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ABSTRACT

The gap in the quality of life between elderly blacks and elderly whites must be closed through the joint efforts of individuals; religious and community organizations; political institutions and the private sector. Solutions are especially needed in urban areas where the minority participation rate in supportive service programs is low and decreasing. Crime, poverty, poor transportation, and unattended illnesses account for this low user rate. Specific suggestions for the alleviation of these problems include: (1) ensuring accessibility to quality health care; (2) improving housing and its affordability; (3) controlling poverty; (4) subsidizing training in geriatrics in black medical schools; (5) enhancing the recruitment of minorities into health careers; (6) monitoring for prejudice and racism toward older black people; (7) assisting the families of elderly blacks with counseling, respite services, and household help; and (8) passing legislation to assure adequate funding for all of the above. Supporting data are presented emphasizing the social and demographic contrasts between sex and race among the elderly. Testimony was submitted by representatives from medical schools and organizations for the aged and minorities, among other individuals. (VM)

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THE PLIGHT OF THE BLACK ELDERLY: A MAJOR CRISIS IN AMERICA

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HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

OCTOBER 3, 1986

Comm. Pub. No. 99-607

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THE PLIGHT OF THE BLACK ELDERLY: A MAJOR CRISIS IN AMERICA

FRIDAY, OCTOBER 3, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The select committee met, pursuant to notice, at 9:00 a.m., in room 2325, Rayburn House Office Building, Hon. Harold E. Ford (acting chairman of the committee) presiding.

Members present: Representatives Roybal, Ford, Saxton, Crockett, Bentley, and Christopher H. Smith.

Staff present: Roger Thomas, general counsel; Christinia Mendoza, professional staff; Diana Jones and Carolyn Griffith, staff assistants; John Murdock, legislative assistant; and Loree Cook.

OPENING STATEMENT OF REPRESENTATIVE HAROLD E. FORD

Mr. FORD. The Select Committee on Aging will come to order.

The full Committee on Aging has called this session today to hear about the plight of the black elderly, a major crisis in America. I am very delighted to chair the committee today on behalf of Mr. Roybal who is chairman of the full Committee on Aging.

I am delighted to have with me as members right now this morning the Honorable George Crockett, who has been one who has been in the forefront of two prior sessions similar to this, and also, Mr. Saxton who is a member of the full Committee on Aging.

Before we get started, I would like to invite members of the National Caucus and Center on the Black Aged, Inc., to come down and take seats on the front panel.

It seems we are in need of a few more seats in the audience and I would appreciate it if the members of the National Caucus and Center on the Black Aged would come down and take this first panel of seats.

We will let the staff know that we will use the first row as guests come in and cannot find a seat in the audience. This hearing has a twofold purpose: to examine the standard of living of the black elderly in terms of health, housing and income, and to develop recommendations on how nongovernmental agencies and communities can improve the status of the black elderly.

Now, a series of hearings and forums are needed to dramatize the plight of the elderly blacks and the obstacles they face on a day-to-day basis. Most people know in a general way that the quality of life is lower for older blacks than for other groups.

The situation for older blacks will deteriorate further under the Gramm-Rudman-Hollings balanced budget amendment if those amendments are not changed in this Congress or the next Congress.

The committee has conducted two sessions similar to this on the black elderly. On March 21, 1986, on the health status of black elderly in Detroit, MI, chaired by Congressman Roybal, the members present were Mr. Crockett, as well as Mr. Conyers, both of the Detroit area.

On May 5, 1986, income services of the black elderly in Memphis, chaired by the Representative from that area, the chairperson today, also a member present was Congressman Crockett. Because of the Gramm-Rudman-Hollings balanced budget amendments, it has limited our resources here in the U.S. Congress and the committee could not hold all of the sessions that we had hoped and planned to prior to the Gramm-Rudman Budget Reduction Act.

But the National Caucus and Center on the Black Aged has sponsored forums that have been held throughout the country. For example, in Chicago, crime and housing, which was on August 18, 1986; in Brooklyn, NY, income and employment, September 12, 1986; in Los Angeles, Older Americans Act services, September 19, 1986; in Philadelphia, Federal budget, September 20, 1986; and in Atlanta, health and long-term care, September 26, 1986.

So the committee at this time would like to say thanks to the National Caucus and Center on the Black Aged for your very able and direct assistance in the area of the plight of the black elderly, which we all know is a major crisis that we are faced with in America.

I would like to thank all of the witnesses for coming out today. I would like to thank all of the participants who will be with us and those who are observing from the audience. I would also like to welcome all of you who are here for the 16th legislative weekend of the Congressional Black Caucus, who are here in the Nation's Capitol and who have been in attendance at all of the workshops this weekend.

We want to thank all of you who have been participants with the Congressional Black Caucus over the past 16 years and those of you who have given support to the legislative workshops.

[The prepared statement of Mr. Ford follows:]

PREPARED STATEMENT OF REPRESENTATIVE HAROLD E. FORD

POVERTY IN AMERICA IS FOLLOWING BLACK AMERICANS FROM THEIR YOUTH TO THEIR SENIOR YEARS. WE ARE GATHERED HERE TODAY TO DISCUSS THE IMPACT OF POVERTY ON ONE SEGMENT OF BLACK AMERICANS, THE BLACK ELDERLY.

BLACK ELDERLY ARE THE POOREST OF THE POOR AMONG THE ELDERLY IN THIS COUNTRY. OUR BLACK ELDERLY ARE THREE TIMES AS LIKELY TO BE POOR AS THEIR ELDERLY WHITE PEERS. IN 1985, 31.5 PERCENT OF ALL BLACKS 65 YEARS OR OLDER LIVED IN POVERTY, COMPARED TO 11 PERCENT FOR OLDER WHITES. WE MUST CLOSE THIS GAP IN THE QUALITY OF LIFE AMONG OUR SENIORS.

CHANGE MUST BE MADE THROUGH THE POLITICAL PROCESS, COMMUNITY SUPPORT, AND INDIVIDUAL EFFORT. AT EACH LEVEL WE MUST ADDRESS A MULTITUDE OF ISSUES INCLUDING HEALTH AND THE MEDICARE SYSTEM, HOUSING, CRIME, COMMUNITY SERVICES, EMPLOYMENT AND INCOME, AND HUNGER AND NUTRITION.

THIS YEAR'S ANNUAL CONGRESSIONAL BLACK CAUCUS IS A VERY SIGNIFICANT TIME TO EXAMINE THE SPECIFIC PROBLEMS ASSOCIATED WITH BEING BLACK, OLD AND IN POVERTY IN THIS NATION. THE CONFLICT BETWEEN THE GROWING NEEDS OF AN AGING SOCIETY, ACCORDING TO CENSUS STATISTICS, AND A FEDERAL BUDGET WHICH CANNOT AFFORD ITS CURRENT COMMITMENTS MAKES THE CARE AND TREATMENT OF THE ELDERLY ONE OF OUR FOREMOST NATIONAL CONCERNS.

IN THE LAST SEVERAL YEARS CUTS HAVE BEEN THREATENED IN SOCIAL SECURITY, MEDICARE, AND OTHER BENEFIT PROGRAMS WHICH ARE OF PARTICULAR IMPORTANCE TO THE ELDERLY. THIS PAST YEAR ALONE, THE CONGRESS PASSED THE GRAMM-RUDMAN-HOLLINGS LAW WHICH AS ONE OF MY CONSTITUENTS SAID, "MUST HAVE BEEN MADE BY MEN WITH NO MOTHERS."

THIS HEARING WILL FIRST EXAMINE THE STANDARD OF LIVING OF THE BLACK ELDERLY IN TERMS OF HEALTH, HOUSING, AND INCOME. SECONDLY, IT WILL DEVELOP RECOMMENDATIONS ON HOW NON-GOVERNMENTAL AGENCIES AND COMMUNITIES CAN IMPROVE THE STATUS OF THE BLACK ELDERLY.

OUR WITNESSES AND GUESTS HAVE VALUABLE INFORMATION AND SUGGESTIONS FOR HOW WE CAN IMPROVE THE CIRCUMSTANCES OF THE BLACK ELDERLY. THEIR MESSAGE MUST NOT BE LOST OVER THE COMING DAYS, WEEKS, AND MONTHS.

OVER THE PAST YEAR MY COLLEAGUE, CONGRESSMAN CROCKETT HAS BEEN WORKING WITH THE SELECT COMMITTEE ON AGING AND THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, TO PUT TOGETHER A SERIES OF FORUMS AND OFFICIAL AGING COMMITTEE HEARINGS. I WAS FORTUNATE TO BE ABLE TO CHAIR ONE OF THE HEARINGS IN THE SERIES. AT THAT HEARING, HELD IN MY HOME DISTRICT OF MEMPHIS, TENNESSEE, WE CONSIDERED IN-HOME HEALTH SERVICES FOR THE ELDERLY. YOU WILL FIND A COMMITTEE PRINT OF THAT HEARING IN YOUR PACKETS.

