision apply to him. Any statement executed and filed pursuant to this subdivision may be withdrawn by a retired member at any time by a statement similarly executed and filed.

§ 2. This act shall take effect immediately.

STATE OF NEW YORK

No. 2289 Int. 2112

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT

To amend the labor law, in relation to creating an office on employment of older workers, defining its powers and duties and making an appropriation therefor

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Article twenty-four of the labor law and sections eight hundred fifty to eight hundred fifty-five, both inclusive, comprising such article, as last renumbered by chapter three hundred seventy-seven of the laws of nineteen hundred forty-five, is hereby renumbered article twenty-five and sections nine hundred to nine hundred five, respectively, and such law is hereby amended by inserting therein a new article, to be article twenty-four, to read as follows:

ARTICLE 24

OFFICE FOR EMPLOYMENT OF THE OLDER WORKERS

Section 825. State office for employment of the older workers.
826. General purposes and duties.
827. Director.
828. Duties of director.

§ 825. State office for employment of older workers. The industrial commissioner shall establish an office for the employment of older workers, composed of three representatives, each from employer and employee organizations, respectively, and one representative of the general public, who shall be the chairman. They, by a majority vote, may designate one of its members, other than the chairman, as a vice-chairman to act in the absence or inability of the chairman. Each member shall be appointed for a term of three years and shall hold office until his successor shall be appointed and has qualified. Vacancies shall be filled by appointment by the commissioner for the unexpired term. The members of the council shall receive no compensation but shall be reimbursed for transportation and other expenses actually and necessarily incurred in the performance of their duties under this article.

§ 826. General purposes and duties. The office shall:

a. attack age barriers to employment through research and education.

b. launch a sustained drive to encourage employers to hire elderly workers.

c. compile for industry a list of jobs for which the elderly have been found particularly suitable.

d. conduct studies on utilization of aging manpower in industry.

e. in cooperation with the homework bureau develop a sound program for expanding work of oldsters at home.

f. help in developing retaining facilities for the aging.

g. encourage creation of sheltered workshops.

h. develop pamphlet on community uses of retired workers.

i. help prepare workers for retirement.

§ 827. Director. The industrial commissioner shall appoint a director who shall be technically trained with adequate administrative experience in personnel and social welfare work and who shall receive a salary to be fixed by the office within the amounts made available by appropriation. The director shall serve at the pleasure of the industrial commissioner.

§ 828. Duties of director. The director shall: (a) be the administrative head of the office; (b) appoint and remove from time to time, in accordance with law and any applicable rules of the state civil service commission, such employees and technical experts as he may deem necessary for the efficient administration of the work of the office. The compensation of such

employees and technical experts shall be fixed by the director within the amounts made available by appropriation; (c) investigate and report from time to time upon the facilities and services which are needed or which may be needed to promote the interests of aging and elderly workers of the state and make such recommendations as may prove beneficial and useful in carrying out the provisions of this article; (d) advise and cooperate with employer and employee organizations on matters relating to the rehabilitation and employment of aging and elderly workers; and (e) perform such other duties as may be necessary to carry out the provisions of this article.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated out of any moneys in the state treasury not otherwise appropriated and remaining to the credit of the state purposes fund in the general fund and made immediately available for use by the office for older workers, including expenses of maintenance and operation and personal service of employees, in carrying out the provisions of article twenty-four of the labor law as added by this article. Such money shall be paid out of the state treasury on the certificate of the industrial commissioner after audit by and upon the warrant of the comptroller as provided by law.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK

No. 2290 Int. 2113

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT

To amend the public health law, in relation to instituting and developing an adult hygiene and geriatrics division in the department of health and making an appropriation therefor

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. The public health law is hereby amended by inserting therein a new article, to be article twenty-three-A, to read as follows:

ARTICLE 23-A

ADULT HYGIENE AND GERIATRICS

Section 460. Adult hygiene and geriatrics.
461. Purpose and functions.
462. Powers and duties.

§ 460. Adult hygiene and geriatrics. The state department of health shall establish an adult hygiene and geriatrics program, designed to improve and protect the health and vitality of middle aged and elderly citizens of the state.

§ 461. Purpose and functions. The department, at the discretion of the commission, shall:

1. Plan the change in emphasis on public health work from communicable diseases to degenerative diseases and chronic illnesses.

2. Develop a program for integrating all public health department activities, ranging from cancer control division, public health nurses, district health officers, health education division on the utilization of geriatric techniques.

3. Develop a program for periodic comprehensive health inventories, for the middle aged and elderly.

4. Plan and promote a health education program for the elderly.

5. Set up a "pilot" old age clinic at a general hospital.

6. Develop plans for expanding the facilities of chronic illness centers to include old age clinics.

7. Explore possibilities of reducing cost and improving care of the chronically ill through use of non-institutional facilities.

