Governor's Conference On Aging

1965 PERSPECTIVES ON AGING

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NEW JERSEY DIVISION ON AGING
DEPARTMENT OF STATE

Richard J. Hughes, Governor of the State of New Jersey

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WELCOME

Mrs. Eone Harger, *Director*
New Jersey Division on Aging

Welcome to the Second New Jersey Governor's Conference on Aging. As indicated in your invitation, this meeting has been called to review briefly what has been achieved since New Jersey first took cognizance of its special obligations in this area and, more importantly, to consider what may be ahead because of the social revolution of lengthened life and shortened work years. It is important in any field of endeavor to take stock, at intervals, of past achievements and future directions. Perhaps it is even more important in the broad field designated as "aging" than in many others because aging means such different things to different people, each meaning accurate but limited.

In opening the conference six years ago, Mr. Lloyd Wescott pointed to this fact and illustrated it with the story of the three blind men describing an elephant—one thought it like a tree because he held the leg—another felt the side and said it was like a wall—another the tail and compared it to a rope, etc.

Our representation here today is a cross section of the community leaders in the field of aging. No attempt was made to fill up this hall with aged persons. We stressed the need for those persons that have a concern for the elderly especially at the community level to come together for a brief review of where we have been, but more importantly, to take a look at the years ahead. Our advance registration more than fulfilled our hopes. You are the ones to whom we must look as we move forward in this field.

In the academic world the subject of aging is being approached under the title, "Gerontology." A recent definition of this new social science describes it as more than a science since it has a reformist commitment with the attributes of a social movement, and added, it is also a crusade to help the older person lead a "full life." This, so far as the New Jersey Division on Aging is concerned, expresses very well the overall objective to which the New Jersey Division is committed, as well as explains the involvement of many of you who have joined us today.

The State of New Jersey and those of us concerned with making it possible for older persons to lead a full life are indeed fortunate that our Governor is a man of compassion and courage. Governor Richard J. Hughes has demonstrated his concern in very practical ways. It is not enough to sit back and merely talk about the problems of the elderly for there are very real problems to be solved. Solutions to some of these have been found during his first term. Answers to others are in the making.

It is with great pleasure that I present to you His Excellency the Governor of New Jersey, Richard J. Hughes.

FOR NEW JERSEY'S OLDER CITIZENS

Richard J. Hughes
Governor, State of New Jersey

The responsibility of government to its citizens makes it imperative that, periodically, we stop and take stock of where we have been and the new directions in which we are moving. This we do today.

Six years ago the First New Jersey Governor's Conference on Aging convened in this hall. The areas of concern then differed from the concerns of today. Dr. Wilbur Cohen, Under Secretary of the United States Department of Health, Education, and Welfare, was then spelling out in detail the principles of a program which has now become known as "Medicare."

Today that issue—just a few years ago the center of a great ideological controversy—is a program that rightfully is becoming part of the American way of life. Somehow medical care in a social insurance program for our older citizens was thought to be inconsistent with our American way of life. But is it? The answer — in my opinion — is no. For the people of this affluent nation have finally persuaded their legislators that medical and hospital insurance for older Americans is in the tradition of responsible American governmental action on behalf of a group of citizens which finds it difficult to solve its most pressing problem by private means alone.

President Johnson summed the situation up in these words:

> "The long debate is drawing to a close. There is going to be a program of health insurance for older people in this country. And the basis of that program is going to be our great social security system. Soon all older people will be able to face a prospect of illness with new assurance that they will not have to bear added worry over how the major costs are going to be paid."

Now, our hospitals, doctors, and other social institutions must begin — if they haven't done so already—to plan for the implementation of that bill which I trust will soon pass the Senate and be signed into law by our forward-looking President.

Six years ago there was great emphasis on employment opportunity for older citizens. In 1962, in fulfillment of our 1961 campaign pledge, I was happy to sign into law an amendment to the New Jersey Civil Rights Act which prohibits job discrimination solely because of age. I have been informed by the New Jersey Division on Civil Rights that the number of cases filed under that amendment is small but growing. New rules and regulations spelling out the age prohibitions in greater detail are currently being devised by Division officials and will be distributed in pamphlet form to corporations and businessmen throughout the State.

However, we would be unrealistic if we did not face the great changes which have taken place in the employment picture throughout the country. Early retirement is, more and more, becoming accepted company policy in many areas. We must give attention to planning for those added leisure years. We obviously need more and better pre-retirement counseling, perhaps greater flexibility in pension programs, and added facilities for adult education programs for senior citizens.

As a step to improve adult education, this administration signed legislation in 1964 which would make it possible for local boards of education to cooperate in hiring trained personnel to develop adult education programs. State aid to implement such programs

has been requested in my 1965-66 Department of Education budget which is now before the Legislature.

Six years ago we pointed to housing as a basic problem confronting our older citizens, a problem which has become more acute. As local real estate taxes have gone up, the burden on low-income retired property owners has become almost intolerable. A constitutional amendment was approved in 1963 by the electorate to give persons over 65 years of age with a combined gross income of $5,000 or less an $80 deduction from their property tax.

While we have endeavored to help older home owners, we also hav moved forward on other housing fronts. There are a number of communities that now have or are contemplating the creation of local housing authorities which are authorized to place special emphasis on housing for the elderly of low income. I strongly urge that more communities take advantage of this mechanism to solve the housing needs of a specialized group of the elderly.

The local housing authority can bring us multiple advantages. It helps bring back to New Jersey federal tax dollars and thus stimulates our economy. It develops housing which permits retired senior citizens to stay in their own home towns, close to families, friends, churches and organizations. It also fulfills the responsibility of government to develop appropriate facilities to meet the needs of its long-time residents.

In addition to public low-rent housing, middle-income housing for older adults has been stimulated by two major housing conferences sponsored by our State Division on Aging along with interrelated agencies of State government and the State Federation of Planning Officials. A Housing Consultant from the Division on Aging is available to local governing bodies, volunteer organizations, and church or union groups to explain all the programs now available for official or community organization-sponsored housing. The appointment of this Housing Consultant is another first for New Jersey.

I recently had the pleasure of joining in groundbreaking ceremonies for yet another community development for older citizens, a $2½ million project known as Heath Village in the northern part of the State, sponsored by the Episcopal Church of New Jersey.

Church groups have taken leadership both in design and provision of service within housing. These programs range from an all-inclusive medical care concept in congregate living to single rental units for older persons. Other non-profit groups are participating and we hope to encourage still more to join.

There are many other areas in which State government has moved to assist the elderly. We have passed legislation to take advantage of the Kerr-Mills Medical Assistance to the Aged Act.

We have expanded the services of the Division of State and Regional Planning to assist municipalities in planning, which includes needs for older adults.

The Division on Aging, with State funds, made it possible for the Urban Studies Center of Rutgers, The State University, to carry on an in-depth study of 1960 census figures showing patterns of population change in selected municipalities.

Today, I would be remiss if I did not also call attention to the distinguished contribution on behalf of the older citizen made by our own Senator Harrison A. Williams, Jr. Especially meaningful was his work on the Special Senate Committee on Aging which

investigated mail order land speculation, medical quackery, and fake health insurance schemes by promoters who prey on older citizens.

Senator Williams is also one of the leaders now steering through the Senate of the United States a bill on aging which would establish a national Division on Aging similar to that existing in our State, with sufficient funds to begin working on myriad problems of employment, housing, and recreation. That bill—significantly—was passed earlier in the U.S. House of Representatives by an almost unanimous vote.

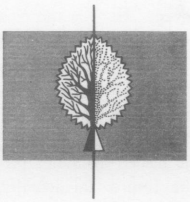
However, these are beginnings and, in some areas, our concern continues to grow. With the influx of older people into our State, the percentage of aging in our population continues to rise. There are today about 650,000 people in New Jersey who are 65 or over. Planning for this growing segment of our population is a major concern of government and, particularly, the Division on Aging.

Just recently, my administration reintroduced into the Legislature a measure to strengthen the structure of the Division on Aging. It provides for public hearings on problems affecting the elderly and for authorization to receive Federal funds which could become available to us under pending Federal legislation.

We seek to make real the promise inherent in the words "golden years." Let us now proceed toward that noble objective.

Commissioner ROBERT M. BALL

Mr. Ball is Commissioner of Social Security, Social Security Administration, United States Department of Health, Education, and Welfare. He began his service with Social Security in 1939, *becoming Assistant Director of the Bureau of Research and Training in* 1949, *and Deputy Director* 1952 *to* 1962. *In* 1961, *he was a recipient of the Rockefeller Public Service Award in the area of administration.*



ADEQUATE INCOME FOR THE NON-WORKING YEARS

Address by Robert M. Ball

Commissioner of Social Security, U.S. Department of Health, Education, and Welfare

(Presented in his absence by Alvin M. David*)

Governor Hughes, Mrs. Harger, Mr. O'Connor and other distinguished guests both on and off the platform: It is a great pleasure to be with you at this Governor's Conference on Aging. Commissioner Ball had looked forward to participating in the conference and is much disappointed that he is unable to be here. The disappointment is not unmixed, however, because the reason for his not being here is the advanced state of legislative consideration of the historic 1965 amendments to the social security program.

The few years since your first conference, in 1959, have been eventful with respect to the aging. In many ways this has been a period in which we rediscovered our elderly people. A great deal of attention has been focused on their problems. They themselves have become more active. The Nation has shown greater awareness and concern, and this has been reflected in legislative activity at the local, State, and Federal levels. I think it is quite obvious that the State of New Jersey and many of its officials and representatives have contributed immensely toward the common goal of security, significance, and fulfillment in older age. Your approach to income needs as well as to other problems has been very broad and a challenge to national action. Commissioner Ball had written that he applauded your work and was honored to be asked to address you. I, too, am honored as well as greatly pleased to be here in the Commissioner's place.

I welcome the opportunity to discuss the subject of "Adequate Income for the Non-Working Years" and to examine with you the implications of the longer life span and the shorter number of working years. These implications need to be examined from time to time. More people are living to be older. They are retiring earlier. Young people are not going to work as early as they used to. They are staying in school longer or dropping out, too often to join the unemployment rolls. Income-maintenance programs will need to take these trends into account and to stay flexible so as to adapt to change — even dramatic change. Another reason I am pleased to be here to talk about our subject is that we in the Social Security Administration have been much concerned with this subject as part of our jobs; it is becoming increasingly evident that social security will continue to be this Nation's basic instrument for assuring reasonably adequate income to retired workers and their widows and dependents.

This is an exciting time to be dealing with the problem of adequate income for the non-working years. As I noted a minute ago, we are in the midst of legislative consideration of the most sweeping set of social security amendments since the original social security law was enacted 30 years ago. It is almost a certainty that the bill now before Congress or something very like it will become law this year. As a result of its enactment, the adequacy of retirement income protection for the people of this country will be greatly improved. President Johnson has called the bill "a tremendous step forward for all senior citizens."

As you all know, the bill provides for two coordinated health insurance programs for people 65 and over. Here in these programs is the "someday" that had to come if

*Director, Division of Program Evaluation and Planning, Social Security Administration.

real economic security ever was to be made possible in old age. Here is the closing of the biggest gap. Not only will the two programs provide relief from the most crushing hospital and medical costs faced by the aged, but as the pressure of inordinately high health costs is eased the income and assets released for other purposes will provide the means for planning a more comfortable retirement. The maintenance of financial equilibrium after age 65 will become much more of a possibility for the 19 million people immediately qualifying for these benefits at the start of the health insurance programs, and for the many millions more who will qualify in the future. Incidentally, State agencies will have important administrative and consultative functions to perform if the provisions of the bill are adopted as written.

So far as the cash benefits of the social security program are concerned, the bill now before the Congress would increase them across-the-board by 7 percent, would increase the maximum limit on the amount of annual earnings taxable and creditable toward benefits—the so-called contribution and benefit base—from the present $4800 level to $5600 in 1966 and $6600 in 1971, and would make other major improvements in the social security program. And, finally, the bill would make important improvements in the Federal-State public assistance programs.