TODAY'S HEARING WILL BRING TO A CLOSE THE SERIES OF HEARINGS AND FORUMS WHICH HAVE DRAMATIZED THE PLIGHT OF ELDERLY BLACKS AND THE OBSTACLES THAT THEY FACE ON A DAY-TO-DAY BASIS. THE SELECT COMMITTEE ON AGING WILL BE COMPILING ALL THE INFORMATION FROM TODAY'S HEARING AND THE OTHERS IN THE SERIES FOR PUBLICATION. I HOPE THAT ALL OF US WILL PUT THAT DOCUMENT TO GOOD USE TO CONTINUE TODAY'S WORK AND THE WORK THAT HAS PRECEDED TODAY.

I WANT TO TAKE THIS OPPORTUNITY TO THANK CONGRESSMAN CROCKETT, THE NATIONAL CAUCUS AND CENTER FOR BLACK AGED, THE STAFF OF THE SELECT COMMITTEE ON AGING, AND ALL OF YOU, FOR YOUR INTEREST IN THE PLIGHT OF AMERICA'S BLACK ELDERLY.

Mr. FORD. At this time, the Chair will recognize Mr. George Crockett.

STATEMENT OF REPRESENTATIVE GEO. W. CROCKETT, JR.

Mr. CROCKETT. Thank you very much, Chairman Ford.

I am delighted to be here because this is really the culmination of about a year of intense work with the National Center and Caucus of the Black Aged. The Select Committee on Aging is a special committee created by the Congress because of a continuing concern about the problems of the elderly.

There are two members of the Congressional Black Caucus who serve on that committee, Mr. Ford and myself. Today's hearing is the culmination of more than a year's planning and that planning began in 1985 when I met with several representatives and board members of the National Caucus and Center on Black Aged.

It was their belief at that time that not enough was being done by our House Select Committee on the Aged to publicize the special plight of the black elderly, or to bring about changes in that plight. After some discussion, we decided that what we needed to do was to hold a series of regional hearings under the aegis of the House Select Committee on Aging. We want to find out from their own mouths, as well as from the experts, what the quality of life truly is for our elderly blacks. Also we want to publicize their living conditions, and gather recommendations on what improvements could be made.

Besides the hearings themselves and besides the people who attended the hearings or heard about the results through the media, we determined to use the testimony that would be taken at these hearings, and the conclusions as well as the recommendations, as the basis for a definitive report on the status of America's black elderly.

This report, hopefully, will be widely distributed to churches, to senior centers, to area agencies on aging, and to community groups, for the purpose of helping them to identify the needs of the black aged in their communities, and to better address these needs. It is our hope that this report will be read early in 1987.

Unfortunately, because of Gramm-Rudman, the Select Committee on Aging had its budget cut and it could not afford to hold all of the hearings that we had envisioned. It was at that point that this Caucus and Center on the Black Aged stepped forward and offered to organize. With the help of the Villers Foundation the CCBA was able to fund the remaining field hearings, or forums, as we call them.

It was thus a joint public/private venture that allowed us to hold seven regional hearings and forums on different aspects of life for the black elders in the past 7 months. We looked at the question of health in the black elderly at our hearing in Detroit. We considered in-home services available to the black elderly in Memphis. We discussed crime and the black elderly in Chicago. We took up the question of income and employment at our recent hearing in Brooklyn.

We reviewed the Older Americans Act, which has to be renewed next year because it will expire at that time. We did this at the hearing in Los Angeles.

We considered the Federal budget about 2 weeks ago at the hearing in Philadelphia, and last Saturday in Atlanta we considered the question of health providers and long-term care for the black elderly.

Now, today we are going to spend about half of our time reviewing much of what we have heard around the country in these regional hearings, particularly as it pertains to three major areas, health, income, and housing. I am hopeful that the other half of the time will be devoted to a discussion of what all of us can do to improve the quality of life of the black elderly.

Unfortunately, Mr. Chairman, I will not be able to stay all morning because I am also helping to chair a brain trust on the role of blacks in the formulation and execution of U.S. foreign policy.

I, therefore, would like to take just a moment, if I might, to introduce two members or officers of the National Center and Caucus on the Black Aged who have been very helpful to us in putting on these regional hearings.

The first one is Mr. Sam Simmons. Is Mr. Simmons around?

Would you stand, Mr. Simmons?

Mr. Simmons is the president of the National Center and Caucus on Black Aged.

Then we have Dr. Aaron Henry. Dr. Henry is a member of the Mississippi Legislature, and is cochairman of the national center. We have Mr. Gorham Black.

Mr. Black, will you raise your hand?

Mr. Black was formerly with the State government in Pennsylvania and he also is a cochairman of the National Center and Caucus. I join Congressman Ford in expressing our sincere appreciation to our staffs: my staff, his staff, and the staff of the Select Committee, for putting together this hearing, and I want to express sincere appreciation to the witnesses who will come before you in order to help us prepare this important documentary record of the plight of the black aged.

Now, I turn to my colleague, Congressman Saxton, who is from what we call South Jersey.

STATEMENT OF REPRESENTATIVE JIM SAXTON

Mr. SAXTON. Thank you very much, Mr. Crockett, and Mr. Ford.

Let me express to you and to Chairman Roybal my admiration and thanks for holding this hearing. I appreciate the fact that the committee is, in fact, holding this hearing today on a very significant and, in my view, oftentimes overlooked set of problems facing the black elderly.

While improvements have been made in the standard of living for senior citizens as a whole, too often problems facing black elderly have been overlooked.

In fact, little improvement has been made in the standard of living at all for the black elderly. The poverty rate for elderly blacks in 1974 was 34 percent. In 1984, a survey conducted that

year, revealed that the rate was 32 percent, a very insignificant reduction, to be sure.

It is likely that the higher rate of poverty for black elderly contributes to their life expectancy, as well. I think that goes without saying.

Most startling of all, however, is the fact that over half of all elderly black women are either poor or considered to be marginally poor. It is even more important to study this issue since the black elderly population will more than triple in the next 50 years reaching 7.3 million people by the year 2030.

Our Aging Committee must not only focus on the problems of today, but also must look toward the future to see how we can best prepare for our rapidly growing population of elderly.

So I am pleased to represent New Jersey, the southern part of that State in particular, and the 60,000 black senior citizens who call New Jersey home. I hope this hearing proves to be informative and successful in focusing on the unique problems of the black elderly.

Thank you, Mr. Chairman.

Mr. FORD. Thank you very much, Mr. Saxton.

Thank you, again, Mr. Crockett.

We will start our public hearings with the witnesses coming to the table. I would like to add to what Congressman Crockett and Congressman Saxton said, and once again give thanks to the National Caucus and Center on the Black Aged. We did start some 12, 18 months ago, but I have had an opportunity to serve on this committee for the 12 years that I have served in Congress and have worked very closely with the National Caucus and Center on the Black Aged and other groups.

It has certainly been a real pleasure to work with my friend and colleague, Congressman Crockett, as we have been directly involved in the issues pertaining to the black elderly. We all know that older blacks are the poorest among the poor as it relates to the elderly.

No other aged racial group has a poverty rate as high as elderly blacks, not the aged Indians, not the older Hispanics, not the elderly Asians. No other group would have that high a rate.

In fact, nearly one out of two blacks—45.6 percent—65 years or older, either live in poverty or so close to the level that it is impossible to tell the difference. Recent improvements in the poverty figure for the aged have created a general impression in some quarters that the elderly are living quite comfortably.

I would hope that we would be able to dispel many of those impressions that are out there.

I think this session today will probably go a long way in trying to do just that. One of the big problems I guess, and it is coming directly from the center, in reading over information that they have been able to collect, when we talk about freedom from fear, is one of their highest priorities needs for older blacks.

They go on to say victimization statistics make it clear that elderly blacks are much more likely to be crime victims than aged whites. As a consequence, thousands of other blacks live under the form of house arrest because they are afraid to venture out into their own crime-infested communities.

When we see information that has been compiled through witnesses, through sessions at the national center, and the full Committee on Aging who have gone across this country to get first-hand information, it is even clearer to this member of the committee and this Member of Congress, that yes, the Gramm-Rudman-Hollings Balanced Budget Act has not only impacted the elderly, but has had severe impact and will continue to have an even more severe impact upon the black elderly.

It is one strike against you when you are old in America, but there are two strikes against you when you are black and old in America.

I think that we are seeing this, not only through Gramm-Rudman, but even prior to the Gramm-Rudman legislation, which has been enacted by the Congress. So we will not continue to prolong the opening part of the session. We will call the first panel.

At this time, we are very delighted to have with the committee one of the very able members of the Maryland delegation, who has been in the forefront of the aged issue not only here on this committee, but also throughout her district.

I would like to yield to Congresswoman Bentley at this time.

STATEMENT OF REPRESENTATIVE HELEN DELICH BENTLEY

Mrs. BENTLEY. Thank you, Mr. Chairman.

I will submit my statement, the full statement, for inclusion in the record with unanimous consent.

I would just say that I commend you for opening this hearing. I think it is very important that we try to resolve this problem, which is beginning to really fester and plague the nation.

I am very happy to participate in exploring the plight of the black elderly population. I think from this we will be able to achieve the first step toward accomplishing our goal.

Mr. FORD. Your statement will be made part of the record.

[The prepared statement of Mrs. Bentley follows:]

PREPARED STATEMENT OF REPRESENTATIVE HELEN DELICH BENTLEY

I am pleased to be here with you today to discuss an issue of growing importance to our nation; the plight of our elderly. Specifically, the chairman has called this hearing so that we, as responsible representatives, may be exposed to the issues facing our black elderly population.