8. Develop, carry out and stimulate laboratory, clinical and statistical research on health problems of older people, as may be recommended by the state medical society or other agencies.

9. Carry on a program of professional education and training of medical students, physicians, and nurses in the prevention, medical, and nursing care of diseases of older people.

§ 462. Powers and duties. The commissioner shall have the power and it shall be his duty to employ such assistants and personnel, within the amount of the appropriation, as is necessary to carry out the provisions of this article.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated out of any moneys in the state treasury not otherwise appropriated and remaining to the credit of the state purposes fund in the general fund and made immediately available for use by the state department of health, including expenses of maintenance and operation and personal services of employees, in carrying out the provisions of article twenty-three-A of the public health law as added by this article. Such money shall be paid out of the state treasury on the certificate of the commissioner of health after audit by and upon the warrant of the comptroller as provided by law.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK

No. 2291 Int. 2114

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT

To amend the executive law, in relation to creating a state council on the elderly; defining its functions, powers and duties and providing for the appointment and term of office of its members, and making an appropriation therefor

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Article fifteen of the executive law, and sections two hundred and two hundred one comprising such article, as last renumbered by chapter seven hundred sixty-three of the laws of nineteen hundred forty-five, is hereby renumbered article sixteen and sections two hundred fifty and two hundred fifty-one, respectively, and such law is hereby amended by inserting therein a new article, to be article fifteen, to read as follows:

ARTICLE 15

STATE COUNCIL ON THE ELDERLY

§ 200. Council created; employees; utilization of departmental personnel and assistance. 1. A state council on the eldery is hereby created to consist of nine members to be appointed by the governor, among which there shall be a representative appointed from each of the following: department of education, department of labor, department of social welfare, department of health, and division of housing. Three members shall be appointed for a term to expire January fifteenth, nineteen hundred fifty-two, and two members for terms to expire on January fifteenth, nineteen hundred fifty-three, two members whose terms shall expire on January fifteenth, nineteen hundred fifty-four and two members whose terms shall expire on January fifteenth, nineteen hundred fifty-five, and their successors shall be appointed for a term of four years. Vacancies for causes other than expiration of terms shall be filled for the remainder of the unexpired term. The governor shall designate one of the members to serve as chairman of the council. The members of the council shall be allowed their actual and necessary expenses incurred in the performance of their duties under this act, but shall receive no compensation for services rendered pursuant to this act.

2. The council may employ and at pleasure remove such officers and employees, and such expert and clerical assistants as it deems necessary and may fix their compensation within the amounts made available by appropriation therefor.

3. To effectuate the purposes of this act any department, division, board, bureau, commission or agency of the state or any politieal subdivision may provide such facilities, including personnel, assistance and data, as will enable the council properly to carry out its activities and effectuate its purposes hereunder.

§ 201. Definitions. As used in this act,

1. "Council" shall mean the state council on the elderly created by this act.

2. "Director" shall mean the director of council to be appointed under the provisions of this act.

§ 202. Purposes and duties of council. The council shall:

(a) Encourage the coordination of the work of various state departments and agencies dealing with the elderly.

(b) Interpret the needs of the elderly to the various state departments and to the public.

(c) Stimulate research on problems of the aging.

(d) Encourage organization of old age committees in each local community.

(e) Spear-head a state program for the elderly, giving it leadership, direction and support.

(f) Report annually on facilities, progress and activities of public agencies dealing with the elderly.

§ 203. Director. The council shall appoint a director who shall be responsible to the council, and who shall receive a salary to be determined by the commission. The director shall serve at the pleasure of the commission.

§ 204. Duties of director. The director shall

(a) Appoint and supervise and direct all officers, agents and employees necessary to carry out the provisions of this act.

(b) Study and report to the council upon the facilities and services for the elderly which are needed or which exist within the state and by consultation with the authorities in charge.

(c) Assist in the correlation and development of programs for the elderly, provided that surveys of the recreation facilities and programs of local agencies shall be made only upon their request.

(d) Advise and cooperate with and encourage community recreation agencies interested in the use of or the development of recreation facilities and programs for the elderly.

(e) Advise the administrative officers of all state agencies authorized by law to perform services for the elderly of regular meetings of the commission and of such special meetings as may consider matters relating to their specific responsibilities, and invite such officers to attend and participate in deliberations of the commission without the authority to vote.

(f) Encourage and render assistance in the promotion of training programs for volunteer and professional personnel dealing with the elderly in cooperation with other agencies, organizations and institutions, and may encourage the establishment of standards for recreational personnel.