Under the cash benefit provisions of the bill, increased benefits will go to all of the 20 million people now on the rolls—retired workers and their families, disabled workers and their families, and surviving families of deceased workers—and, of course, benefits for people coming on the rolls in the future will also be higher. Under the $5600 contribution and benefit base, there will be a new maximum monthly benefit for the retired worker of $135.90 now and a maximum of $149.90 for people coming on the rolls in the future, instead of the $127 maximum at the present time; and the present $254 family maximum benefit would go to $312. Under the second-step increase in the wage base to $6600, which will take effect in 1971, the maximum benefit for a retired worker will go eventually to $167.90 a month and the maximum family benefit will go to $368. Under the bill, the average benefit for a retired worker with no dependents will amount to $80 a month, as compared with $74 under present law; for an aged couple it will amount to $142, as compared with $131 under present law; for an aged widow it will amount to $74, as compared with $68 under present law.

Perhaps the impact of the bill can best be gauged in this way: It would increase the total social security expenditure by one-third—from a projected $19 billion in 1967 under present law to $25 billion. The value of the increased protection provided by the bill to the average retired worker 65 or over now on the rolls, including the increase in the cash benefits and the new health and hospital insurance protection, is about $20 a month; for the average retired worker and wife 65 or over, the value is about $36 a month.

We can look forward, then, to a very substantial improvement in the adequacy of the retirement protection of the people of the country just on the basis of legislation likely to be enacted this year. What can we look forward to for the future?

The problem of adequate coverage under social security for the future is just about solved. Nearly everyone in the future will qualify for benefits under social security or some other public retirement system, such as those covering railroad workers, Federal employees, and State and local government employees. About 16 million of the more than 18 million people aged 65 and over are eligible for benefits under one or another of these programs—15 million under social security alone. More than 9 out of 10 people who are currently working are covered or eligible for coverage under social security. This universal coverage assures them of protection whenever they shift from one job to

another. The effectiveness of this continuous coverage is reflected in the fact that between 95 and 98 percent of all people past 65 eventually will be eligible for social security. Virtually all will have some retirement income.

What about the role of private pensions? This question is important because those who qualify for such pensions are, in general, better off than the remainder of the retired group. But they will be in the minority.

Private retirement plans have grown rapidly since the end of World War II, but nevertheless, only about 2 million people age 65 and over are benefitting from these plans today. An estimated 25 million current workers are covered under private retirement plans, but even by the year 1980, according to estimates of the President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs, the number of retired workers actually receiving private pensions, plus their wives, will probably not exceed 30 percent of the total population aged 65 and over.

Private pensions of any significant amount go primarily to regularly employed members of the labor force with average and above-average earnings and to the career employee. The amount of the pension is typically related to the individual's length of service with the particular firm or industry, and to his earnings. Long service requirements, employee turnover, and the lack of vesting provisions combine to work against a more important role for the private pensions. The Social Security Administration's 1963 Survey of the Aged found that private pensions provided people 65 and over with only 7 percent of their income from retirement programs in 1962, while social security was responsible for 70 percent.

Social security, then, will have to do the major part of the job of providing retirement protection for our people. What about the adequacy of the protection?

A great many of our present aged are poor. We have recently developed what we call poverty indexes in the Social Security Administration. I know many of you are aware of this work, since you have written us about it. The indexes were developed because we think there is an essential fallacy in having a fixed poverty line. A family with many children obviously requires a higher minimum than a family with no children. Farm people are able to manage on somewhat less cash income than city dwellers and so forth. Therefore we define poverty in terms of equivalent levels of living for families of different size.

Taking the lower of the two levels of living we have considered, we have concluded that an aged married couple, for example, would need 74 cents a day for food and $2 a day for all other expenses if they were to escape poverty. But a total of more than 5 million of today's aged exist in poverty even by this strict definition. And almost 2 million more get by only because they live with families above the poverty level. Almost three times as large a proportion of the aged as of people 18 to 64 are poor.

According to the Survey of the Aged conducted by the Social Security Administration in 1963, the median income of nonmarried people aged 65 and over was $1,130 for the year 1962. For the married, the median income was $2,875. Almost 3 in every 10 couples had less than $2,000.

Social security benefits were practically the sole source of cash income for almost one-fifth of the couples and for more than one-third of the nonmarried beneficiaries. About one-half of the beneficiaries have less than $12.50 a month in continuing retirement income other than their social security benefits, and for all but about one-fifth of the beneficiaries, benefits are the major source of continuing retirement income. The

welfare of the beneficiaries is very closely tied, then, to the level of the social security benefits, and, as we have seen, those benefits are modest in amount.

Of course, as I have already mentioned, the provision of health insurance for the aged and the benefit increase that will in all likelihood be enacted this year will improve this picture very considerably. But additional improvements will be called for as our economy continues to grow and prosper. The level of benefits provided under the social security program, for example, needs to be looked at continually to assure that it is kept up to date. In fact, the Advisory Council on Social Security, which met and studied the program over a period of a year and a half and reported its conclusions on January 1, recommended a benefit increase averaging about 15 percent, rather than the 7 percent provided for by the social security bill under consideration. The Council indicated that the increase over and above that needed to make up for the increase in the cost of living (7 percent, the same as that provided by the bill) should be devoted largely to increasing benefits for low-paid workers who are regularly employed in work covered by the program. Further consideration will undoubtedly be given in the future to improving the adequacy of the benefits for these people.

Consideration will need to be given also to further improvements in the contribution and benefit base of the program, even though the improvement that will be made by the social security bill is a very substantial one, the increase, in fact, being equal to all of the increases in the contribution and benefit base that have been made so far in the history of the program. It is extremely important to keep this base in line with rising earnings, not only to maintain the wage-related character of the benefits and the adequacy of the protection of the program, but also to maintain a broad financial base and to apportion the cost of the program among low-paid and higher-paid workers in the most desirable way. When the social security program started, the $3000 base that was then established covered practically all earnings in covered work. The Advisory Council, while noting it would not be practicable to attempt at this time to restore all of the ground that has been lost over the years, pointed out that a base of $14,500 would be needed now to cover the same proportion of total earnings in covered work as was contemplated in 1935. The Council recommended that the base be increased to at least $6000, effective in 1966, and $7200 effective in 1968. Consideration will unquestionably need to be given to further increases in the future as earnings levels rise. Consideration may be given, too, to the possibility of providing for automatic increases, both in benefit amounts and in the contribution and benefit base, as earnings and prices rise.

A problem that will become increasingly troublesome in the future is that of how to provide adequately for people who are forced into early retirement. In this connection, I should like to mention the results of a Gallup Poll reported just last month. Question number one was: "What do you think should be the retirement age for men—that is, when should they begin to receive social security benefits?" Thirty-two percent of the respondents felt the retirement age should be 65, fifteen percent said age 62, and the largest group—42 percent—favored retirement under social security *before age* 62. Yet it is very expensive to lower the age of eligibility under social security, and it must be noted that when the Congress did lower the age from 65 to 62—first for women and later for men—it avoided excessive increases in the cost of the program by providing for the payment of reduced benefits to people retiring before age 65—reduced sufficiently so that the total amount of benefits that a person could expect to get over his lifetime would be the same if he retired before 65 as it would be if he retired at 65 or later.

There are at present more aged persons coming on the social security rolls each month with reduced benefits than with full benefits. And already more than one-fourth

of all retired worker beneficiaries—men and women—are receiving reduced benefits. For men the problem is compounded by the fact that the ending point for computing their average monthly earnings, on which benefits are based, is the attainment of age 65 rather than attainment of age 62, as it is for women. Thus, if a man does not work after age 62, his average monthly earnings are reduced, while for a woman they are not. As a result, benefits payable to men who come on the rolls before age 65 are on the average *much* lower than the benefit amounts payable to men who come on the rolls at age 65 or after—for 1964 awards, $75 for men who came on before 65 as compared to $105 for men who came on at or after 65.

The Advisory Council recommended that the ending point for computing benefits for men be reduced to age 62, but recognized that this change might not improve benefits enough for people who are forced into early retirement. The Council recommended also, therefore, that the Social Security Administration continue to collect information about people who come on the benefit rolls before age 65. Unquestionably further consideration will be given to this problem with a view to developing recommendations for remedial legislation in the future.

There are now more than 18 million Americans age 65 or older. This is twice as many as in 1940. The number will continue to increase during the rest of this century and is expected to be about 50 percent larger by the year 2000 than it is today. And today social security is directly concerned with the 62-to-64 age group as well. There are now about 4 and one-half million people in this group and the total of all persons age 62 and over now constitutes about 11.5 percent of the total population of all ages. Looking ahead another 30 years, we find that the relative weight of the population 60 *and over* is expected to be 11.5 percent—the same ratio as the 62-and-over population today. And the most important factor in the economic well-being of these people may be what happens in social security.

I think we have reason to be optimistic. I believe that the very significant improvements that are going to be made this year indicate that the will to provide more adequately for the non-working years is growing, and that the recognition that the major way to do so is through improving the social security program has also gained acceptance.

And I think there will be growing acceptance of the proposition that more can be done for retired people in the future. We are enjoying a degree of prosperity unmatched in our experience. We are producing in a year $660 billion worth of goods and services. We are producing in a 40-hour week three times as much as our grandfathers did in a 70-hour week. Almost everywhere there are new records in car sales . . . growing bank deposits . . . higher new housing starts . . . rising sales curves. And we are only on the threshold of the new technological revolution. The automatic factory, where a continuous process is controlled and directed by the machine, is already a reality in some industries, and it will certainly become widespread.

In the meantime, judging by almost any standard, there remains ample room for growth of the income maintenance programs. We are still spending only about 6 percent of our gross national product for social security and related benefits of all types. According to a recent report of the International Labor Office, in most of the countries of Western Europe and in Canada the ratio of social security expenditures to gross national product is between 9 and 14 percent.

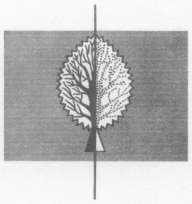
To a greater extent than ever before in our history, the way in which our aged population lives is determined by social policy—by decisions as to the adequacy of

benefits and the extent to which they are adjusted to reflect improvements in general levels of living. Britain's C. P. Snow recently said, "Aging . . . is intolerable if it's made worse by an absence of ordinary care, by financial worries, by a lack of the minimum requisites of life at a time when one needs them. That is, no civilized society ought to have any part of its aging population, for any reason, really feel the desperate bite of unassuageable poverty. No country can take that."

I don't think America is going to have to take it. I think we are on our way toward ending poverty among the aged as well as among our population generally.

MR. ARTHUR P. CRABTREE

Mr. Crabtree, now a free-lance consultant in adult education, is a former President of the Adult Education Association of the United States. In Indiana, in addition to being a teacher, he was a practicing lawyer and Assistant District Attorney. In the Department of Justice in Chicago he served as Education Director for the Immigration and Naturalization Service. He spent 17 years with the State Education Department in New York, 12 of them as Head of Adult Civic Education.



EDUCATION — THE KEY TO SUCCESSFUL AGING

Arthur P. Crabtree
Past President of the Adult Education Association of the United States

America, today, is confronting many issues of deep social significance. One of the foremost is the welfare of our aging population. While we have glimpsed the projecting shadow of this problem for some time, it has emerged in serious profile within these recent years. Powerful causative factors, now converging in our time, have projected this problem of the aging to the center stage of public concern.

What are these factors that have created this sensitivity to the welfare of our senior citizens?

First, perhaps, is the simple fact that we have more of them and that they will be with us for a longer period of time. The achievements of modern medicine and improved conditions of living have lengthened the life expectancy of man during the last century by twenty years. The child born today can expect to live seventy years. Since 1900 our population has doubled but our aging population has quadrupled. We now have 12,000 Americans over 100 years of age. Each day we add more than 1000 persons over 65 to our population. The count is now 18 million. It is expected to reach 25 million by 1980 and 30 million by 2000. And that date is not as astronomical as it sounds. It is only 35 years away.