No one in this prosperous country should be forced by economic conditions to go without food, housing. and health care. However, it is a fact that from 1969 to 1983 the percent of aged whites living below the poverty line dropped from 23.3 to 12 percent, while poverty among older blacks decreased during this same period from 50.2 to 36.3 percent. It is obvious that progress has been made, but we still end up with a ratio of 3:1 of poor elderly blacks to poor elderly whites.

Recently, the burgeoning numbers of elderly in the United States have brought this issue into the limelight. Although no individual or organization has offered a panacea, the testimony of knowledgeable witnesses such as yourselves will assist the members of this committee in formulating pertinent legislation.

I am eager to explore the plight of the black elderly population. I believe that the purpose of this hearing, which is to examine the living standards of black elderly and to develop recommendations on how groups and individuals can improve the status of the Black elderly, will be the first step towards accomplishing this goal.

Again, I thank the Chairman for calling this hearing and I welcome the witnesses here today.

Mr. FORD. Also, we would like to thank Chairman Roybal, who is the chairman of the full Committee on Aging, who has worked very closely with Congressman Crockett and I in trying to assist with severe budget problems with the committee, and his strong commitment in this area and I would like to include his statement and make it part of the record and would also ask it be made as the first opening statement in the record today.

[The prepared statement of Mr. Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

I want to extend my appreciation to everyone attending today's hearing on the "The Plight of the Black Elderly: A Major Crisis in America. Today's hearing will examine the standard of living of the Black elderly in terms of health, housing, and income and to develop recommendations on how non-governmental agencies and communities can improve the status of the Black elderly.

During the past several months, the House Committee on Aging has conducted hearings on the status of aged Blacks in the United States. In addition, I commend Mr. Samual Simmons, President of the National Caucus and Center on Black Aged for conducting separate forums to provide further information about conditions for older Blacks on income, employment, the budget, crime and supportive services.

These hearings and forums are designed to provide a comprehensive overview of the state of affairs for aged and aging Blacks in the United States. Recent improvements in the poverty issue for the elderly have created a general impression that older Americans are living quite comfortably. Contrary to that rosy picture, persons 65 or older have the highest poverty rate among adults. Only young people,individuals 21 or younger, have a higher poverty rate than the elderly.

Most people know that the quality of life is lower for older Blacks than for other groups. But, they are surprised by the degree of deprivation among aged Blacks. For example, older Blacks are the poorest of the poor among the elderly and often face difficult daily choices as to how they spend their limited income. They face choices of either buying necessary prescription drugs, food, or heat.

Economic deprivation is just one facet of the plight of the Black elderly. Other problems exist such as the cutting the cost of health care, housing and social security. This point has been made strongly in the hearings and forums that have been held in Detroit, Memphis, New York, Chicago, Los Angeles, and Philadelphia.

The recent forum in Los Angeles provided powerful evidence that aged Blacks and other elderly minorities are underserved by the Older Americans Act. In fact, the minority participation rate for both the supportive services program and the elderly nutrition programs are at all time lows for this decade.

The minority participation rate for the supportive services program has fallen by 24.7 percent during this decade, from a high of 24.7 percent in fiscal year 1980 to a low of 16.5 percent in 1985. The aged Black participation rate has dropped by 23.0 percent during this same time frame.

The hearing today is designed to provide further information and to fill in gaps for certain key subject areas which have not been covered fully in prior hearings or forums. I look forward to hearing from our expert witnesses. Your suggestions and recommendations will assist the Committee in formulating legislation and other governmental policies that will help support the Black elderly.

Mr. FORD. I would like to call on Dr. Ron Manuel of Howard University; Dr. Robert Butler from the Mount Sinai Medical Center in New York; Dr. Robert C. Weaver from the Office of Housing and Urban Development; and Ms. Eloise Ellis, who is the chairperson of the D.C. Legislative Committee of the American Association of Retired Persons.

I would like to ask you to come and be seated here at the witness table directly in front of the tier. Let me say once again, on behalf of the Select Committee on Aging, we are very delighted to have the witnesses here before the committee today and we certainly look forward to your input in this Select Committee hearing.

At this time, the Chair would recognize Dr. Manuel.

PANEL 1, CONSISTING OF RON C. MANUEL, PH.D., PROFESSOR OF SOCIOLOGY, HOWARD UNIVERSITY; DR. ROBERT N. BUTLER, CHAIRMAN, GERALD AND MAY ELLEN RITTER DEPARTMENT OF GERIATRICS AND ADULT DEVELOPMENT, THE MOUNT SINAI MEDICAL CENTER, NEW YORK; ROBERT C. WEAVER, FORMER SECRETARY OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, WASHINGTON, DC; AND ELOISE ELLIS, CHAIRPERSON OF THE D.C. LEGISLATIVE COMMITTEE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

STATEMENT OF RON C. MANUEL

Dr. MANUEL. Mr. Chairman, members of the committee, I welcome the opportunity to speak with you on the topic of the plight of the black elderly, in particular. I have been asked to give some brief over all demographic characteristics of the black aged. I would like to submit my full statement for the record.

Mr. FORD. Let me say for the record your full statements will be made part of the record if you would like to summarize your testimony and that is true for all witnesses who will testify today.

Dr. MANUEL. As a preface to my commentary, let me note that the importance of our being ever mindful of characteristics of particular subgroups within the general older population, in this case, of course, the black Americans, namely, we too easily make the mistake of concluding or inferring that the circumstances of the aged have been sufficiently addressed when we fail to consider that the aged are not a homogeneous group.

That is when we read conclusions or make inferences from reports, such as in the 1985 report of the President's Council of Economic Advisors, that elderly Americans are no longer a disadvantaged group.

This type of inference or conclusion too easily leads to public opinion that overlooks the fact that there are pockets of significant need that continue to uniquely characterize this target population.

Let me now briefly direct your attention to three or four circumstances in the older population among black Americans that give evidence to the problems that the aged continue to have and that tell us that the problems have not been sufficiently addressed.

According to the latest U.S. Government statistics, black older Americans are about three times more likely than their white counterparts to have annual incomes below the official poverty

threshold. Even with similar levels of education, poverty among older blacks is over two times that of older whites.

In 1984, the median income of black older males was 57 percent of their white counterparts. The median income of black older females was about 60 percent of their white counterparts.

The data for 1984 are not unique. When we observe data in 1959 before the great society legislation or after, the ratio of older black to older white incomes has had a very narrow range; namely, between 54 and 64 percent.

Now, the lower incomes of black elders transfer into relatively poor health, housing, public safety, and a general standard of existence. Thus, for example, at birth blacks can expect to live about 5 to 7 years less than their white counterparts.

Older blacks are about twice as likely as older whites to report that their health is poor. Yet 58 percent of older blacks in the Census Bureau's survey of income and participation say that they are without private insurance, relative to 27 percent of older whites.

About 4 percent of older blacks say in that survey that they are without Medicare relative to about 2 percent of older whites. The story is basically the same when we look at housing.

Not only does the literature show the quality of the housing to be relatively inferior among older blacks, but evidence shows older blacks, particularly low-income home owners, are more likely than similar white owners to have excessive house-related costs.

Now, these selected highlights about the black aged, I think, take on greater significance when we consider the growth of this population. Because it is a population that is growing at a faster rate than the total older population, it results that while blacks comprised about 7 percent of the 16 million older persons in 1960, they comprised about 8 percent of the 28.5 million older persons in 1985.

In the year 2000, they will comprise 8.5 percent of all older persons. By the year 2040 they will comprise 12.5 percent of all older persons.

In short, the bottom line of this is that older blacks are constituting a greater and greater proportion of the total aged population. Increasing numbers of proportions of older black, often impoverished persons, mean corresponding increases in the number and proportion of persons potentially dependent upon their families and upon society.

In sum then, when compared to the general older population, or to the older population of whites, which I would like to take as a general, normative standard of the lifestyle and the chances in life that are potentially available in the United States for older people, it is clear that older blacks are systematically more likely to have inadequate income, and then in turn, poor health, poor housing, accessibility to health and poor social care services.

So my conclusion is the problems of the aged have not been solved. There are pockets of substantial, unique needs that characterize—that have characterized and will continue to characterize the older population in this country.

Thank you, Mr. Chairman, for the opportunity to call your attention to some of these often overlooked demographic characteristics in our older population.

[The prepared statement of Dr. Manuel follows:]

PREPARED STATEMENT OF RON C. MANUEL, PhD

A SOCIO-DEMOGRAPHIC PROFILE OF THE BLACK AGED

The gradual, conatant increaae in the number and proportion of the total U.S. population, that ia age 65 and over, is well recognized. Varioua characteristica about thia population are lesa well understood, however. For example, it ia not unuaal to read or hear that the population aged 65 and over, commonly referred to aa the aged or older population, ia economically well off.[1] Speaking directly to the point, Jane Seaberry, writing in the Washington Poat (1985) and summarizing the annual report of the President'a Council of Economic Adviaors, observea:"elderly Americans have achieved baaic economic parity with the rest of the population and no longer are a disadvantaged grouo." One rather easily deduced implication is that the problema of the aged have been solved. When taken at face value, aa it frequently ia, thia concluaion, aa falae aa it ia, entera the compendium of knowledge about the aged population.