(g) Assist any department, commission, board, agency and officers of the state in rendering services for the elderly in conformity with their respective authorized powers and duties and encourage and assist in the correlation of state and local activities for the elderly.

(h) Perform such other duties as may be prescribed by law.

§ 205. Grants. The commission, with the approval of the governor, may accept as agent of the state any gift of funds for the purposes of this act.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated out of any moneys in the state treasury not otherwise appropriated and remaining to the credit of the state purposes fund in the general fund and made immediately available for use of the state council on the elderly created by this article, including expenses of maintenance and operation of the council, and for personal service of employees, in carrying out the provisions of this article. Such moneys shall be paid out of the state treasury on the certificate of the chairman of the council after audit by and upon the warrant of the comptroller in the manner provided by law.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK

Nos. 2293, 3054 Int. 2116

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Judiciary—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT

To amend the civil rights law, in relation to providing that applications for licenses, certificates or permits from the state may not be denied because of maximum age limits

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. The civil rights law is hereby amended by inserting therein a new section, to be section seventy-three, to read as follows:

§ *73. No application by a person who is in all other respects qualified for any license, certificate or permit issued by the state or any department, commission, authority or agency thereof, or by any municipality, shall be denied because such person is over any specified age. Nothing herein contained, however, shall prevent the state board of social welfare from adopting reasonable age requirements for licenses, certificates or permits for foster mothers in charge of infants and children.*

§ 2. This act shall take effect immediately.

STATE OF NEW YORK

No. 2294 Int. 2117

IN SENATE

February 21, 1950

Introduced by Mr. DESMOND—read twice and ordered printed, and when printed to be committed to the Committee on Taxation

AN ACT

To amend the tax law, in relation to allowing contributions made or amounts paid by employees to pension trusts or retirement plans maintained by their employers

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. Section three hundred sixty of the tax law is hereby amended by adding thereto a new subdivision, to be subdivision nineteen, to read as follows:

19. Contributions made or amounts paid, withheld or incurred by the taxpayer during the taxable year with respect to any pension trust or retirement plan maintained by the taxpayer's employer in an amount not exceeding in the aggregate, five hundred dollars.

§ 2. This act shall take effect immediately and shall be applicable to returns for any taxable year beginning on or after January first, nineteen hundred fifty-one.

STATE OF NEW YORK

Nos. 2273, 3091 Int. 2096

IN SENATE

February 21, 1950

Introduced by Mr. CAMPBELL—read twice and ordered printed, and when printed to be committed to the Committee on Finance—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT

To amend the social welfare law, in relation to adult recreation and making an appropriation therefor

The People of the State of New York, represented in Senate and Assembly do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. The social welfare law is hereby amended by inserting therein a new article to be article ten-a, to read as follows:

ARTICLE 10-A

RECREATION FOR THE ELDERLY

§ 481. Declaration of intent. Recreation is a basic human need. The state of New York has already authorized a program of state-aid for recreational facilities for youth. However, the recreational needs of our senior citizens have not as yet been met. Many of our older persons, shunted aside by industry, leading lonely lives in what should be golden years, rooming in dreary boarding houses or crowded in with relatives, feeling unwanted and insecure, and plagued by boredom, are in urgent need of recreational facilities for the preservation of their mental and physical health.

The tremendous increase in the number of our elderly, the longer life span now vouchsafed our people, the huge burden on our state and citizens of persons on old age assistance rolls, the mounting costs, for care of the chronically ill, and for wards for the senile in our mental institutions, together with the real loss to our economy entailed by loss of the production of which many of our elderly are capable, are but some of the factors that cry out for establishment of a recreational program for the elderly. There is ample evidence that a recreational program can retard some of the characteristics of senility, encourage the vocational rehabilitation of the elderly, and give new zest to their lives.

It is the purpose of this bill to encourage establishment of recreational programs for the elderly which will promote (a) the social and emotional adjustment of the older person by making it possible for him to find companionship and create an environment that is favorable to continuing growth and give him a sense of personal stability and security, (b) the rehabilitation of the personal efficiency of the older individual by making it possible for him to make maximum use of his time and of capacities least impaired, and (c) community usefulness by creating a feeling of adequacy and accomplishment through activity.

§ 482. Adult recreation council created; functions, powers and duties. There is hereby created in the state department of social welfare an adult recreation council to consist of five members to be appointed by the state commissioner of social welfare, including the director of adult education of the department of education, ex officio. The council shall have power to organize, elect a chairman and secretary, adopt, promulgate and make effective, plans, rules and orders with respect to the furnishing of recreation in school buildings and properties or elsewhere for adults over sixty years of age.