A second major factor in the creation of the present situation is the impact of technology. Man is swiftly inventing himself out of employment and the older worker is the first to feel the consequence. The invention of labor-saving machinery forces the worker into premature retirement and overwhelms him with a surplus of leisure time that he is not prepared to use.

Your program chairman has suggested that I discuss the role of education as it relates to this problem this morning. It is a pleasure to do this for the subject lies very close to my personal and professional interests. Within this context, therefore, it is relevant to point out that, in addition to these quantitative factors of more retired persons in our population, and their increased expectancy of life, there are also certain social and psychological factors that further complicate the solution of our aging problem. I would list these as (1) our philosophy of education and (2) our traditional concept of the relationship of work and leisure time.

It is these two latter factors that have to do with our social attitudes and patterns of thinking that I would like to deal with in these next few minutes.

First, I submit that any satisfactory adjustment of the problems that affect the lives of those who are growing old in our society requires a change in the philosophy of American education. Perhaps, in this connection, a look at the major purpose of education in our society is in order.

In the drawing board days of our young nation, when the blueprint for this daring experiment in self-government was being fashioned, the founding fathers perceived the imperative kinship between free men and free education. They foresaw, with 20-20 vision, that a nation which stakes its survival upon the decisions of its people, must provide, at the same time, the means by which these decisions will be as wise and sound as possible. This was the role assigned to education. Jefferson echoed this perception when he observed that "if a nation expects to be free and ignorant, it expects what

never was and never will be." Madison, too, shared this view of education's role in a free society. Writing in 1882, his words have spanned the years with added wisdom. "A popular government," said Madison, "without popular information, or the means of acquiring it, is but a prologue to a farce or a tragedy, or both. Knowledge will forever govern ingnorance and a people who mean to be their own governors must arm themselves with the power which knowledge gives."

To the founders of the republic, then, the purpose of education in this nation was crystal clear. It was to serve as the supporting instrumentality by which this way of life we call democracy could realize the full potential of its great promise. It was education's task to equip the citizen with the wisdom and inspire him with the will to make the decisions in our society that shaped our course and determined our national fortune. Education was not regarded as a gift, or a privilege, of the individual. It was construed as a service to society. In these days when we hear so much about the vocational purpose of education, it is well to remember this distinctive public political purpose with which education was endowed by the men who gave it life in the formative years of the nation. And, as we consider the role of the aging in our midst, it is well to remind ourselves that retirement cannot divorce them from the role which they can play in public service when viewed in the light of the Jeffersonian philosophy of education. We may retire from work but we do not retire from citizenship.

But the judgment of the founding fathers, while surpassingly sound with respect to the purpose of education, left something to be desired in its application and structure. They established a system of free public education that tackled the Herculean task of "educating all the children of all the people." It was a trail-blazing example of democracy in education for children but it was founded upon a terminal philosophy of education, the premise that the educative process stops at a given point in life. Its rationale was the false assumption that the individual can be spoon-fed with enough learning in childhood to last a lifetime.

Thus, we have tolerated a curious contradiction in education throughout our history. We have educated the child, who could not act in democracy's affairs, while we denied education to the adult, who was responsible for making the decisions that determined our national destiny. It is the adult who must always make the decisions for democracy. To make these decisions, he must be armed with the latest facts and the wisest knowledge. We live today in an age of swift and drastic cultural change. The tempo of life has been accelerated to a pace unparalleled in history. This quickened tempo in human affairs has revolutionized the educative process. It has produced a new and significant fact of life; namely, that learning is now becoming obsolescent with a rapidity heretofore unknown. The one central reality that now stands out in this situation is the fact that no matter how well educated the child may be today, without the benefit of continuous education, he becomes the obsolete man of tomorrow. No clairvoyance is needed to realize that the nation which makes its educational investment in children alone, imperils its chance of survival in the modern world. Adult education has now become a social imperative. The world of tomorrow cannot be built upon the obsolescent facts acquired in yesterday's classroom. We must reexamine our educational philosophy and provide, before it is too late, a program of education that offers the adult the opportunity of continuous schooling as long as he lives.

Thus far, I have been discussing the rationale for continuous education for all adults. Now, let us become specific with respect to the need for education for the retired and aging in our society.

First of all, let's put to rest the old wives' tale about the "old dog not being able

to learn new tricks." Unfortunately, this old bromide became a slogan that has characterzed education in this country for much too long a time. Edward L. Thorndike, Professor of Education at Columbia University, branded this for the lie that it is some forty years ago. Thorndike established, through a series of tests, that age is no barrier to learning up to about 55 and that, at any age, the learning ability of the individual depends more upon his desire to learn than upon his chronological age. When I was in charge of adult education in Indiana a few years ago, I had an old fellow in one of my classes that had been a slave during the Civil War. To the best of our calculation he was 94 and, at that age, he learned to read and write for the first time in his life.

Who among us would care to argue that Eleanor Roosevelt, Albert Einstein, Herbert Hoover, Winston Churchill or Robert Frost were incapable of learning in their twilight years? Or that Albert Schweitzer, Bernard Baruch or Carl Sandburg is unable to learn today?

There is no question, then, that the older adult can learn if he has the desire to do so.

Now, what kind of education does this retired segment of our population need? Well, it may surprise you a bit to know that a considerable amount of illiteracy exists among this group. When most of today's older adults were young, schooling did not have the importance it has since acquired. Only about one-half of our present retired population went to high school, and college was for a select few. According to figures of the U. S. Census Bureau in 1957, nearly 60% of our functional illiterates in the nation was over 55 years of age. A "functional illiterate" is the Census Bureau's designation for those persons who have not completed a fifth grade education. Other Census Bureau data on the same date, 1957, revealed that more than one-fifth of all persons over 65 had less than a fifth grade education and that 7% had no formal schooling at all. These educationally underprivileged oldsters, then, need help in mastering the basic skills of the language. The challenges of the later years are difficult enough without this educational handicap.

The increase in life expectancy is creating the need for another kind of education among our older population. This is in the area of family life education. Increased longevity means a longer period of years together in the household after the youngest child has grown up and departed from the family "nest." Young people are now marrying earlier and having their children earlier than ever before. In 1957 the average American mother was having her last child at the age of 26. This mother will be around fifty years of age when this last child enters college, or gets married. Assuming that she and her husband live to be seventy—the present expectancy—they will now be able to spend sixteen to eighteen years together after they are free of the duties of child-rearing. Many men and women experience some difficulty in adjusting to the full-time roles of husband and wife again, partly because the corresponding period earlier in their family circle was so short before the coming of their children. In reality, it's almost a new experience. When this situation is coupled with other present social trends such as earlier retirement for the husband, curtailed working hours and longer vacations, with a greater emphasis on the worthwhile use of leisure time, the need for educational assistance that can help them through this period of readjustment becomes apparent.

In this connection I cannot refrain from pointing out that the disparity of life expectancy between men and women also creates an educational problem in the field of marriage counseling or, perhaps, more accurately, "remarriage" counseling. In our present population the ratio of men to women over 65 is 87 to 100. By 1980 it will be

75 men to 100 women. Now, this may seem to be a male paradise but, unfortunately, we males won't have as much time to enjoy the situation. You women are going to outlive us. The Census Bureau today estimates that the average married woman will live 16 years longer than her husband. Thus the problem of remarriage looms for the surviving widows. One prominent social scientist has half-facetiously suggested that we alter our mores to permit a form of polygyny for persons over 70 years of age. Seriously, however, there is an educational need here to be served by those who operate in the field of marriage counseling.

Another type of education needed by our retired population lies in the field of the cultural subjects—courses in the arts and humanities, the languages, psychology and literature, music and drama. This is the great area of personal reward in adult education that adds enrichment and beauty to the cultural life of the individual. In these classes we find those people who come back to school to pursue the studies they missed when they were young.

It is in this field of the humanities that the adult enjoys an advantage over the youngster for the adult brings to the learning process the reservoir of life experience that he has acquired through the years. This life experience, the unique possession of the mature adult, lends understanding and depth to the whole learning adventure. The lines on the printed page in literature, or history, are interpreted against the background of all the things that have happened to the learner. Sir Richard Livingstone, the great British educator, makes much of this point in his provocative book, *On Education.* Says Livingstone, "I was educated at an age when I knew so little of life that I could not really understand the meaning or use of education. Now that I have seen something of the world and human beings, I realize what education can do for me and the real value and significance of many subjects which I studied years ago with little appetite and less understanding under the compulsion of a teacher. If I could only go back and have again the chances which I wasted, simply because I was not old enough to use them!"

How many of us have had this feeling! This is the great advantage of education in later life: It transforms the learning enterprise into a cross-fertilization of theory and experience. Each illumines the other, and education takes on an overtone of significance and beauty that only age can know.

You will note that I have neglected to include, so far, the need for vocational education in listing the educational needs of our people in retirement. This is a conscious omission. I do not find myself in agreement with those who believe that we should retrain our older people and return them to the active labor market. In the face of a growing nationwide practice of earlier retirement, shorter working hours and longer vacations, I see no logic in the serious vocational training of our older workers that returns them to the already crowded labor market. We can't have it both ways. Sooner or later we must face the inevitable fact that the invention of labor-saving machinery is destroying the balance between jobs and job-seekers. In the 1963 Manpower Report of the President, we find this statement, "Since 1957 employment has increased an average of only 0.9 percent a year. This is less than half a million jobs a year, *not nearly enough to keep up.*" Oh, we'll stem the tide for a moment, perhaps, with such things as the Economic Opportunity Act but not even a sophisticated WPA is going to solve this basic problem. It goes much deeper than that. Eventually, and the sooner we do it the better, the leadership of our society is going to have to sit down and recognize the inescapable fact that technology has transformed our world, that our whole industrial, economic and social philosophy must undergo an overhauling and that, perhaps, the

fundamental question to be faced in this appraisal is more simply asked than answered: How many hours of work are going to be required of each worker in order to sustain our society and provide a decent standard of living for all Americans? Obviously, it is a question which is basically concerned with our distribution of national income.

Not long ago I listened to a speech in Chicago by Robert Theobald, a nationally known economist and author in the field of technology. Theobald's central thesis was that we are now entering a new socio-economic order in which manpower below the managerial level will largely be replaced by machine power. He warned that the pace is much more rapid than we realize. In the course of his remarks he quoted a statement by Richard Bellman of the Rand Corporation, another leader in this field, in which Bellman said that "in the discernible future, 2% of our population at the upper administrative levels will be able to produce all the goods and services needed to feed, clothe and run our society, with the aid of machines."

Now, nobody can say if these gentlemen are right or over what time-span their predictions may, or may not, be verified. But I do know one thing: I know that if their viewpoint has any validity at all, if they are one-half right or even one-tenth right, we have a problem on our hands. Even though we are still in the stage of speculation with respect to the ultimate effect of automation, there is enough evidence around us to give us cause for concern. The updating of the retirement age, the four day week that is now being sought by some labor unions, the hungry coal miners in Appalachia and elsewhere that have been victimized by machinery in the mines: these are the tangible criteria that tell us we have a problem. I return then to my original point: It seems to me that we serve our total society no useful purpose if we use our educational resources in the serious vocational training of our retired people to return to a labor market that is already over-crowded and growing smaller. We are merely delaying our confrontation with the much bigger problem. As long as we hesitate to face this situation with courage and determination we are doing a disservice to the national interest and merely dishing out a palliative to the older worker that is, at best, a temporary relief.

Let me add, in this connection, that I have no objection to that kind of vocational training for the retired person which is designed to equip him for a new business venture, as a hobby, or even part-time avocational employment. My point of major concern is the issue of whether we retrain the retired worker for serious, full-time reemployment in the main stream of our working world. This is a point on which our society has not yet quite made up its mind.

I have dealt at length with this whole concept of automation and its affect on our world of tomorrow because I believe that it is going to revolutionize our philosophy and our ways of living. Moreover, I happen to believe that our adjustment is going to depend, in large measure, upon the role of the retired person and the role of education in our society.