To conclude, aa ia reflected in the Seaberry (1985) article, that the economic problemsof the aged have been solved--becauae, for example, the per capita family income for the population aged 65 and over was $9080 in 1983 in contrast with $8960 for nonaged families—fails to conaider that the aged are not a homogeneous group. It is rather easy to conclude or deduce that the problems of the older population have been addresaed if one accepta that all older persona experience the same conditiona of aging. Observing a more complete set of data that reflecta the heterogeneity in the older population, one could not escape the concluaion that there are pockets of significant need that continue to uniquely characterize the older population.

The purpose of this paper ia to deacribe a few of the socio-demographic characteristica, and impending changea in theae characteristica, of the older population in the United Statea that document thia aimple concluaion. It ia important for aociety to recognize that the aged population is a multi-faceted, heterogenoua one. Summary statistics, auch aa the per capita income, about the general population in no way reflect the potentially unique, often numerially aignificant subgroupa within this total population.

The diacuasion begina with a study of the aize, growth and diatribution of the older black population. Next a study of a aelected number of the character-iatica of the aged black population ia made. Specifically, the health, houaing and economic circumatancea are deacribed.

[1]The older or aged population is defined aa peraona aged 65 and over, unleas otherwise noted.

THE SIZE, GROWTH AND DISTRIBUTION OF THE OLDER BLACK POPULATION

Population Size

The growth of the older population, as was noted, is generally well known (see Table 1). What is less well recognized is that, at least since 1930, the black older population has been increasing at a substantially faster rate than the general older population. The elderly black and the total older population increased between 1920 and 1930 by about 12 percent and 36 percent, respectively; the corresponding rates of increase between 1930 and 1940 were roughly 65 percent and 36 percent (see Table 1). A similar pattern holds for the comparison of older whites and blacks inasmuch as the general population largely reflects the characteristics of the numerical majority group.

The greater relative growth rate among older blacks has continued since the 1930s and 1940s. For example, between 1960 and 1985, there was a 104 percent increase in the black older population relative to a 73 percent increase in the white older population (see Table 2). Both figures highlight the growth of the aged population when compared to the 33 percent increase in the total U.S. population during the same time period.

Gender variation is also a distinguished aspect of the data in Table 2. It is among females that one sees the most pronounced population increases, black or white. The growth rate of the older black female population substantially exceeded that for black males at each age level. The 1960 to 1985 increase was sharpest among the oldest old, that is, persons aged 85 and older. Here there was a 211 percent increase in the female black older population relative to a 124 percent increase among their male counterparts.

The population of black older females was also generally growing faster than their older white female counterparts. One variation from this pattern, however, is evident when the target population, by age, is again narrowed to the oldest old, another distinguished subgroup within these data. There was a 259 percent increase in the female white older population relative to the 211 percent increase among female black older persons. This pattern, however, is not expected to continue. For example, the data in Table 4 show that for each of the projected twenty year projections of population size, starting with 1980 (i.e., 1980 to 2000), the rate for female black older persons exceeds that for their white counterparts whether one studies the group aged 65 and over or aged 85 and over.

Generally, with the exception of the racial contrast for males between

1980 and 2000, the data on projections in Table 4 show that the trend of faster relative older black (male and female) growth is expected to continue throughout the next century. Thus, while the total U.S. population is only expected to grow by 18 percent between 1980 and 2000, the increase of black older females is projected to increase by 53 percent between these same years. The population of white older females will increase by 35 percent between 1980 and 2000.

An Aging Population

One result of the faster rate of growth in the older black relative to older white population is that older blacks comprised slightly over eight percent of the 28.5 million persons aged 65 and over in 1985, wheras older blacks comprised about seven percent of the roughly 16 million persons aged 65 and over in 1960. Older blacks are thus constituting a greater and greater proportion of the total aged population.[1]

The 2,343,000 elderly blacks in 1985 (Table 2) also represented slightly over eight percent of the total bl[illegible]lation; about 12.5 percent of the white population was aged 6[illegible]35 (see Table 3). When compared to the fact that in 1900, 4.2 p[illegible] total white population was aged, relative to about 2.9 percent of the black population, it is clear that both populations are aging.[2] Yet, the white population is distinctly older than its black counterpart, despite the current generally faster rate of increase in the latter population.

Projections for the future show that these two populations will continue to age (see Table 4) in their own distinctive ways. A narrowing of the gap of the relative aged status of the two groups will not become evident until after the post World War II baby boom cohort has fully entered the ranks of the elderly, after 2020. Between 1980 and 2000, for example, the percentage of white female society that will be old will increase from 13.9 percent to 16.5 percent; the corresponding increase for black older females will be from 8.9 to 10.2 percent. In 2040, the percentages of these respective populations that will be old are 26.2 (white) and 19.5 (black); the respective percentages are 27.4 and 25.1 in 2080. It is not clear, however, that this convergence will necessarily represent or reflect the homogenizing effect of similar lifestyles or circumstances at work in the two populations.

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[1]Conclusions are based on tabulations of: (1) data in the Public Use File (One in a Thousand Sample) of the 1960 Census of the U.S. Population; (2) data from the U.S. Bureau of the Census (1986a).

[2]An aging population is one whose total population count, over time, is characterized by increasingly greater proportions of persons aged 65 and over.

It is clear from the projections in Table 4 that older blacks, whether having more or less similar lifestyles to whites, will become a much more visible component of the aged population. The need for special, minority sensitive planning for policy and services would surely seem warranted given the dramatically distinctive projected growth rates of the black, particularly female, oldest old. Increasing numbers of older black and often impoverished persons mean corresponding increases in the number of persons who will be potentially dependent upon their families and the society.

The Distribution of the Black Older Population

Fifty-six percent of all black older Americans were concentrated in one of the ten states most populated by older blacks in 1980 (see Table 6). Five States: New York, Texas, Georgia, North Carolina, and California accounted for almost one-third of the total population of older blacks.

Eighty one percent of older blacks were concentrated in urban locations in 1980 (see Table 5). Of that group who lived in urbanized areas, 69 percent were in central cities. Older whites were also primarily living in urban locations. Of those in urbanized areas, however, only 39 percent lived in central cities. Rather, older whites are more frequently living in the urban fringe. About 15 percent of their black counterparts are similarly situated. Clearly, older blacks are disproportionately concentrated in central cities and thus, at greater risk to various urban problems including: congestion, housing shortages, living costs and general problems with health and well-being. It is, therefore, fitting in this analysis to devote some commentary to a selected number of indicators of these problematic concerns for older blacks.

HEALTH CHARACTERISTICS

Progress in health is frequently measured in terms of improvement in life expectancy and life expectancy is directly influenced by patterns in mortality which, in turn, are influenced by patterns in health safety, status and functionality. It is thus appropriate to begin the study of health at the broadest level (i.e., life expectancy) and work a path backward to more specific indicators on the health of the black aged.

Life Expectancy

Life expectancy is a measure of the average remaining lifetime in years for a specific age, assuming a constant distribution of death rates over time. The average white newborn female in 1982 had a life expectancy of about 79 years. The average black newborn female could expect to live another 74 years (see Table 7). The male counterparts, respectively, had life expectancies of roughly 72 years (white males) and 65 years (black males). Generally, white life

expectancies represent a roughly five to seven year advantage over blacks, an advantage that has been reduced from the roughly six to eight year white to black advantage appearing in 1960, before the country's Great Society domestic governmental assistance programs. For context, Table 7 also presents life expectancy data for 1900.

Most of the 1900 to 1982 improvement in survivorship for both blacks and whites was consequent of mininizing the effect of the infections diseases that primarily affect those in infancy and childhood. This improvement in life expectancy at age 65 or age 85 (see Table 7) has been less noticeable. For example, relative to the 28 year increase in life expectancy, at birth, among black females from 1900 to 1982, life expectancy increased by only about six years at age 65 during the same years. Interestingly, the latter rate is not substantially different for white females: (18.9-12.2=6.7 years), while the racial differential at birth is clearly more distinguished (38.5 years of improvement among white females) versus 27.8 years of improvement among black females).

The importance of this observation rests with its possible differential implication, by race, for where work must be concentrated to gain future improvements in life expectancy. Namely, the emphasis that is increasingly, and rightfully so, placed on the importance of controlling the chronic diseases that primarily affect older persons--as a method for sustaining future improvements in life expectancy for the general population (see Manton, 1982)--must be amended to include a special continuing emphasis on improving conditions surrounding the birth and infancy of black Americans. Elevated black infant mortality rates, such as reflected in the black to white male infant mortality ratio for 1983 of 2.13 (see Table 8), is a major indicator of the need for continuing special targeting of attention on the health conditions surrounding the birth process and infant and mother care. This awareness points anew to the observation that aging is a life long process. A significant extension of the life expectancy of blacks is dependent on what happens to the high rate of unwed mothers and the care they and their infants receive.