§ 483. Powers of cities with respect to recreation for the elderly. 1. Each city of the state is hereby authorized to furnish and foster recreational activities for adults over sixty years of age, as may be authorized by the council, and to receive and expend moneys from the state, the federal government or private individuals, corporations or associations for furnishing such recreation in accordance with plans, rules or orders of the council.

2. The furnishing of such recreation is hereby declared to be a proper municipal purpose for which the moneys of such city may be raised and expended.

3. The chief executive of a city may appoint a recreation for elderly committee to advise and assist in the provision of such recreation and facilities therefor.

§ 483-a. Adult recreation projects; approval. 1. Any city desiring to establish a recreation project for the elderly may apply to the council for its approval of its plans. The application shall be in accordance with rules, plans and orders promulgated by the council, shall be in writing and shall specify the nature of the project in such detail as the council shall require.

2. No application for the approval of plans for a recreation project for the elderly shall be considered which has not been first approved by the governing body of the municipality making application.

3. The council may approve or disapprove the proposed project as filed or if its modifications are consented to by the applicant, approve the same with such modifications.

4. The approval of any proposed project by the council shall authorize the municipality to establish, operate and maintain the recreation project, and shall be entitled to state aid as hereinafter set forth; provided, however, the council may at any time subsequently withdraw its approval or require changes in a plan or program previously approved.

§ 483-b. State aid. 1. Each city operating or maintaining a recreation project hereunder shall submit to the council quarterly estimates of anticipated expenditures for operation and maintenance of the recreation project, including also rental of buildings, purchase of equipment and administrative expense, not less than thirty days before the first days of the months of April, July, October and January, in such form and containing such information as the council may require. At the end of each quarter each city shall submit to the council, in such form as the council may require, a verified accounting of the financial operations of such project during such quarter together with a claim for reimbursement of one-half of such amount as herein provided.

2. The council shall thereupon certify to the comptroller for payment by the state of one-half of the entire amount of such expenditures as approved by the council; provided, however, that the amount of state aid shall not exceed the sum of one dollar for each ten persons over sixty years of age, residing in the municipality, as shown by the last preceding federal census, nor in any event more than one-half the amount of such local expenditures for such project.

3. For the purpose of reimbursement by the state, administrative expenses shall include compensation for personal services paid by a municipality to any employee, for the purpose of administering the benefits provided by this act.

§ 483-c. Withholding state aid. The council may authorize or require the comptroller to withhold the payment of state aid to any municipality in the event that such municipality alters or discontinues, without the approval of the council, the operation of a recreation plan approved by the council, or fails to adopt or change a plan as recommended by the council, or fails to comply with rules or regulations established by the regents.

§ 483-d. Grants. The council, with the approval of the commissioner, may accept as agent of the state any gift or grant for any of the purposes of this article, and any moneys so received may be expended for any of the purposes of this act in the same manner as other state moneys appropriated for the purposes of such adult recreation.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated to the social welfare department out of any moneys in the state treasury in the general fund to the credit of the state purposes fund not otherwise appropriated, and made immediately available for the purposes of this article, including approved payment, of state aid, and, to the extent of not over ten thousand dollars thereof, for expenses of maintenance and operation of the department and personal services of employees, in carrying out the provisions of this act. Such moneys shall be paid out of the state treasury on the certificate of the commissioner after audit by and upon the warrant of the comptroller.

§ 3. This act shall take effect August first, nineteen hundred fifty.

STATE OF NEW YORK

No. 2173 Int. 2022

IN SENATE

February 20, 1950

Introduced by Mr. HORTON—read twice and order printed, and when printed to be committed to the Committee on Finance

AN ACT

To amend the education law, in relation to providing for adult education for older persons, and making an appropriation therefor

The People of the State of New York represented in Senate and Assembly, do enact as follows:

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

Section 1. The education law is hereby amended by inserting therein a new section, to be section forty-six hundred fifty, to read as follows:

§ 4650. Adult education for middle-aged and elderly persons. The education department shall stimulate the development of adult education for middle-aged and elderly persons. Such program shall include, but not be limited to, pre-retirement counselling, classes in health education for older persons, education for leisure time in retirement and classes in crafts or other suitable activities or subjects of interest to older persons. The department shall train teachers in the motivation and instruction of older persons.

§ 2. The sum of fifty thousand dollars ($50,000), or so much thereof as may be necessary, is hereby appropriated to the education department out of any moneys in the state treasury in the general fund to the credit of the state purposes fund not otherwise appropriated, for the purpose of carrying out the provisions of this section. Such funds shall be payable on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner of education, in the manner provided by law.

§ 3. This act shall take effect immediately.

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Additional copies of this report are available free of charge by writing to State Senator Thomas C. Desmond, Chairman, New York State Joint Legislative Committee on Problems of the Aging, 94 Broadway, Newburgh, N. Y.