Reason would seem to indicate that the principal change in our world of the future will be the increase of leisure time. This will be doubly so for the retired person for he will retire earlier and his life expectancy is constantly increasing. Oh, yes, I know some of you are smiling at this statement for we have been talking about this increased leisure for some time and many of us are still wondering where it is and when it is going to get here. I, myself, retired last Fall from the State Education Department in New York and I've been busier since I retired than I was before. As a matter of fact, I've been considering the advisability of asking New York to take me back on the permanent payroll so that I might have a little more free time for myself. Seriously, however, if the

evidence around us means anything at all, we are moving in the direction of less working time and more leisure for all Americans.

This new leisure will require a totally new concept on our part with respect to its nature and purpose. Already some Americans have grown uncomfortable with the leisure we have won for ourselves. We hear much talk of the cold war these days. If we don't change some of our patterns of thinking, the Russians may not have anything to worry about. The behavior of some of us would seem to indicate that, if the Russians will just wait a while, we may use our new leisure and our material wealth to bore ourselves to death.

Leisure, in the American sense, has long been equated with loafing, with getting away from responsibility, with self-indulgence. Henry Thoreau once reminded us that "we can't kill time without injuring eternity." That admonition was never so relevant as now. This is a job for education, and for adult education in the later years. The task is to reshape our thinking toward the whole purpose of free time. Perhaps we could borrow a clue from Greek philosophy. The genius of the Greek civilization rested squarely on the fact that the Greeks did not regard leisure time as something that existed for the purpose of doing nothing. They viewed their leisure as an opportunity to do things they wanted to do, not as an escape from the things they disliked doing. With it, they devoted themselves to art, science, philosophy, education and, above all, to the affairs of the state. It is, therefore, no accident that the Greek word for leisure, "schole," became our word "school." "I grow old," said Solon, some five centuries before Christ, "learning some new thing each day." Most of his fellow countrymen followed his example and they gave Athens the most exciting intellectual and cultural life the world has ever known.

This brings me to the most significant suggestion I have to offer. Our American life has reflected a work-oriented society. This, of course, has not been unique to us. Throughout the history of man, most of his waking hours have been spent in the acquisition of food, clothing and shelter for himself and his family. What is now unique to America is this promise of leisure time in greater abundance than any society in the world's history has ever experienced. Nowhere has man's emancipation from the bread-winning responsibilities of life changed the nature of his existence as it promises to do for us. If and when this gift of leisure comes (and I happen to believe that it will, at least, in greater measure than we have ever known) man will be free to turn his genius to the creative dreams that economic responsibility has so long denied.

As we face this exciting prospect, then, the central consideration seems to emerge with obvious clarity: how are we going to spend this new-found leisure? What are we going to do with this abundance of time?

I have a suggestion. In fact, it is more than a suggestion. It is in the nature of a dream that I have nurtured for several years and now seems to carry some hope of realization. As some of you know, I have spent my professional life in the field of adult education. More specifically, I have spent it in the field of citizenship education at the adult level. My philosophy holds that the most important job of all education is that of creating an informed and participating citizenry. If there is a more important purpose in a free society I have yet to find it. Professional education can afford to commit itself to nothing less.

I would submit, therefore, that we use our leisure time in the attainment of this ideal. It well may be that technology will create the first opportunity in American history for the adult to enjoy the nearest approach he has ever known to full-time citizenship. It

well may be that we will now have the time to turn our attention to the solution of those vexing social problems that enshadow our societal landscape. Certainly, this course of action is possible for our retired men and women. Given a reasonable means of economic livelihood in their later years, there is no reason why our senior citizens cannot turn their full capabilities of time, effort and wisdom to the removal of these social ills that now pockmark the fair face of America. Eighteen million men and women over the age of 65 represent 1,170,000,000 years of life experience. What nation in its right mind can fail to utilize this vast reservoir of wisdom and leadership potential? Indeed, it is my sincerest conviction that our greatest hope for the realization of the democratic ideal lies in the utilization of the resources of these men and women who have lived and learned from life and now have the time to apply their knowledge.

New York State has taken a step in this direction. Since 1950 the New York State Education Department has been assisting public schools to expand their programs of adult education to meet the needs of older men and women. About 125 New York communities now have programs of this nature. It was my pleasure to have this program under my supervision for 15 years. These groups meet during the day when most retirees want to be actively engaged, in places convenient to them, under a program that aids them in the development of new skills and new interests. Through these programs older adults have been helped to express themselves creatively, to have a greater concern for community problems and to assume leadership responsibilities both within their own groups and the community at large.

Under this program, adult education classes have also been organized in day centers for older persons and homes for the aged as a part of a constellation of services which includes education, recreation, health and counselling.

In addition to this program for those actually retired, the New York program has set up classes in pre-retirement education for those contemplating retirement in order that they may explore opportunities for future involvement in community affairs and other constructive avenues of leisure time utilization.

Finally, in 1956, an amendment was passed to the New York State Education Law which declared recreation to be a basic human need and established recreational services for the elderly as a proper municipal function for which public funds could be expended. This law made state aid available to the towns and cities of the state in the amount of 25 cents for each person over 60 years of age, such funds to be matched by the local government. These funds are used to establish recreation programs at the local level, programs which, I might add, strive to go beyond the business of merely providing tea and crumpets and card-playing facilities for these oldsters. These two programs, education and recreation, operate in conjunction with each other in New York, both receiving financial aid from the state and both under the professional leadership of the Bureau of Adult Education in the State Education Department.

While it may not be appropriate for me to make the suggestion, it seems that New Jersey might wish to consider similar legislation. With the passage of your new Adult Education Bill last year, thanks to the action of your Legislature and Governor Hughes, now would seem to be the propitious time to consider such a step. Under the administration of Commissioner Fred Raubinger and your State Director of Adult Education, Dr. Clyde Weinhold, it would be assured of the highest professional leadership.

Thus, it may be that if we move along these lines technology will prove a blessing in disguise and provide for us what slavery provided for ancient Athens: the oppor-

tunity to devote more time to the improvement of our society. Released from the servitude imposed by the struggle for food, clothing and shelter, it is not too much to hope that man may find the time to build a better world. We indulge in no gossamer dream when we envision the America of the future as a giant laboratory of democracy, with educational classes, forums and discussion groups of citizens dotting the landscape of the nation — men and women engaged in a serious consideration of poverty, civil rights, housing, education and all the other societal problems that now plague our national conscience. There are communities in which this is now taking place. There is no reason why we can't make it a national way of life. And this exciting adventure in adult education may find its best leadership among those who have the time and ability to do the job: the oldsters in our society who have retired from work, but not from life.

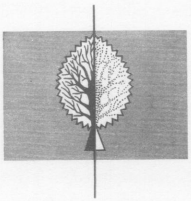
This, then, is my concept of what the America of tomorrow can become if man is, in truth, a thinking animal. Continuing learning is, of course, a requisite of this concept. Man's education must travel hand in hand with his dilemmas. A terminal philosophy of education is as absurd as a terminal philosophy of food and water. To cease education at graduation from high school or college is as unnatural as to die at 18 or 22. The one is intellectual death, the other physical. Either defeats the God-invested purpose of man to advance the limitless horizon of his mind and soul. In this refinement of man the animal, to man the Godlike, there can be no vacuum, no interregnum, no lapse in the eternal process. The generic march of man is as important to sustain at 90 as it is at 19. There should be no such words as "aged" and "old" in the vocabulary of a dynamic society or a dynamic human being. We are not "aged" and "old" — we are just a little further along the tortuous trail that leads to the spiritual and intellectual immortality of the human species. The importance of life is not measured in terms of one's years but in terms of one's breadth of view in space and time and humanity. The secret of life consists not in adding years to life but in adding life to years, not in the pursuit of happiness but in the happiness of pursuit. This is the distinctive philosophy that differentiates between a life of enrichment or a life of rocking chair loneliness in the later years. It was this philosophy which Homer breathed into the lines of Ulysses as he talked with his son, Telemachus, on the eve of his departure "to follow knowledge like a sinking star, beyond the utmost bound of human thought." His words might well become the creed of all who enter the sunset years of life: "How dull it is to pause, to make an end, to rust unburnished, not to shine in use." Centuries later, a similar philosophy, couched in the poetic beauty of John Masefield, expressed the thought in a gentler way:

So, from this glittering world with all its fashion,
Its fire and play of men, its stir, its march,
Let me have the wisdom, beauty, wisdom and passion,
Bread to the soul, rain where the summers parch.

Give me but these, and though the darkness close,
Then the night will blossom as the rose.

DR. ROSCOE P. KANDLE

Dr. Kandle has been New Jersey State Commissioner of Health since** 1959, **coming from the New York City Department of Health where he served as First Deputy Commissioner. While serving as Field Director of the American Public Health Association, he made a survey which led to a complete change and modernization in health procedures in the Health Departments in Philadelphia and the State of Pennsylvania. He is a Diplomate of the American Board of Preventive Medicine and a Fellow of both the American Medical Association and the American Public Health Association.



COMMENTS AT GOVERNOR'S CONFERENCE ON AGING

by

ROSCOE P. KANDLE, M.D.

Commissioner, New Jersey Department of Health

This Second Governor's Conference on Aging continues with an examination of the "Shifting Health Emphases."

Dr. Leona Baumgartner is in Africa. It is always a disappointment not to have the privilege of being inspired by Dr. Baumgartner.

Mrs. Harger and the others responsible for this program wisely decided, however, in my opinion, not to try to replace her. First of all *nobody* can take Dr. Baumgartner's place. Secondly, this gives us the opportunity to savor fully the presentations of Dr. James, Dr. Lilienfeld and Mrs. Harger. We can thus have an unhurried session with just the right amount of content — this will be a welcome change of pace, it seems to me.

I do want to remind you about some of the basic concepts we have here in New Jersey in the Division on Aging and the State Health Department with respect to health and our present goals.

It is hard to remember that there was a time when health was thought of merely as the absence of disease. Then we progressed to a definition of health as feeling *well,* in body, mind and spirit. You almost have to shout it, to get over the idea of zestfulness and a positive kind of health, and the trinity of body, mind and spirit. This concept applies particularly well to our modern perception of aging.

We know now that health is a norm, or a state, which varies within what we understand as normal limits. It is a circumstance for which we must always strive. Ill health then becomes an alteration away from these normal limits. Unfortunately, there are situations when these alterations become irreversible and a return to the same state is not possible. We do, however, with our emphasis on rehabilitation and restorative services, expect to try always to restore as nearly normal function as possible.

The opposite direction of shift from normal to above normal, however, presents the fascinating and compelling challenge as to whether man or any of us individually has ever achieved really optimum health. The fact that athletic records continue to be broken, often to remarkable extents, the rich life of increasing numbers of older people, and the remarkable performance, productivity and genius of such people as Dr. Baumgartner, suggest strongly that we should expect and strive for a state of health above what we now consder normal, in terms of function.

This concept is intriguing in all sorts of ways but consider just one. There are few instances today, in this country, of disease conditions of deprivation. We do see, unfortunately, some dietary deficiencies among older people, particularly those who live alone and who do not have the stimulus to prepare or seek out a balanced and adequate diet. We are also acutely aware of the pervasive, complex, often serious and sometimes

irreversible effects of social deprivation among disadvantaged families and among the aging.

For the most part, however, we deal today with conditions and diseases of excesses. We have too much food, too much fat in our food, too much speed, too many accidents, too many automobiles, too much stress, too much pollution of land, water and air, and possibly too much pollution of our minds.

Theoretically, at least, these excesses can be controlled and reduced. It isn't as easy as adding vitamins and other protective foods, but it is clear what our task is.

We realize, as we think of such environmental factors, including food, the ever changing reciprocal relationship of man and his environment. Each is changing the other unrelentingly.

This brings us then to our current concept of health. We now think of health as a satisfactory adaptation to the environment in order to function well and happily.

Let me repeat. Each word is important.

My friends, this is a vastly different concept and it forces us into different attitudes and ways of achieving and protecting our health.

Health is not an end in itself. Health has a purpose — to function.