Relative improvement of the life expectancy for blacks is similarly dependent on what happens to high black relative to white rates of mortality at each of the age levels shown in Table 8. The fact that the black to white male mortality ratio was 2.17 to 2.57 in 1983, during the young adult years, transfers into the task of identifying why the death rate from homicide, for example, among young black males far exceeds that of their white counterparts. What is it about victimization by poverty

and minority status among blacks that leads to greater violence as a possible means of coping? The hope is that by understanding the psycho-sociological mechanism of this and similar connections, an infomed society will see the need for eliminating poverty and discrimination. This recognition and action to address it is a major step in the process of lessening the racial gap in the mortality rates and consequent life expectancies of black and whites.

Health Status

Those black Americans who live to old age have sometimes been called special survivors. Yet, the mere fact of survival leaves unanalyzed the state of the health of these survivors. Is the health of older blacks commensurate with what is generally available in the society to the nonminority (i.e., white) community?

The data in Table 9 show that older blacks, more often than their white counterparts, report: (1) health conditions that limit their activity; (2) bed disability days; and (3) illnesses that are unattended by medical personnel. The result is that older blacks are much more likely to be functionally limited and, naturally, more likely to see themselves in poor health (see Table 9).

Health Care and Social Service System Accessibility

One avenue for reducing the relative health risks of aging and aged blacks is by ensuring accessibility to the health care system. Findings that show that older blacks are less frequently covered (than whites) by Medicare or private insurance (see Table 10) implicate the importance of planning, to ensure that the health care syatem in this country is more accessible to blacks throughout their lives. On the other hand, it would appear that of those eligible for Medicaid and other social service programs, that contribute to well-being and thus indirectly to health (e.g., Food Stamp Program, Aid to Families with Dependent Children, General Assistance, Supplemental Security Income and Housing Assistance), there is a higher rate of use among older blacks than among older whites. Whether this circumstance stated as simply as above, can be taken as indication of equity in black and white use of these programs is a separate question and one beyond the purview of the discussion here.

HOUSING CHARACTERISTICS

Housing Tenure and Quality

In 1983 there were about 919,000 older black heads of household living in owner occupied housing. Regardless of income level, the majority of older black household heads were in owner-occupied housing (see Table 11). Yet, the data show that older black ownership rates lag behind that of their white counter-

parts. Because home equity is the dominant asset holding of the elderly (Murray, 1972), it is clear that older blacks and their families are relatively disadvantaged not only on economic grounds but also for reasons related to the socioemotional value represented by home ownership.

The question of the relative quality of the housing of older blacks is also of interest when considering the question of the economic and symbolic value of housing. The 1983 data confirms again what has largely been the conclusion during the last few years (Struyk, 1985). Namely, the housing stock of older blacks generally remains inferior to that of their white counterparts. This conclusion is conditional, however. Thus, while the black disadvantage is generally evident throughout the income and tenure controlled analyses on whether there are cracks or holes in the walls/floors of the housing, plumbing and kitchen facilities are generally not problematic for persons with incomes about the median income level (see Table 11 for details).

Housing Affordability

One frequently asked question is whether older blacks spend an excessive share of their income on housing. Taking an acceptable housing cost (or rent) to income ratio as one under 35 percent, it is seen in Table 11 that older black household owners are more likely than whites to be paying above the criterion amount, particularly among those with incomes below the median. On the other hand, older blacks regardless of income are slightly less likely than whites to have an excessive rent to income ratio (see Table 11).

SELECTED ECONOMIC CIRCUMSTANCES IN THE BLACK OLDER POPULATION

Relative Income Status

By any indicator of income and economic well-being, the black aged are a particularly disadvantaged group. In 1984, the median income of black males aged 65 and over was $6163, about 57 percent of the median income ($10,890) of white males in the same age group. The median income of older black females ($4345) was 69 percent of the median income of their white counterparts ($6309) (U.S. Bureau of Census, 1986b).

The 1984 median income of families headed by a black older person was $11,983, about two thirds (64 percent) of the median family income of white families headed by an older person ($18,775) (see Table 12).

The use of data from 1984 to illustrate the point of the relative income disadvantage of older blacks does not tell a unique story. Whether observing

data before the 1964 Civil Rights Act and other Great Society legislation, or after, the ratio of the income of older blacks to older whites has had a very narrow range. The data in Table 12 show that the median income of older black families has consistently ranged between 54 percent and 64 percent of the comparable incomes of older whites.

The Adequacy of Income

The typically used measure for the study of the adequacy of income is the poverty ratio. The poverty ratio is the ratio of money income available to the money income thought to be necessary to provide the food for a minimum temporary adequate diet for a specified number of persons, with still enough money left to purchase other necessities.

Table 13 presents a display of these ratios for older blacks and whites, over time. Generally, the data show that the black poverty rate has been consistently higher than the white rate. Moreover, the gap between the proportion of the black aged having incomes below the poverty threshold and the proportion of the white aged with incomes below the poverty threshold has widened over time. In general, in 1959 the rate of poverty for older blacks was approximately double the rate for older whites. Relative poverty for older blacks then increased, even before the Reagan era of federal retrenchment, and has been approximately triple the rate for older whites since 1981. Lower rates of poverty, overtime, for both older whites and blacks, but a widening black to white ratio, reflect the fact that the decline in poverty for older whites, over time, has proceeded at a faster rate than that for their black counterparts.

Table 13 also extends the application of the poverty measure to include controls for educational attainment and source of income for the 1982 data. While a control for education reduces the magnitude of the racial contrasts, it is obvious that even with education controlled, the incidence of poverty among older blacks is over two times that of older whites.

The role of multiple income sources in poverty incidence is instructive of where the poverty gap between blacks and whites is accentuated. Thus the gap, by income source, as is indicated by the ratio of the black to white poverty rate (see Table 13), only approaches the overall ratio in 1982 (3.08) when black and white incomes are compared among those with incomes based on multiple sources, including social security and earnings, plus either/or property income (e.g., interest, dividends) or pension income. Only at this point, like for the case of the overall poverty data, is it revealed that over three times more older blacks have incomes below the poverty level than their white counterparts.

The importance of earnings, and other income sources, shows the critical role that multiple income sources play in the accentuation of disadvantage of older blacks. Clearly the data in Table 13 show that an emphasis on earnings, as a source of income, contributes to heightening the black disadvantage. The data on unemployment in Table 14 shows, in part, why. In 1982, for example, the unemployment rate for older blacks males was 9.3 percent, relative to 3.2 percent among older white males.

Earnings from employment, as an income resource, simply are not as frequently available to older blacks. A similar reasoning underlies the availability of property or pension income to older blacks.

In conclusion, the data on the relative incomes of older blacks and whites suggest one inescapable conclusion: the elderly black's income position, while improved over time, is an deprived or more deprived today--relative to their white counterparts-- as it was in 1960.

Summary

The discussion in this paper has emphasized the relative plight, demographically, of older blacks in the United States. Older blacks relative to whites much more frequently were shown to have inadequate incomes. Their, in turn, poorer health, housing and inaccessibility to the health, and social care system, transfer into higher death rates and thus lower life expectancies than is generally characteristic in the society.

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TABLE 1: Decennial

Decade	U.S.

TABLE 2:

Race by Age

TABL

Age

TABL

YEAR

Male

TABLE 5: UNITED STATES POPULATION AGED 65 AND OVER: NUMBER AND PERCENTAGE OF TOTAL IN 1980, BY RACE, FOR RURAL URBAN LOCATION

Geographical Location	White		Black	
	# (1000s)	%	# (1000s)	%
	Rural Urban Distribution			
U.S. (Aged 65+)	22942		2067	
Urban				
Total	16927	73.8[a]	1666	80.6[a]
Urbanized Areas:				
Central City	6602	39.0[b]	1151	69.1[b]
Urban Fringe	6801	40.2[b]	256	15.4[b]
Rural				
Total	6015	26.2[a]	401	19.4[a]
Farm	691	11.5[b]	17	4.2[b]

SOURCE: United States Bureau of Census (1984b)

[a]Percent of U.S. Total Population, aged 65 and over.

[b]Percent of Total Urban or Total Rural Population, aged 65 and over.

TABLE 6: TEN MOST POPULATED STATES WITH BLACKS, AGED 65 AND OVER

State Distribution

State	Rank	# (In 1000s)	Cumulative Percent[a]
New York	1	165	8.1
Texas	2	137	14.8
Georgia	3	123	20.9
North Carolina	4	112	26.4
California	5	110	31.8
Florida	6	107	37.1
Louisiana	7	102	42.1
Michigan	8	98	46.9
Mississippi	9	94	51.5
Pennsylvania	10	92	56.0

SOURCE: Based on tabulations from the One in a Thousand Public Use Sample (Sample A) of the 1980 Census of the Population (U.S. Bureau of the Census).

[a]Cumulation of the percentage of each state's population that is aged 65 and over and black.

TABLE 7: LIFE EXPECTANCY, BY AGE, BY YEAR, BY RACE, BY GENDER FOR THE UNITED STATES

Age by Year	Race by Gender					
	Black Male	White Male	Black Female	White Female	All Other Male[a]	All Other Female[a]
At Birth						
1900[b]	32.5	48.2	35.0	51.0		
1960[c]	61.5	67.6	66.5	74.2		
1982	64.9	71.5	73.5	78.8	66.8	75.0
At Age 65						
1900[b]	10.4	11.5	11.4	12.2		
1960[c]	12.8	13.0	15.1	15.9		
1982	13.3	14.5	17.2	18.9	14.1	18.2
At Age 85						
1900[b]	4.0	3.8	5.1	4.1		
1960[c]	5.1	4.3	5.4	4.7		
1982	4.8	5.3	6.5	6.7	5.8	7.5

SOURCE: National Center on Health Statistics (1985b).