Health is not an end in itself but rather a means to a *constructive* life, a means to a richer life as measured in constructive service to mankind.

Such a point of view obviously lends itself directly to theological goals as well.

This means that a major goal of community health services and of community social services is the prevention of disability.

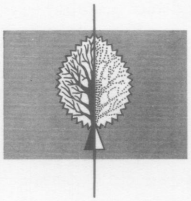
All health services, prevention, diagnosis, therapy, rehabilitation now come together in this common goal, the prevention of disability.

It is now my special privilege to introduce my good friend, Dr. George James.

Dr. James is now Commissioner of Health of the city of New York!

DR. GEORGE JAMES

Dr. James, Commissioner of Health for New York City since 1962, *started in that Department as Deputy Commissioner in* 1956. *He worked for the New York State Department of Health from* 1945 *to* 1955. *Dr. James is a member of the U.S. Committee, World Federation for Mental Health, and on the Expert Advisory Panel on Public Health Administration of the World Health Organization.*



ENVIRONMENT FOR HEALTHY LIVING

by

GEORGE JAMES, M.D., M.P.H.

Commissioner of Health
New York City

Millions of years from today as the sun cools down, man may be drawn back to immediate concern with his natural environment. He does deal with it, even today, when we have storms and earthquakes. But this is an era where man has nearly achieved a stranglehold over his environment, especially in urban settings, where he has most altered what he found when he got there. The urban environment is almost entirely man-made or man-processed. Food is processed, air is polluted, the very soil of the earth is covered with concrete and asphalt so city man does not touch it directly.

Early man's attention was concentrated on obvious natural hazards — wild beasts and the like — and later, as he got more sophisticated, on smaller natural hazards like bacteria and viruses. Today, however, his main problems are ones he creates himself, either by establishing wholly new environmental hazards or by influencing old ones.

Some of his problems are completely man-made. Motor vehicle accidents, for example, certainly did not exist before the era of the automobile. A man-influenced problem would be lung cancer. This did exist years ago but was a rare disease. Man did not invent lung cancer, but by smoking cigarettes he made it an epidemic. So, in speaking of older people, I will emphasize the man-made and man-influenced environment.

Of course we should not think of our older population as a wholly separate tribe of people. The elderly patient is the final, long-term analysis of a baby. Whatever the effect of the present environment on our older people, the process of aging begins at birth, and if we were to examine one thousand older people here today we would find that their medical problems continually lead back to the time when they were middle aged, or young adults, or teenagers, or children, or infants, and if one includes the science genetics, even before birth.

We even have to consider the world these people came from. A man of 75 in our clinic today, if he finished his formal education at age 20 (which gives him more than the average for that time) ended that education in 1910, and is, to a large extent, a product of our society in the years before the First World War. He has adapted since, of course, to automobiles and television and airplanes. But his formative years were in a lost world many of us can never quite understand.

I do not think there is any point in reiterating many figures about older people. The nation expects to have 25 million persons 65-or-older by 1980. In my city, we will have one million persons 65-or-older by 1970. There will be very substantial numbers of 70-year-olds, 80-year-olds, 90-year-olds. The health problems of our elderly individuals will be enormous and will have to be handled at the same time that we continue treating illness in other age groups.

Older People and Chronic Disease.

We all know facts about older people, that they are more apt to be sick than younger people, that they have less education than the average of the adult population

and that they have less money with which to pay for medical care. We say over and over again that their main problem is chronic disease — disease that lasts a long time and for most of which we have no biological cure.

We are not dealing here with pneumonia that kills or goes away in a few days but with conditions lasting years. Although most of these conditions cannot be cured, by and large they can be significantly helped by treatment. It is perfectly obvious that a person with a chronic disease lasting 20 years, receiving periodic treatments for it over a long period of time, is likely to use up many, many more man hours of health professionals' time than the patient with a short, acute disease, no matter how serious it is. We will have to be more efficient in giving care, because we do not foresee an increase in the number of professional health workers nearly great enough to cover the problem of chronic disease using present methods. Sometimes, of course, we will enable the patient to treat himself, at least in part. This is only one of the many methods that may help us to cope with the situation.

The picture of an elderly person with a chronic disease is actually inaccurate because we find that the real problem is the individual who has several chronic conditions, sometimes four or five or six. The National Health Survey indicates that there are in this country over 73 million people with one *or more* chronic diseases. A large proportion of these people are elderly. Thus our problem is to arrange to meet the needs of a large group for whom continuing illness will be a way of life.

Four Enemies of the Aged

The health problems of the aged fall into two categories — first, those problems that we might perhaps speak of in an old fashioned way as premature death, and second, those which cause disability.

Very high on both lists is heart disease, largely coronary heart disease. Heart disease caused about 39 percent of the deaths in the United States in 1964 (about 700,000 people) and is also a major cause of disability. Other major causes of disability are arthritis; visual, hearing and orthopedic impairments; and, of course, combinations of these.

We all know that natural environmental hazards continue to be problems. Certain viruses infecting an individual as a child may cause a condition that will last into his old age. But I want to talk today about four enemies of old age that are essentially of our man-processed environment. These are environmental factors that nature never made. They are enemies for which man himself has been the architect. Each of them, in our country, is a major factor in promoting ill health.

1. *Diet.* At the dawn of civilization the diet eaten by human beings was hardly man-made or man-chosen. For in the beginning man ate what he could get and his problem was to get enough. Although here and there were places where food was plentiful, the great cry was for enough food, and in parts of Southeast Asia today the struggle to get enough food is a very large proportion of man's total effort. Indeed, I read the other day that in France, a relatively more prosperous area, only recently, for the first time in recorded history has the average Frenchman begun to spend less than half of his income on food.

But in the United States things are different. Although we do have hollows of poverty where some people do not get enough food, we have in general come through

the era of struggle to get enough, and now face the dangers of getting too much, especially of the wrong things.

One of our problems is obesity, almost always due to eating too much. The obese individual is more likely to have diabetes than the average. He is more apt to have heart disease than the average. He dies sooner than the average. If he has hypertension, for example, there is a higher mortality risk if he is obese than if he is not. Obese people have notably higher death rates from cerebral hemorrhage, chronic nephritis and liver and gall bladder conditions than the average. They even have more deaths from appendicitis. Obesity is a factor tending to compound the difficulties of the patient with arthritis.

There are, of course, psychological reasons why some people eat too much. Sudden crash dieting has been known to lead to severe behavioral disorders of other types. But it should nevertheless be possible to start people out in life with dietary ideas that would lead to less obesity. I do not know whether it has ever been calculated how many lives could be saved and how many cases of disability avoided if only we could eliminate obesity, but the figures would certainly be huge.

Obesity is one problem with nutrition. But the one that seems preeminent today is the tendency for the average American to stuff himself with too high a proportion of saturated fats. We now have very solid evidence that if man reduces his total fat intake slightly and reduces the ratio of saturated to polyunsaturated fats considerably, so that the saturated fats constitute a smaller percentage of his fat intake — if he does this, he can lower his serum cholesterol level and greatly reduce his chance of having a coronary heart attack.

In studies at our Bureau of Nutrition, we have a group of middle aged men on their regular diet and another group on what we call our Prudent Diet, which is just a more sensible choice of foods. Coronary heart disease has been three times as prevalent in the men on the regular diet as among those on the Prudent Diet, with its much lower percentage of saturated fats.

These are middle aged men, and this conference is about the aged. But, as so often, we cannot isolate out many problems as beginning suddenly at age 65. Some people enter old age suffering the after effects of a coronary. Some have coronaries after they attain old age. The trouble, however, has its roots earlier. The fat child is likely to become the fat adult, and the dietary problems affecting the older person generally began years before he became old.

I concede that the foods people eat generally began as part of the natural environment. Man did not invent milk, nor develop the chicken. But his *influence* on foods and diets has been so strong that what we eat is now essentially part of the man-designed sector of the environment. Man has done two things in this situation:

First, he has turned to processing a large share of everything he eats in this country. Chickens are natural, but he has eaten drugged chickens packed in tins. He eats dozens of products that have been hybridized and changed from their original state. He eats small quantities of insecticides, whether he wants to or not. He eats fats that have been hydrogenated to make them easier to spread, but worse for health.

Second, man has shaped the form of his diet, the range of it, the sum of what is in it. While he might buy bread, for example, baked the way it was 100 years ago, this is likely to be inconvenient. It may not be available.

The promotion of special foods has helped shape the American diet. There are

dozens of associations promoting individual foods and groups of foods. Spices, green olives, soybeans, mushrooms, Brazilian nuts, figs, coffee and vodka — and many more — all have their special pleaders. The advertisements for the end results of various packaged mixes are enough to make almost anyone hungry. Individual foods promoted by these groups may be highly nutritious, but final result of all the motivating does not result in a diet that would be chosen by a group looking at the matter scientifically. And the promotions result in an actual change in what is available at the market. Thus hungry man is faced with a manipulated selection of manipulated foods.

2. *Exercise.* I suppose the relationship between exercise and health is now rather widely accepted. Admittedly, we do not have as much quantitative information as we would like, because it is difficult to assign figures to the amount of exercise a man has unless he has it in a laboratory, connected to a machine. Some studies of men aged 40 to 69 have shown a death rate 75 per cent higher in individuals receiving no exercise as compared with those receiving moderate or heavy exercise.

Like so many other enemies of the aged, lack of exercise is clearly a pattern apt to begin early in childhood, although even the active child may become the inactive adult.

We believe that a history of inadequate exercise is relevant to heart disease. Many authorities feel that the loss of elasticity in arteries through combined aging and lack of exercise is as important as the fact that the diameter becomes smaller through deposits of cholesterol and other substances. It has now become the rule to promote exercise after major surgery in order to prevent respiratory and circulatory complications. In the aged individual who has a health problem of one kind or another, lack of exercise at that time can be one of the important factors pushing him toward dependence on his family or on society as a whole.

It could be argued that lack of exercise is not environmental but rather a free choice on the part of the subject. This is only partly true. The fact is that we have organized our society and technology so as to make exercise increasingly difficult, or unpopular to get. The country road that was a favorite walking place 50 years ago, is now streaming with fast cars and is dangerous for pedestrians. The cars themselves deprive their drivers of exercise. A ride in the country, which has the fresh sound of getting back to nature, is really a prescription of inactivity. Paul Dudley White said recently that, "The chief danger of automobiles isn't from accidents but from the fact that they take people off their feet." Not long ago Jean Mayer commented on one aspect of man's retreat from exercise, observing that a high school near Boston has changed half of its athletic field into a parking lot for the students.

Much exercise has been made flatly unpleasant. If we do want to walk a couple of flights of stairs in an apartment building, we may find them dirty, and less well illuminated than the elevator. We may even have trouble finding the door to them. And if we walk to the third floor, the door out of the stair well may be locked. We are now at the point where devices have been designed so that we do not have to get up and switch the television set. We do not have to move our arm back and forth when we cut our high-saturated-fat roast beef, and we even have technology to eliminate the tiny amount of exercise needed to brush our teeth. Our lack of exercise may be becoming a significant health problem and it is getting worse with the proliferation of labor saving devices. Some couple lack of exercise with diet as one of the two most important causes of coronary heart disease. With its relationship to obesity it is undoubtedly important in many other conditions, including degenerative arthritis or osteoarthritis. I would not be surprised if it is taking a real toll in lives and disability which, if we could document it, might be very nearly as ugly a curve as the one for lung cancer.

3. *Cigarette Smoking.* In the case of smoking, man has taken a rare disease, lung cancer, and he has made it a substantial public health problem. It is a problem that bothers us a great deal because it is the only important major chronic disease now rising in so steep an epidemic curve.

We believe it a conservative estimate that at least 70 per cent of our lung cancer deaths are due to cigarette smoking. More probably the correct proportion is nearer 85 per cent. Even at 70 per cent the cigarette killed nearly 2,000 persons in New York City alone last year.

Cigarette smoking does not relate just to lung cancer. It is a contributory factor in many other diseases including chronic bronchitis and emphysema, coronary heart disease, cancer at various sites other than the lung, and numerous other ailments.

It is difficult to assess the total effect that would be achieved if we could convince people not to smoke. We would save at least 70 per cent of our deaths from lung cancer, and if we were able to motivate people toward proper diet plus the giving up of cigarettes, a strong argument could be made that we would thereby eliminate or at least substantially postpone as many as 500,000 deaths a year from heart disease, plus a great deal of disability, especially among older people.

Smoking is part of the man-made environment, and in the absence of a safe cigarette, which may never be found, we ought to change smoking habits in adults and prevent the smoking habit from starting in children. The theoretical saving of lives and disability that could be achieved in this way would be far greater than could come from the universal application of any purely medical methods we have, such as surgery or drugs. In fact, the need to learn better methods for changing human behavior and the man-made environment is so important that it is a major part of our research program in New York City, and we spend about one-fifth of our health budget on research.

Consequently we have been conducting anti-smoking programs, not only to try to save participants from lung cancer or coronary heart disease, but to learn techniques for motivating people to do what is healthy for them. It is a key area and whatever we learn about it will have many applications beyond smoking itself.

We have been conducting four step anti-smoking sessions (planned lectures and films) followed by anti-smoking clinics for persons who do not stop smoking as a result of the four step anti-smoking sessions.

We have found that of the persons who attended one entire series of the four step anti-smoking sessions, 59 per cent were still smokers after the last session. This appears to indicate that 41 per cent were able to break the habit but the figure is not nearly that good because many people dropped out of the anti-smoking series before completing it. We made a study of persons who attended at least one of our four step anti-smoking sessions in October and November and who had given us their addresses. We sent 500 letters and received 208 replies. Out of those who replied, half said they had stopped smoking and were still non-smokers, 22 per cent said they had cut down their cigarette consumption, and 2 per cent said they had switched to cigars or pipes. These letters were sent out at the end of January of this year to persons who had attended sessions in October and November of last year.

There was some indication that many of the hard core smokers may not really have expected the four step lecture program to cure them of the habit, and were waiting for the anti-smoking clinic where lobeline sulphate was to be given, thinking that the drug would do the job. But in general, after the first visit to the clinic, attendance fell

sharply. Although we are working diligently on the problem, we have not yet found the formula which can make a dramatic impact on the smoking habit.

4. *Isolation and idleness.* Part of the environment that affects older people consists of things we can see and measure, like tobacco smoke, diet, air pollution, water pollution, and alcohol, but in many ways the most serious environmental problem relating to older people is the tendency of society to push them aside — to press them into ill health. It is true, for example, that by and large older people are more likely to have incapacitating mental health problems than younger adults. But there is increasing evidence that much so-called mental disease in older people is reversible, and what we attribute to arteriosclerosis is really only partly due to it. As MacMillan[1] says, "The chief manifestations of what is called senile psychosis or senile dementia are not organic; they are an emotional response to unfulfilled, basic emotional needs."

The fact of the matter is that society has not prepared to use the large numbers of older people it now possesses and the larger numbers it soon will have. We tend to think in terms of separating them out, rather than bringing them in.

For example, although the *number* of older people in our country has been rising for years, the *proportion* of them in the labor force has been decreasing and is now less than half what it was in 1940. Some firms already refuse to hire anyone over 40. A man of 50 who finds himself without a job can be in very serious trouble.

I should think we could see clearly enough by looking at high school dropouts and juvenile delinquents how serious it is when a human being at any age beyond babyhood has nothing meaningful to do. It leads to disorientation — to personality disintegration.[2] We know that even the otherwise vigorous younger adult who suffers a heart attack may find it difficult to maintain his mental equilibrium. We know that even a strong young man condemned to solitary confinement may quickly become disoriented. The human mind needs constant feedback from other minds and things to keep itself established. How much more difficult for the older person who wants to support himself, who wants to be useful, but who is told on every side, "We don't want you," or who is offered a course on basket-weaving at a neighborhood center.

We find older people increasingly living alone, even more so in urban centers than in the country, and thus separated they are apt to wind up needing to be put in an institution. But we cannot allow this to happen because nobody has money enough to use institutionalization as the main thrust of the attack on medical problems in the aged. The effort must be to maintain health, to keep the elderly couple busy, united and functioning, instead of divided up as so often happens and sending the wife to one nursing home and the husband to another and thus compounding unnecessary civic expense with horrible and frequently avoidable human tragedy.

The best medicine for many older people is participation, which we generally deny them. The man in his seventies, working hard at a job, may have minor problems remembering recent occurrences. But remove him from that job — from meaningful activity — and within a year he may be a candidate for an institution: one more case of something that could have been prevented.

Other Enviromental Factors

The major environmental factors of diet, exercise and cigarette smoking all involve the voluntary acts of the individual, in an environmental setting created for him. He *could* eat a more healthful diet, but the environment is stacked against it. He *could*

get more exercise, but it is inconvenient. He *could* stop smoking, but the media of communication urge him to go ahead.

Air Pollution. There are numerous environmental factors over which, as an individual, he has even less control. Air pollution, for example, is largely forced on him. He can live in an air conditioned, air-filtered apartment, but for him completely to escape contact with air pollution would be practically impossible.

Of all acute medical conditions, respiratory diseases are the number one cause of restricted activity among our citizens. There is also restricted activity due to respiratory diseases that are chronic, rather than acute.

We are particularly interested in respiratory diseases among the aged, because older people have more trouble with them. The pneumonia-influenza group, for example, still constitutes the sixth leading cause of death in the United States, but it is a factor mostly in the very young and the very old.

Emphysema, like lung cancer, is a disease now rising very sharply as a cause of death and disability. While death rates from lung cancer in New York City have been running above those for the United States, those for emphysema are much higher for the nation than for the city. Chronic bronchitis is rising, the last rates we have being higher in the city than for the country as a whole. Air pollution in the urban areas is higher, of course, than for the nation.

When we take death rates for the category listed as "other diseases of the lung and pleural cavity," we find a very sharp rise for the city and the nation during the 1950's, and for the city through 1962.

We have much more to learn about air pollution, what causes it, and what its effects are. We know enough to warn older people with respiratory problems to remain indoors as much as possible during period of severe inversion, and we do so warn them, as publicly as possible. There is no question that heavy air pollution adds to the death rate from respiratory disease, and that this effect is most marked among the elderly.

Air pollution is an environmental factor that results from thousands of individual and corporate decisions: to build factories, to build electrical generating plants, to build automobiles, and so on. No one needs to prove that air pollution is undesirable . But attempts to eliminate it place public health people in conflict with individuals and groups who are doing essentially worthwhile things. It is not at all like attempting to get rid of dope pushers, who are clearly disruptive in our society. With air pollution our conflict is with good people — people providing transportation, power, manufactured products. And this is a characteristic of today's attempts to change the environment.

Worthwhile products are involved, and established value systems. Nobody is going to accept abolition of factories or power plants as a means of ending air pollution, effective as it would be. And as the automobile manufacturers complain that it is economically unfeasible for them to install devices on their cars that will cut their contribution to pollution, one is reminded of the fight the milk industry put up over pasteurization. They couldn't survive economically, they said. But they are still with us, and very solvent, and we expect the same of the automobile makers.

Food Contamination. We have a relatively new environmental problem, or possible problem, in the appearance in our foods of small amounts of pesticides. The pesticides we use are of enormous value, and there is no question that our food economy, if not our food supply, would be in danger without them. In recent years perhaps this

has not been enough emphasized. Yet we are justified in being concerned about the effect small amounts of man-made chemicals may have if ingested over a long time.

It seems to me that the increasing age of our population is a factor that should increase our general alertness to the possible medical effect of repeated small insults in the environment over many years. As the average life expectancy rises, of course, the average citizen gets a longer run through the gauntlet of environmental factors, and they, in a sense, get a longer chance to do him in.

Accidents. Accidents are more prevalent in older people than in younger adults. The automobile is a major factor in accidents, but more fatal accidents occur off the highway than on it — especially in the home. Falls at home are a frequent cause of accidental death among older people. We know that environmental factors such as slippery rugs and the absence of handholds in bathrooms are important, but we suspect, again, that the way society tends to push the elderly out of participation, and often into living alone, may be even more important in encouraging home accidents in older people.

Fatal accidents are more frequent among persons with chronic disease than among those who are healthy, and this makes accidents more likely among older persons. They are also more prevalent among poor people than those with good income, and older people tend to be poor.

It would be valuable if we could control the environmental factors favoring accidents in the aged, for accidents themselves are contributors to chronic medical problems. They are, for example, a substantial cause of visual defects, and visual defects can be a cause of accidents. The whole thing may become a vicious circle for the older person, a circle that might be cut by environmental control.

Pre-Disease Factors

It makes perfectly good sense to talk about chronic disease as we know it among the elderly, but it nearly always has a history going back into middle age, into youth, into childhood. It has a beginning somewhere. And the figure we have on people with chronic disease — 73 million — is probably just the top of the iceberg. What about the people with pre-disease conditions — people who have no symptoms, but are beginning to develop disease?

We do not know how many such people there are, and for many medical problems there is no pre-disease state that we can define even fairly clearly. But there are some places where we have better knowledge and where we can act. We *can* detect glaucoma before the patient knows about it, provided the patient will come and be examined (or provided we go where the patient is and offer the examination there). We do have reasonably defined pre-diabetic state; it can be detected, and we can do something about it. There is a limit to how much we can do, but we do know that obesity can trigger the pre-diabetic state into frank diabetes, and we may be able to control that. If frank diabetes develops we think it is better to have it under treatment than not, even though it is still a major cause of death after four decades of insulin. Whether, outside of controlling obesity, we will learn to apply what might be called prophylaxis at the pre-diabetic state, we do not know, but research on this is now in progress.

We can detect cancer of various kinds early enough to do something about it, provided we can get people to be examined. Cancer of the cervix can be detected before it creates symptoms. At this point it is almost always curable. Later it often is not. We need to move as far forward on these things as we can. Early detection of cancer

of the lung is better than late, for example, but of course the real place to deal with this problem is even earlier, at the beginning of cigarette smoking.

Meeting The Older Person's Needs

There is one part of the man-made environment, very important to the health of older people, that I have not mentioned. That is the system we have for the medical care of the aged. It is, of course, part of our total medical care establishment.

Since the aged are more likely to be poor than younger persons, many of them receive care that is paid for by government at one level or another. In my city about one third of all medical care of all people is now paid for out of taxes, not under any one plan, but under a welter of different programs, some of them built around certain organ systems, some around certain groups of disease, some around the past history of the patient (is he a veteran?) and some around his economic circumstances (is he on relief?).

Our total elderly population, therefore, is cared for by a mixture of government and private medicine, plus some private philanthropy. But, although the manner of paying money for medical care does influence its quality, the real problems we face are not dependent on who supplies the money. And the basic difficulty is that our medical care system was built — and just grew — to deal with acute episodic disease and is very good at that. It is not at all well adapted to the needs of patients with chronic disease, or who are leading up to chronic disease.

Our system of care is very badly adapted to older people. We may require one old man to go to five clinics because he has five things wrong with him. If he is old enough and creaky enough he is likely just not to go to the five clinics. So he doesn't get the care he needs, which could keep him up and about, his condition worsens, and he may well reach a point where he indeed must be put in an institution. We must arrange to get care to him before it is that late, and before it is too late.

It is important in my view that we make our patient care *comprehensive,* and that includes these points:

1. *It must reach everybody who needs it.* Care reaching only part of the population cannot, in this day and age, be called comprehensive.
2. *It should be practical to get.* A clinic that closes at 4 P.M. is of zero value to the individual who can't get off his job until 5 P.M.
3. *It must have a total approach.* If the patient's main problem is tuberculosis, the care he receives must be good enough to detect diabetes too, if he has it.
4. *It must go beyond traditional medicine.* Problems like lung cancer won't be solved by drugs or surgery at today's level of knowledge, but will require changing human behavior and altering the environment. Poverty is a major cause of death and disease: we can achieve certain improvement within the culture of poverty, but there is a point beyond which we cannot go without changing poverty itself.
5. *Our medical establishment must know itself.* The patient should not have to shop around. Wherever he makes contact with our medical care system, whether clinic physician, private physician, public health nurse, he should be enabled to know what total resources are available for his care.