[a]Includes data for Blacks.

[b]Data are for death registration states for the period 1900-1902.

[c]Data are for "All Other Races" (other than white). Blacks, however, accounted for over 90 percent of all racial groups other than whites.

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TABLE

TABLE 9: PERSONS AGED 65 AND OVER IN THE UNITED STATES: SELECTED INDICATORS ON HEALTH NEEDS

Health Indicators	Race	
	White	Black
Health Need or Status		
A. Health Conditions		
1. At least one health condition that limits activity	43.8%	56.6%
2. Persons with a second activity limiting health condition	9.4	12.8
3. Persons with a third activity limiting health condition	2.3	2.1
B. Poor Self Perceived Health	11.6	23.5
C. Two or More Illnesses Unattended by Medical Care System	.7	2.2
D. More Than 20 Bed Disability Days in Last Year	12.8	20.0
E. Most Severe Functional Limitations Score	4.7	8.5

SOURCE: Based on data from the Public Use Data file of the National Medical Care Utilization and Expenditure Survey, 1980 (National Center for Health Statistics).

TABLE 10: HEALTH CARE AND SOCIAL SERVICE SYSTEM ACCESSIBILITY AND USE, BY RACE FOR PERSONS AGED 65 AND OVER

Service	White(%)	Black(%)
Health Care System Accessibility		
1. Without Private Insurance Coverage[a]	26.7	57.7
2. Without Medicare Coverage[b]	2.4	4.2
by Type of Covarage:		
Type A	9.4	12.8
Type B	2.5	3.7
Type A and B	80.4	72.4
No Medicare Card	7.6	11.0
3. Without Medicaid Coverage any time: October 1983 to January 1984[b,c]	3.1	.7
4. Nursing Home Residents	49.7[f]	30.4[f]
Social Service System Use		
1. Food Stamp Program[b,c,d]	3.3	19.3
2. Aid to Families with Dependent Children[b,c,d]	.1	.5
3. General Assistance[b,c,d]	.1	1.1
4. Supplemental Security Income[b]	4.7	22.4
5. Rent Subsidized Housing[b,e]	13.1	15.2
6. Residence is in a Public Housing Project[b,e]	16.0	35.6

SOURCE: Based on data from the Public Use Data files of the: (1) National Medical Care Utilization and Expenditure Survey (National Center for Health Statistics, U.S.D.H.H.S); and (2) Wave One of the Survey of Income and Program Participation (SIPP) (Bureau of the Census, U.S. Dept. of Commerce); Nursing Home data are from the National Center for Health Statistics (1985).

[a]Based on 1980 data from the Public Use Data File of the National Medical Care Utilization and Expenditure Survey.

[b]Based on October 1983 to January 1984 data from the Public Usa Data file of the Survey of Income and Program Participation.

[c]Universe refers to person aged 65 and over and who meet eligibility requirements.

[d]Participated in the Program for each of the four months of Wave 1 of the SIPP.

[e]Households with a Head, aged 65 and over in January, 1984.

[f]Data are for 1977 and refer to the rate per 1000 population. Data on blacks are actually for nonwhites.

TABLE 11: INCIDENCE OF HOUSING QUALITY, AFFORDABILITY AND TENURE BY RACE AND BY INCOME FOR PERSONS AGED 65 AND OVER: 1983

Selected Housing	Tenure:	Owners				Renters[a]			
	Income:	Below Median[b]		Medium or Above		Below Medium		Medium or Above	
	Race:	White	Black	White	Black	White	Black	White	Black
Tenure									
Owners		64.3%	54.7%	84.9%	76.6%				
Renters						31.7%	40.7%	14.0%	22.0%
Quality									
Complete Plumming Facilities		97.0	87.0	99.5	98.5	97.7	89.0	99.2	97.3
Complete Kitchen Facilities		99.3	95.1	98.8	99.7	98.7	93.6	99.1	98.3
No Cracks/Walls		96.0	87.0	97.9	93.4	93.7	85.5	95.0	80.9
No Holes/Floors		98.5	93.8	99.6	96.8	98.6	93.7	98.7	96.0
One or Less Persons Per Room		99.8	99.3	99.7	97.7	99.7	99.9	99.6	93.9
Affordability									
Housing Cost to Income Ratio: More than 35%		27.4	37.7	4.7	5.3				
Rent to Income Ratio: More than 35%						54.9	53.3	15.4	9.8

SOURCE: Based on data from the Public Use File of the Annual Housing Survey, 1983: National Core File, U.S. Bureau of the Census, 1984.

[a] Houses rented for cash.

[b] The median income of household heads, aged 65 and over, in the 1983 Annual Housing Survey file is $10640.

TABLE 12: Median Income of Families Headed by a Person Aged 65 Years and Over, by Race, by Year[a]

Year	Median Income ($)		Ratio of Black to White Income
	White	Black	
1959	3311	1791	.54
1970	5263	3282	.62
1980	13382	8383	.63
1982	16809	9618	.57
1983			
1984	18775	11983	.64

SOURCE: Based on tabulations of data from the United States Bureau of the Census (1963) and various publications from the series: Current Population Reports (United States Bureau of the Census).

[a]Incomes are reported in current, rather than 1984 constant dollar amounts. The emphasis is not on income trends, per se, but rather the systematic relative income position of older black and white families.

TABLE 13: PERSONS 65 YEARS OF AGE AND OVER IN THE UNITED STATES WITH INCOMES BELOW THE POVERTY LEVEL, BY RACE, BY YEAR, BY EDUCATIONAL ATTAINMENT, BY SOURCE OF INCOME[a]

Year	Controls	Poverty Rates (%)		Ratio of the Black to White Ratio
		White	Black	
1959		33.1	62.5	1.89
1969		23.3	50.2	2.15
1979		13.3	36.2	2.72
1980		13.6	38.1	2.80
1981		13.1	39.0	2.98
1982		12.4	38.2	3.08
1983		12.1	36.2	2.99
1984		10.7	31.7	2.96
	Educational Attainment[a]			
	Elementary School or Less	19.7	45.6	2.31
	Five or More Yrs. College	4.9	10.1	2.06
	Income Source (Persons who head a Household)[a]			
	Social Security (SS) Only	48.4	60.0	1.23
	SSI[b] Only	77.5	98.1	1.27
	Public Assistance (PA) Only	100.0	100.0	1.00
	SS and SSI Only	70.4	86.2	1.22
	SS and PA Only	74.8	—	
	SS and Earnings Only	12.8	16.5	1.29
	Earnings & Other Income	3.0	14.5	4.83
	SS; Earnings and either: (a) Property or (b) Pension Income	6.6	21.6	3.27

SOURCE: Based on data from various publications from the United States Bureau of the Census's Current Population Reports; and tabulations of data from the Public Use File of the March 1983 Current Population Survey (United States Bureau of the Census).

[a] The data for the study of poverty and income source are for 1982 only.

[b] SSI: Supplemental Security Income.

[c] No data.

TABLE 14: UNITED STATES LABOR FORCE UNEMPLOYMENT ANNUAL AVERAGES, AGED 65 AND OVER, BY RACE, BY GENDER, BY YEAR

Year	Race x Gender			
	White Male	White Female	Black Male[a]	Black Female[a]
1960	4.0	2.8	6.3	4.1
1980	2.5	3.0	8.7	4.9
1981	2.4	3.4	7.5	6.0
1982	3.2	3.1	9.3	4.5
1983	3.2	3.1	11.8	6.3

SOURCE: United States Bureau of Labor Statistics, 1981; 1985.

[a]Black and other.

Mr. FORD. Thank you very much, Dr. Manuel.
At this time the Chair will recognize Dr. Butler.

STATEMENT OF DR. ROBERT N. BUTLER

Dr. BUTLER. I would like to submit two items for the record, Mr. Chairman, members of the committee, an essay restructuring of Medicare toward a step of universal health care.

Mr. FORD. Without objection, it will be made part of the record. [See appendix.]

Dr. BUTLER. Mr. Chairman, members of the committee, I am proud to be a member of the board of the National Caucus and Center on the Black Aged, which has set the stage for this hearing. I am a teacher in a medical school, Mount Sinai School of Medicine, and I am the chairman of the Nation's first and still only department of geriatrics and adult development at Mount Sinai School of Medicine and Medical Center.

I am codirector of the National Alzheimer's Disease Research Center. We are just 3 years old as an academic entity but I still see patients, which I always intend to do to the end of my life.

New York City, an extraordinary city, as you know, has 1 million people over 65 years of age. In New York State, 2.3 million people. New York State altogether has the highest number of black older Americans. My outpatient services program is now able to serve some 2,500 patients in East Harlem where we abut.

We have patients with an average age of 83 with multiple, complex, interacting, physical and often psychological problems.

In short, we really have an extraordinary group of wonderful patients who have many, many serious problems. It is, therefore, all the more disquieting, as I see the inadequacies of home care, of long-term care and the increasingly special plight of older black Americans experiencing, as they do, the dramatic, conscious-less cutbacks in Medicare and the impact of Gramm-Rudman.