Above all, of course, our care system must be built around the patient. It is not our job to squeeze him into what we have, but adapt what we have to his needs. We

must not, as has been said of other conditions, attempt to solve problems solely by rearranging them to fit already available solutions.

Nowhere is comprehensive care more needed than in dealing with the elderly patient. We think of him as having medical conditions, usually with one predominating. But I think he is brought down very often by what might be called a ring of mild conditions, rather than one major one. He has visual troubles, plus auditory troubles, plus arthritis, plus some after effects of a heart attack, plus foot problems. Many of the conditions our elderly people have are in themselves minor and quite amenable to treatment, even if not curable. But we must attack all together, for they are the collection of problems of a human being. We are beginning to do this. We are beginning to change this part of our man-made environment. We are beginning to concentrate on health maintenance rather than health repair. We are beginning to be concerned with the patient who does not have symptoms and the patient who does not get to the doctor's office. We stand at the beginning of a new era, one that will try our imagination and skills. It is an era where man realizes that he has become his own worst enemy, and a time when changing the environment he himself has made and influenced, offers promises of advances in public health far beyond all the drugs and all the surgery he now prizes so much. It is more difficult to prevent smoking than offer a drug or remove a lung. It is more intricate to influence the American diet so as to reduce the risk of coronary heart disease than to care for the patient with a heart attack. It is far more challenging to rearrange our medical care organization to fit the needs of the aged person and keep him active at home than to institutionalize him. Yes, all of these health maintenance measures are much more difficult — but if they were not, then, of course, we would have already accomplished them.

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PATTERNS OF PATIENT CARE

by

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The area that I am to discuss this afternoon is a very broad and general one. It seemed to me that it would be most profitable to focus on a very specific type of program that has been recommended at a national level and which, if implemented, will have a large impact on the patterns of patient care, particularly for the older citizens of our population. I am referring to some of the recommendations made by the President's Commission on Heart Disease, Cancer and Stroke, for which I had the privilege of serving as Staff Director during the past year. However, prior to discussing the Commission's recommendations that are concerned with patterns of patient care, I thought it might be of interest to provide you with a brief historical background and review of the mode of operation of the Commission. This will give you some idea of the basis for the Commission's recommendations.

History of Commission and Mode of Operation

In his Health Message to Congress in February 1964, President Johnson indicated he would set up a Commission, specifically he stated, "I am establishing a Commission on Heart Disease, Cancer and Stroke to recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge we already have."

In March, he established the Commission which was chaired by Dr. Michael DeBakey, Professor of Surgery at the Baylor University School of Medicine. It was composed of 28 members, about ⅔ of whom were physicians and/or research workers, and ⅓ were laymen distinguished in public affairs. The first meeting was held on April 17th, at which the Commission organized itself into Subcommittees and determined its mode of operation. It's worth mentioning the names of these Subcommittees since this provides you with an idea of the breadth of interest of the Commission. The following are the Subcommittees: heart disease, cancer, stroke, research, manpower, communications, facilities, rehabilitation. The chairmen of these Subcommittees constituted the Executive Committee of the Commission. A staff was recruited and staff personnel was assigned to each Subcommittee.

The following methods of operation were established by the Commission:

I. Information was collected from agencies, groups, and institutions, etc., by various means:

   a. Staff visits to agencies.

   b. Letters to professional organizations and voluntary health agencies in areas relevant to the Commission's interests. These letters stated that the Commission "would welcome a written statement setting forth the overall news of the organization on the problems pertinent to the mission of the Commission and any suggestions and recommendations." The response was excellent.

c. A survey through a questionnaire sent to all of the medical, dental, osteopathic, public health and veterinarian schools; to research institutes; and to a national sample of community hospitals. This questionnaire was mailed to 378 such biomedical institutions. Despite the limited time available, we received a response from 76% of the institutions.

d. Material prepared by the staff of the Second National conference on Cardiovascular Diseases which met in Washington during November 1964 was made available to the Commission. This material reviewed present knowledge and made recommendations for future planning.

e. A detailed analysis of the economic costs of heart disease, cancer and stroke was secured which is published in Volume 2 of the Report. In addition, Dr. Walter Heller, the then Chairman of the Council of Economic Advisors to the President, called together a group of economists for a meeting to discuss this area. A report of this meeting is also published in Volume 2.

f. Staff prepared reviews and analyses on a variety of subjects pertinent to the Commission's activities, as follows:

1) A survey of the magnitude of the cardiovascular and cancer problems of this country.

2) A survey of the present status of medical library facilities in this country.

3) A review of the status and problems in the field of biomedical communications.

4) A review and analysis of recent reports and surveys of the health manpower situation.

II. Hearings:

Each of the Subcommittees held hearings to which were invited individual experts, representatives of selected voluntary health agencies and professional organizations, and official Federal, State and local health agencies. These experts were asked for their opinions and recommendations as to what should be done to reduce the incidence and burden of these 3 diseases — in research, patient care, etc. 45 such meetings were held and about 200 experts appeared at these hearings. Many of these experts came with extensive prepared statements.

The staff member assigned to each of the Subcommittees served as Executive Secretary to the Subcommittee. He prepared minutes which were circulated to all members of the Commission. After the hearings were completed, the staff extracted from the minutes all the recommendations that were made. These were presented to the Subcommittee for review and discussion. The Subcommittee then selected certain recommendations and added others of their own; these comprised the Subcommittee's recommendations. The staff then prepared descriptions of these specific recommendations and translated them into programmatic terms and obtained estimates of the costs of such programs. These were then included into a Subcommittee report which was presented to the Executive Committee. The Executive Committee reviewed these reports and program recommendations. These then went to the Commission as a whole for review and approval.

From the Subcommittee Reports and Source Material, Volume 1 of the Commission's Report was prepared, which essentially represents a summary

of recommendations and background material. The individual Subcommittee reports are published in Volume 2.

I have reviewed this process in detail because it's important to appreciate the fact that the recommendations and programs do not represent the thinking of only one or two individuals or of only the Commission Members. In fact, they represent a sampling of opinions, ideas, and recommendations of a fairly large group of individuals with a variety of attitudes and with a great deal of experience in the various aspects of the problems posed by these three diseases.

THE RECOMMENDATIONS

Many of the innovative features of the Commission's recommendations in the area of patient care are contained in the first three recommendations.

These recommendations relate to the development of a national network for patient care, research and teaching in heart disease, cancer and stroke. Since these recommendations are those that are basically related to strengthening and expanding our resources for the provision of patient care, I would like to spend the remainder of my time discussing them.

The general purpose of the network is to bring together the best in medical care and the best in medical research in every region of this nation. It proposes to make the best of medical care easily accessible to individuals with these diseases in their own communities and regions. Each component of the network would also serve as a teaching and training center which would transmit to the practicing physicians and to the public the latest developments in scientific medicine.

This proposed national network is not envisioned as a totally new and separate pattern of medical service superimposed from above. Rather, it is designed to become a part of the existing fabric of medical services. Existing universities and community hospitals will be the focal points for the centers and stations that are proposed. The purpose of the system is to assist the doctor in practice in the care of his patient who is suffering from these diseases. It will make available to every doctor in the country the newest and most effective diagnostic methods and the most promising methods of treatment.

The first recommendation is for the establishment of Regional Heart Disease, Cancer and Stroke Centers in universities, hospitals, research institutes, and other institutions throughout the country. Specifically, it is recommended that 25 such centers for heart disease, 20 for cancer, and 15 for stroke be established over a five year period. To give you some idea of the concept of these regional centers, I would like to describe briefly a regional heart disease center as visualized by the Commission.

A heart disease center is defined as a unit, including individuals from various disciplines in medicine, the broad purpose of which is to conduct research and training aimed at the prevention, alleviation, and cure of heart and blood vessel disease. Such a unit should be part of a large medical complex which is already engaged in medical research and training.

The research program should include clinical investigations, with hospitalized patients, outpatients in certain instances, and a variety of modern laboratory facilities. It is mandatory that the personnel of each center be large enough to number and represent enough specialties to facilitate investigation in depth, including a broad range of

scientific methods. Such a center might include internists, cardiopulmonary physiologists, cardiologists, peripheral vascular specialists, etc.

Such centers would be strongly oriented toward clinical investigation but at the same time would provide high-quality patient care, including rehabilitation, and would also be concerned with teaching and the training of personnel concerned with heart disease. The teaching function should include the training and support of physicians, surgeons, radiologists, nurses and professional personnel in other pertinent specialities. Also included should be training programs for personnel staffing the heart stations, which we will discuss later. The center should also serve as a teaching resource for the medical community of the region.

It is visualized that each center will require hospital beds — medical, surgical and rehabilitation — in addition to those already available in that hospital facility as well as an outpatient care facility. The center will have areas for specialized care and research beds related to laboratory facilities for specialized diagnostic studies and new treatments under investigation. In addition, it will have operating rooms and other facilities for complex diagnoses and treatment.

The Commission's second recommendation is for the establishment of a national network of diagnostic and treatment stations in communities throughout the nation. Specifically, it recommends the establishment of 150 such stations for heart disease, 200 for cancer, 100 for stroke, and 100 for rehabilitation. In each disease category, one half of the stations should be established in medical centers and in clinical facilities of medical schools, and the other half in community general hospitals, not necessarily connected with medical schools. At this point, it should be noted that it was realized that the number of these stations would not fill national needs — many more would be necessary — but these would serve as a demonstration and pilot program which could be expanded further.

In the heart disease field, these diagnostic and treatment stations would have the following principal functions:

1. Immediate and emergency care for patients with acute cardiovascular emergencies.
2. Provision of cardiovascular diagnostic facilities for the screening of patients with cardiovascular, including peripheral vascular, diseases to determine whether they will require the more highly technical facilities available at the larger medical centers.
3. Outpatient services for patients with cardiovascular and peripheral vascular disease.
4. Stimulation of interest of medical students and practitioners.
5. Training of physicians in the community.
6. Education of the general public concerning prevention and treatment of heart disease.

Stations will have intensive care units for the emergency care of patients with heart disease. They will provide limited laboratory facilities, an outpatient clinic, electrocardiographic and radiologic services. Each station would be in close contact with the Regional Center in order to obtain directly from these research centers information and training in newer methods of diagnosis and treatment. The stations will in turn convey information to other community hospitals and physicians. To fulfill its

graduate educational function within its own community, each station must have resources to provide to the practicing doctors a 24-hour, 7-day-a-week specialist consultation service without charge.

Each of the Regional Centers would develop relationships with the stations set up in community hospitals in its region. These relationships could take various forms: For example, one can visualize the establishment of closed circuit television between centers and stations to be used for educational purposes, for obtaining consultation on individual diagnostic and treatment problems. There should be rotation of intern and residency staff. Full time staff of the center could rotate through the various stations and full time medical staff could be assigned to the stations, whenever necessary and desirable, to provide the consultation and educational services envisioned. The development of such relationships clearly has enormous implications for the provision of high quality services for patient care.

The Commission's third recommendation is for the provision of a broad and flexible program of grant support to stimulate the development of these relationships between the centers and stations in the form of Regional Medical Complexes.

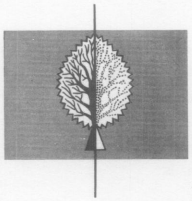
Basically, these recommendations allow the medical school and teaching hospital to go outside their four walls and to expand their patient care, educational and research potentials to the small community hospital. However, one must also realize that there are patients who are outside the hospital walls — who are in homes or other types of institutions. The Commission appreciated this and made several recommendations for the provision of patient care services for such patients. These were for the support of demonstration programs in the community and for community health research and development. Such community programs would include programs for the early detection of disease, the development of effective referral systems for patients with these diseases, the development of home care programs, and the development of community rehabilitation programs.