I also see, what troubles me especially, in New York City, the increasing gentrification of the communities with not only gentrification with regard to housing, but hospitals and health care, too, where you see boutique or gourmet-type services for those who can afford them within hospitals and less than adequate care in the rest of those hospitals.

This gentrification, I am afraid, has developed a kind of set of citadels in which those of us who are more fortunate can live, can go to special private schools, can have many advantages in hospitals and health care. I wonder if this is really the shining city on the hill that someone in high public office really has in mind.

With this we see an increasing corporatization of American medicine, moving it to be perhaps more interested or increasingly interested in profits rather than interested in the direct provision of decent health and social services.

I have often spoken of what I call the longest revolution, the gain of an extraordinary 25 years in average life expectancy in less than a century throughout the industrialized world, nearly equal to what had been attained in the preceding 5,000 years of human history, from 3,000 years B.C., the Bronze Age, to the year 1900, but I

regret to say black America has not, not enjoyed the same remarkable, unprecedented gain in average life expectancy.

Certainly in no small measure as a result of the poverty Dr. Manuel so dramatically outlined, the crime victimization and the issues of access and quality of care. In the interest of time I want to get to some direct practical suggestions. First, we really must support the development of geriatrics in the United States.

I really appeal to you, Mr. Chairman, and to the members of the committee here to recognize Medicare supports graduate medical education in the United States today, last year to the tune of $2 billion—that is a "b". Not one nickel of that $2 billion has gone to the development of geriatrics in the United States.

It is little wonder that I chair the one and only department of geriatrics in the United States. We need to have effective congressional pressure upon the 127 American medical schools to ensure us that we will have adequately trained people to provide care in nursing homes, in hospitals, in outpatient clinics, and in home care programs in the United States.

Second, there should be a major expansion and support for the National Institute of Health and specifically the National Institute on Aging to study the disabilities and diseases of old age with a specific focus upon black problems.

Third, there should be a national health promotion and disease prevention campaign, again, particularly focusing upon the many special problems that black America experiences, an example, high blood pressure.

Fourth, there is a need to subsidize black medical schools, the three of them, for training in geriatrics.

Fifth, to enhance what had started but has now dwindled away, the recruitment of minorities to health careers in our country.

I am pleased that Mount Sinai School of Medicine, last time I had looked, has 14 percent of its class minority, the highest of any medical school in the State of New York.

Six, we must create an index of severity and complexity, in addition to the DRG in order to avoid the prejudicial, premature discharge called sicker and quicker and perhaps much more neglected, the exclusion at the gate, that is the subtle extent to which the physician will not admit a patient to the hospital because that hospital may be too expensive for the patient given the perspective payment mechanism of DRG and the issue of exclusion at the gate has not received the attention that sicker and quicker has.

Seventh, we must monitor the situation of black older persons living in nonminority homes, nursing homes, homes for the aged, to protect against racial abuse and examine the admission policies of nursing homes to monitor evidence or racism.

The Friends and Relatives of the Institutionalized Aging [FRIA] has presented evidence as recently as 1984, of such discrimination.

Eight, we must particularly aid the minority elderly living alone, most of whom are older women, most of whom are 75 and above, and we must help them surely to get registered for the entitlements that already exist, such as medicaid and supplemental security income, and as you know, an extraordinarily high percentage of older persons are not registered.

Finally, we need the restructuring of Medicare. When Medicare was passed into law, as you know in 1965, it was the end product of an extraordinarily difficult political climate with the adverse and negative response of the American Medical Association, and the pressure of the insurance companies.

Out of this came a program that was modeled specifically upon young people and upon those who had acute illnesses that might require hospitalization. If any of us together in this room, any 10 of us had sat down around a table to create a Medicare Program for older people, we would not have created one that didn't provide outpatient medications, essentially no long-term care and no real efforts with regard to prostheses, eyes, teeth, glasses, or hearing aids.

In short, what we created was a young person's program, a valuable one and I am not meaning to be destructive to the importance of Medicare, but not one that is derived from an understanding of the multiple, complex needs of older people such as I see them and have seen them for some 30 years.

So the proposal, which I will not present in detail to you, covers the range—the spectrum from health promotion and disease prevention all the way to rehabilitation, a rehabilitation that is geared not to the notion that older people can't get better, but geared rather to the idea that a great deal can be done for them which is true.

We run a mobility program at Mount Sinai. In fact, I just realized that Mr. Weaver is on my board of trustees at Mount Sinai. I am reporting directly to one of my bosses. We have an effort to try to assist people who have problems of falls, gait disorders, which is the No. 1 reason for admission to nursing homes. Memory loss and Alzheimer's disease is No. 2, but No. 1 is the problem of mobility.

We have to provide within this restructured medicare rehabilitation, long-term care, home care, respite care, counseling and training of the families which are, after all, the principal and extraordinary care givers in our society for older people.

Now, you asked in your opening remarks, Mr. Chairman, to not only focus upon Government, but the community and what the community can do.

I am pleased to report that I am chairing two programs for the Commonwealth Fund, an outstanding foundation, one connected with the issues of helping people remain at home as long as possible.

We have a major grant in East Harlem under the Commonwealth Fund where we hope to learn new ways of helping coordinate services that will prevent unnecessary institutionalization.

A second program is called the Commission for the Elderly Living Alone, focused upon that most at risk group, 75, 85 and above, largely women, and among them, as has been pointed out, the poorest of the poor, black minorities.

So we must have both the private sector and the Government, function together in beginning to meet the needs of older black Americans and older Americans in general, and we must do it very soon because there is nothing more clear than the fact that exist-

ent policies, both in the private and public sector, are not moving toward a solution of these challenges.

There is nothing self-correcting in anything that is presently happening today. In fact, there is an erosion of what has already been gained.

So in conclusion, I thank you for this opportunity to speak before you and my hope is that this might inaugurate the beginnings of a new sensibility in this country toward the specific needs of minority and black Americans.

Thank you.

Mr. FORD. Thank you very much, Dr. Butler.

[The prepared statement of Dr. Butler follows:]

PREPARED STATEMENT OF DR. ROBERT N. BUTLER

I am proud to be here to speak on the necessity for our country to meet the health needs of the black aged, and our failure so far to do so. I am proud to represent the National Caucus and Center on Black Aged of which I have been a member of the board since its inception. It was founded in 1970 by the late Hobart C. Jackson, Sr., and other concerned leaders to respond to the unique needs of the lower income and minority elderly, and has done so in an extraordinary fashion, during increasingly difficult times.

The 1983 National Caucus and Center on Black Aged established a committee on long term care of the black aged to develop a policy statement that would provide the basis for NCBA'S public position. This excellent and valuable report, which became available in April 1986, was prepared by NCBA intern Sydney Kathryn Allan from the New York State Office for Aging.

Increased life expectancy is one of the extraordinary events of the twentieth century. There has been what I have called a Longevity Revolution: an increase in the industrialized world of an average of twenty-five years — twenty-six in this country — in life expectancy in less than a century, — nearly equal to what had been attained during the preceding five thousand years of human history, from the Bronze Age (3,000 B.C.) to the year 1900. This unprecedented accomplishment reflects dramatic reductions in maternal, childhood, and infant mortality rates, but, also, gains in life expectancy after age 65. Indeed, since 1900, we have gained five years in average life expectancy from base year 65, 20% of the entire gain in life expectancy.

While life expectancy has increased for all Americans, blacks do not enjoy the same life expectancy as whites, although the gap between them has fortunately narrowed in recent decades. Black males have an average life expectancy of 64.9 years, compared to 71.9 years for white males, a difference of 6.6 years. Black females' life expectancy is 73.5 years compared to 78.8 years for White females, a gap of 5.3 years.

This lower life expectancy is clearly a consequence of a long history of inadequate access to health care for Black Americans, the two-tiered health care system, when access is attained, the continuing inequities of health care in the later years, and poverty.

There is high unemployment among urban blacks, and measures of black unemployment may be underestimated because they do not measure economic distress very effectively in rural areas. The occupational histories of blacks who do have jobs are likely to encompass disabling and toxic environments. Blacks also suffer from certain diseases more commonly than whites, such as hypertension and earlier onset of prostatic

cancer. Homicide, suicide, alcohol and drug abuse are prevalent and deserve special attention.

Much is made of the fact that after age 75, black Americans have lower mortality rates than white Americans. That is impressive, interesting, and important. Nonetheless, Black Americans after age 75 have greater morbidity and poverty. Poverty is staggering among older blacks. Social Security (47%) and Supplemental Security Income (10%) account for 57% of the total income for Blacks 55 years or older (1981 figures), and this demonstrates how vital these programs are to the survival of older blacks.

Black males, 65 years or older, had a median income of $5,807 in 1983. Black females, $3,995. The latter is $780 below the official poverty index for the single aged person. But it's clear how extraordinarily limited the official poverty index is — $4,979 per year, or $96 per week, is the poverty threshold for the individual. With that, one has to buy food, housing, medical care, transportation, and other necessities.

In 1984, there were 710,000 poor black aged, according to the official poverty line, but another 312,000 were marginally poor. That is 25% more than the worst poor. This is a total of 1.1 million older blacks who are either poor or marginally poor: one of nearly every two, or 45.6% of all blacks live in abject poverty or close to it, and women are the worse hit.