The Commission made additional recommendations for expanding outpatient care, research and training resources and facilities as well as for increasing the needed health manpower. However, I will not review these in detail.

As is natural with a report to the President, the recommendations emphasize Federal action and Federal planning. However, to any discerning reader of the report who is familiar with the large needs in the health area, there are magnificent opportunities to move ahead in the development of the recommended programs at State and community levels. The recommendations can serve as a conceptual framework for programming within the State and local community. It is clear when one realizes the magnitude of the problem facing the nation that the specific recommendations of the Commission represent only a beginning effort even at the Federal level. Many of the recommended programs are pilot and demonstration programs. Their full implementation on a national basis, community by community, region by region, will require local community and State developments in cooperation with Federal developments. If the necessary cooperation at all political levels is achieved in developing the recommended programs, I think we can look forward to seeing a major impact made toward the conquest of disease in our country.

MRS. EONE HARGER

Mrs. Harger has been Director of the New Jersey Division on Aging since its inception in 1958. *She is a Vice-President of the National Association of State Units on Aging, and a member of the Advisory Committee on Housing for Senior Citizens, Housing and Home Finance Agency. She is a member of the Gerontological Society, American Public Health Association, and the American Public Welfare Association. She also has been a member of the Board of Control of the New Jersey Department of Institutions and Agencies.*



NEXT STEPS FOR NEW JERSEY

MRS. EONE HARGER
Director, New Jersey Division on Aging

As you have listened to our distinguished speakers today, I hope that each one of you saw your own place in this far-ranging field called "aging." I hope too that you have gained a new perspective in regard to the very important role that each of you can play.

A phrase that has been repeated over and over in the last few years is "spectrum of service." This means, of course, that there is available a place with trained people where a person can turn in times of crises so that the feeling of helplessness that so often comes to our older people can be overcome. In this "spectrum of services" there should be many opportunities for recreation, new friendships, referral services, counseling of various kinds and a place to learn. We have discussed some of these areas today. Our exhibits have pointed up what has been done in the past, but for the closing statement of this conference I want to direct your thoughts toward the future.

President Johnson has called it "The Great Society." Within this concept there is a place for everyone. We need to be on the alert and conscious of the need for including the elderly in this Great Society, not in some isolated reservation that establishes a new segregation.

While much activity that is related to "aging" has not been specifically reported today, what our speakers have said, what has been on display, and the experience of the past six years has underlined the breadth and depth of the social revolution that has lengthened life and made employment in later years unnecessary.

Commissioner Ball, in the paper read for him by Mr. David, discussed with us the problems of providing the financing for these added years. Mr. Crabtree discussed the role that education can play in making added years synonomous with a better life. Dr. James and Dr. Lilienfeld have charted new approaches to solving some of our health needs. With a healthier life, with lessened financial worries and with free time used constructively, it can indeed be a Great Society in which to grow old.

From this compilation of experience and knowledge emerge two clear directives — one — the need for *every* community to recognize the needs and rights of its present past-65 generation along with those of younger age groups. Secondly — the necessity of assuring that the elderly of the future are *adequately* prepared for these added years.

To accomplish these goals, there are some practical steps to be taken in New Jersey which will move us along at a faster pace. Governor Hughes this morning referred to the Older Americans Act which is currently before the United States Senate. This legislation passed the House of Representatives 374-1 and undoubtedly will pass the Senate within the next few weeks. It calls for a State plan which, when approved, would make available Federal support for a wide variety of activities, providing the State carries its appropriate financial contributed share.

An important element of this State plan should be the establishment of strong *community* councils on aging which understand the broad areas for which they are

responsible. A start in this direction was made with *county* committees on aging formed in 1959 prior to the 1960 White House Conference on Aging, but *nowhere* have these councils developed with the vigor, vision and scope that are needed. Full time professional staff and grants, both made available through Federal funds, could provide the continuing help and guidance necessary to develop programs and services. With such leadership, councils could develop community resources such as:

Centers for the aging to turn to in time of crisis, more than just recreation programs.

House Finding Committees to help those who need a place to live, and

Referral services so that appropriate agencies would not be unknown to families or individuals unfamiliar with such community resources.

New facilities and services for which need for them evolves.

With such a network of community councils, our patchwork of successful demonstration projects could be expanded to form a statewide pattern to make the "spectrum of services" a reality. Just as the experimental seminars in driver education for older people have demonstrated the value of such classes — so that education for *all* drivers may become a statewide policy — so can *other* successful demonstrations become part of the fabric of a better life.

In addition to expanding the community base of programs for older people, there must be begun the *broad* preparation for aging implicit in the words of our speakers today. Just as in the past six years we have held statewide meetings at which there was concentrated attention given to the specific areas of concern, touched only lightly at the Governor's Conference in 1959, now we must do the same in the areas covered today. The Division on Aging will want help from all of you here — the leadership of government, industry, and voluntary agencies, as well as that of older people already familiar with the signs on this new road.

We must recognize that the added years should not be years of banishment. The proportion of older people in New Jersey will increase. Because there is a desire to stay close to family and friends, there is an influx of elderly from metropolitan Philadelphia and the urban areas of New York City and surrounding communities. This increasing number makes it imperative that our State plan be flexible and broad so that we do not let problems develop and can provide the "spectrum of services" that the aging may need.

We hope that this conference has stimulated you, that it has given you ideas, and that you go away from it determined that aging in your community will be a good, independent, and healthy life for your older Americans.

We look forward to hearing from you and to working with you in the months ahead.

PARTICIPATING ORGANIZATIONS

American Cancer Society, New Jersey Division, Inc.
American Legion Auxiliary
Consumers League of New Jersey
Licensed Nursing Homes Association
Medical Society of New Jersey
National Council of Jewish Women
New Jersey Association of Chests & Councils
New Jersey Association for Mental Health
New Jersey Association of Homes for the Aged
New Jersey Association of Hospital Auxiliaries
New Jersey Association of Housing & Redevelopment Authorities
New Jersey Bankers Association
New Jersey Council of Churches
New Jersey Education Association
New Jersey Federation of Planning Officials
New Jersey Health Officers Association
New Jersey Heart Association
New Jersey Home Economics Association
New Jersey Industrial Union Council AFL-CIO
New Jersey Library Association
New Jersey Neuro-Psychiatric Association
New Jersey Nutrition Council
New Jersey Optometric Association
New Jersey Pharmaceutical Association
New Jersey Psychological Association
New Jersey Public Health Association
New Jersey Recreation and Parks Society
New Jersey Society of Architects
New Jersey State Dental Society
New Jersey State League of Municipalities
New Jersey State Nurses' Association
New Jersey State Safety Council
New Jersey Tuberculosis & Health Association
New Jersey Welfare Council
State Federation of District Boards of Education of New Jersey
The Salvation Army
United Church Women of New Jersey
United Synagogue of America

CO-OPERATING NEW JERSEY STATE DEPARTMENTS

Conservation and Economic Development
Education
Health
Institutions and Agencies
Labor and Industry
Law and Public Safety
Treasury

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Rev. Claude L. Roe, Princeton

EXHIBITORS AT THE GOVERNOR'S CONFERENCE ON AGING

WAR MEMORIAL BUILDING, TRENTON

APRIL 27, 1965

Johnson and Johnson, New Brunswick

New Jersey Department of Civil Service

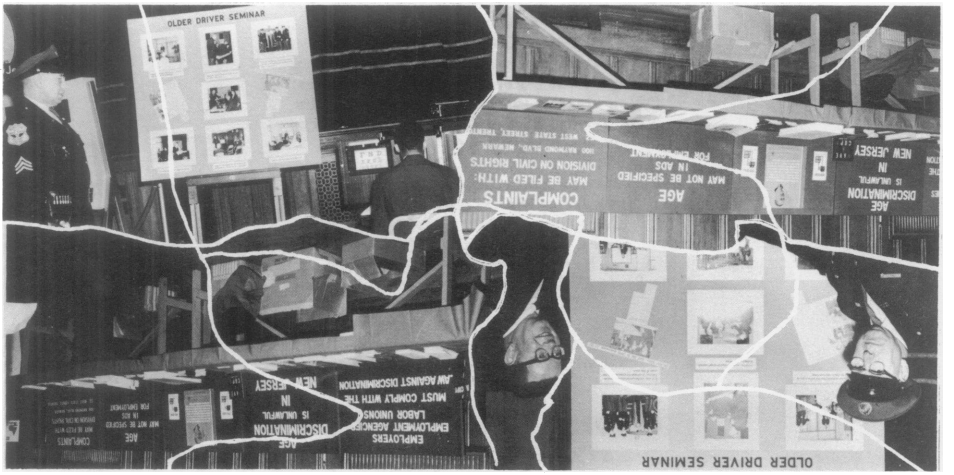
New Jersey Division of Pensions

Social Security Administration, U. S. Department of Health, Education, and Welfare

Farmers Home Administration, U. S. Department of Agriculture

New Jersey Division of State and Regional Planning, Department of Conservation and Economic Development

New Jersey Association of Homes for the Aged, Inc., Moorestown



The Presbyterian Homes of the Synod of New Jersey

State Employment Service, New Jersey Division of Employment Security

New Jersey Division on Civil Rights, Department of Law and Public Safety

Health and Welfare Council of Camden County

Senior Citizens Day Center, East Orange

Summit Area Association for Gerontological Endeavor, Summit

The Greater Plainfield Senior Service Center, Plainfield

Bureau of Consumer Frauds, Department of Law and Public Safety

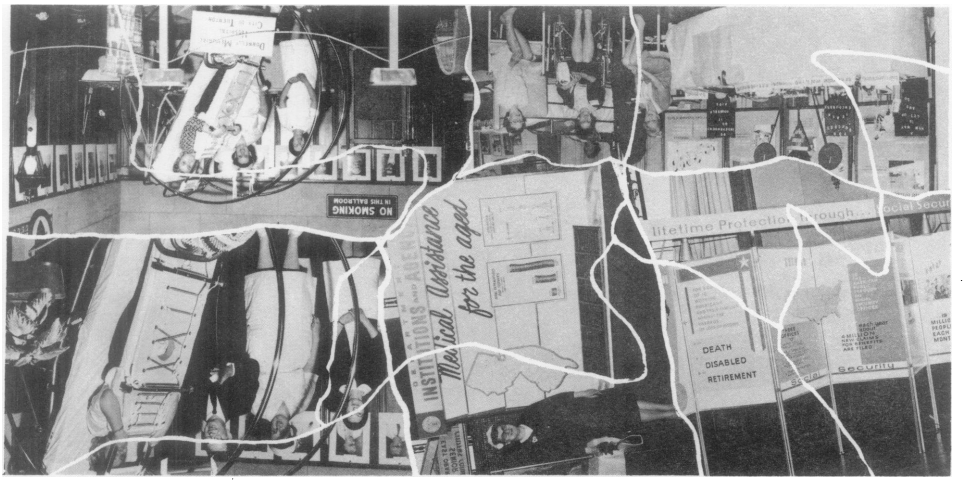
Consumers League of New Jersey, Montclair

New Jersey Association for Adult Education

New Jersey Division of Motor Vehicles, Repartment of Law and Public Safety

Senior Service Corps, Newark

Friendly Visitors, Department of Health



Middlesex County TB & Health League
Parks and Recreation Bureau (Green Acres), Department of Conservation and Economic Development
Promotion Section, Department of Conservation and Economic Development
New Jersey Division on Aging, Department of State*
Office of Aging, U. S. Department of Health, Education, and Welfare
Gerontology Branch, Division of Chronic Diseases, U.S. Public Health Service
New Jersey Commission for the Blind
New Jersey Rehabilitation Commission
Diet Counseling, Department of Health
Diabetes Control, Department of Health
Restorative Services, Department of Health
Department of Health, Recreation, and Welfare, City of Trenton
New Jersey Division of Public Welfare, Department of Institutions and Agencies

*The Bureau of Housing and the Division of Local Property Tax are exhibiting with the Division on Aging.

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