There are more than 2.2 million blacks, sixty five years and older who have contributed throughout their lives to this great country. Because of the Social Security reform of 1983, social security eligibility will be phased in at age 67. Given the lower life expectancy of blacks, especially black men, a significant number will not live long enough to receive the Social Security to which they have contributed all their lives. They must be helped to enjoy the longevity revolution to the same extent as white Americans, particularly in this time of increasing corporatization of medicine, medicare cutbacks (an $80 increase in the Medicare Part A Hospital Insurance deductible from $492 to $572 is projected in January 1987), diagnosis related groups, the impact of "sicker and quicker," and the less commented upon "exclusion at the gate", as well as the effects of Gramm-Rudman type thinking.

There are broad social, national, and even international issues that affect the present and future of the black aged. We must ask the following questions: To what degree has the politics of the Aging Movement taken into account the black aged? To what extent do multinational corporations give jobs to the third world and at the same time take them away from black youth? To what extent is the incomplete architecture of the welfare programs in this country become even more weakened under global economic competition? To what extent is nuclear redundancy and the unchecked arms

race likely to contribute to a continuing erosion of present entitlements?

We need imaginative new steps to deal with the plight of the black aged. Specifically, what should we do?

1. We must support the development of geriatrics in the United States. Medicare supported graduate medical education last year to the tune of two billion dollars. And yet, such funds have not gone to the support of geriatrics. Congress should make that change.
2. There should be major expansion and support for the National Institutes of Health and the National Institute on Aging to study the disabilities and diseases of old age, with a special focus on black-specific problems.
3. There should be a national health promotion/disease prevention campaign.
4. We need to subsidize the black medical schools for training in geriatrics.
5. Recruitment of minorities in health careers needs to be expanded.
6. An index of severity and complexity must be incorporated into the DRG to avoid prejudicial exclusion at the gate or premature discharge.
7. We must monitor the situation of the black elderly living in non-minority homes to protect against racial abuse and examine admission policies of nursing homes to monitor any evidence of racism. The Friends and Relatives of Institutionalized Aged (FRIA), for example, presented evidence in 1984 of such discrimination.
8. We must aid the minority elderly living alone, most of whom are elderly women over the age of 75.

It has been my privilege to chair two major programs of the foundation, the Commonwealth Fund: the Living at Home Program and the Commission of the Elderly Living Alone. The first program was a competition open to organizations within the 100 American Cities with the highest concentrations of older people to create programs that would maximize the opportunity for older people to remain at home. The Commonwealth Fund, the Pew Memorial Trust, and other foundations worked together to support twenty awardees. Special requirements were made for representation of minority communities, and I am pleased that the East Harlem community, adjacent to Mount Sinai Medical Center, won one of these awards. It is our pleasure to work directly with the community to help implement this program.

The second program, the Commission of the Elderly Living Alone is a blue ribbon group that includes Professor John Hope Franklin, Governor Bruce Babbitt, Peggy Tishman, and others. The program officer is Dr. Karen Davis of The Johns Hopkins University. Her intention is to help register those who are eligible, but unregistered, for supplemental security income.

9. We must restructure Medicare so that it is more in touch with the realities of old age. This includes the need to assure post-hospital care, which is not fully considered under the DRG strategy. I testified on February 19, 1986 before the Sub-Committee on Health and Long-Term Care of the House Select Committee on Aging, at which time I submitted a proposal for the restructuring of Medicare. I'll now resubmit it for the entire Committee and briefly highlight its contents here.

In the absence of a national health insurance, we must improve the policies and programs we now have. From a geriatric viewpoint, neither public nor private programs satisfactorily monitor the independence of the frail elderly person.

Medicare was designed for people of young and middle age when the main threats to financial security arose out of acute illness rather than chronic incapacity. But the health care needs of the elderly population is substantially different from the younger adults. A distinguishing characteristic of old age is the likelihood of multiple, simultaneous crises or losses which may be superimposed on chronic illness and anxieties about incapacity and death. Such a framework, so different from that common in the younger adult, necessarily changes the work of professionals and consequently requires a restructuring of Medicare so that it covers major geriatic needs. These needs include community-based services, long-term care, respite care, and counseling and training of the family — the principal caregivers of the at-home elderly.

We need to create a logistical effort to support chronic care services to the elderly. To accomplish this, the Medicare prohibition against funding preventive and custodial services must be lifted, and a parallel program for developing long-term care services for elderly in the community must be instituted. Biomedical, social, and behavioral research projects, such as those conducted by the National Institutes of Health, must be properly funded.

While the Medicare program can not be expected to cover the enormous gamut of societal adaptations required for the safety and care of the very old, improvements in services for the elderly could be achieved through a restructuring of the existing Medicare program and a more efficient use of resources.

Mr. FORD. At this time, the Chair will recognize Mr. Weaver. We are very honored and delighted to have you before the committee and will recognize you at this time.

STATEMENT OF ROBERT C. WEAVER

Mr. WEAVER. My testimony will be directed to the housing plight of the black elderly.

Obviously, it is a segment of the housing problem of all senior citizens. However, their conditions are more severe because of the significantly higher incidence of poverty among older blacks and the continuing racial discrimination in shelter. Nevertheless, it is within the perimeters of the housing crisis facing all low-income individuals that my discussion must be centered.

The current situation may be described as follows: more than one-quarter of American households today are unable to secure adequate housing at affordable prices. Low-income senior citizens are among the groups most adversely affected, especially black low-income senior citizens.

The principal cause of the severity of housing problems among the less affluent in general and the elderly less affluent in particular has been the recent trend toward drastic reduction in publicly assisted housing.

This has occasioned a quantitative reduction of affordable units as well as a qualitative decline in the paucity of shelter with special equipment designed to meet special needs. Homeless people and "bag women" on the streets are an ever-present reminder of the housing crisis: Their numerical increase is a symptom of the severity of housing problems confronting the poor.

For decades the largest source of housing assistance for the poor has been provided by the Federal Government in the form of rent subsidies. The largest sources are public housing and section 8. In recent years, the emphasis has been away from new construction toward assistance in the form of a certificate or voucher usually used to secure shelter in an existing dwelling.

Yet today, the gap between housing needs and housing assistance remains enormous. Four-fifths of very low income households receive no housing assistance and it is estimated that at least two-thirds of them face problems of physical inadequacy, crowding, or excessive costs. Some 6 million of the poorest households receive income assistance from welfare but this aid is rarely, if ever, sufficient to assure decent and affordable shelter to the recipients.

The prognosis for the future is even more bleak. Not only has the present administration apparently succeeded in placing a virtual moratorium upon new construction or modernization of subsidized housing, but has concurrently cut back upon public assistance targeted to utilization of the existing housing stock.

Recent efforts of the House to increase the budget for HUD and to augment housing assistance funds in the appropriations bill for 1987 faced the threat of Presidential veto. And, of course, all of these changes, which I have talked about, are preceded and become more accentuated by the Gramm-Rudman provisions to which references have been made.

With the cessation of Federal subsidies for new rental housing, shortages of low cost units have arisen in some markets and seem destined to occur in others.

The situation is further complicated by the fact that there are some 2 million privately owned rental units with Federal project-based subsidies. Expiring section 8 contracts and mortgage prepayment options in other programs will permit many owners to terminate their obligations to make affected units available to low-income tenants.

Should HUD substitute a new housing voucher for every last subsidized unit, there would still be a significant curtailment of low-cost housing units. The plan for the sale of public-housing projects, which seems to be favored in one form or the other by the administration, will produce further restrictions on the housing supply. In light of all these trends, it would not be surprising if, by the year 2000, close to a third of all households and 70 percent of very low-income households will confront problems of either housing adequacy or housing affordability.

Among those competing for a dwindling volume of housing assistance are the black elderly. Although their relative need is greatest, their access to the supply is severely restricted. The data on blacks indicates the poverty among that segment and the adverse impact of recent Federal housing policies upon this element of the population.

Continuing changes in Federal policy have generated a dramatic increase in housing and community development program participation by State and local governments, community organizations, and neighborhood groups. All 50 States and the District of Columbia have established housing finance agencies while many cities have more effective authority and programs for dealing with local housing problems. With growing State and private foundation support, neighborhood-based community organizations are increasingly involved now.

Neighborhood housing service programs are currently active in some 200 areas within 135 cities. There are also several national private organizations providing financial and technical assistance. One of the most outstanding is the Enterprise Foundation headed by James Rouse, the successful developer of the new community, Columbia, MD. His organization expects to have neighborhood-based housing developments in 50 cities before the beginning of 1987. The Ford Foundation has long been engaged in providing similar assistance.

In my written testimony I summarize a recent personal involvement with State, local, community, and neighborhood groups actively engaged in housing. There were two outstanding findings. First, the zest in creativity of those involved and the universal recognition on their part that the shelter crisis for the disadvantaged results primarily from cutbacks in Federal assistance to low-income housing.

Not only did I encounter a cadre of capable people apprehensive about retrenchment in low-income housing assistance, I also discerned recognition that a significant reduction in revenue sharing funds would further reduce their city's capacity to develop increased funding for housing of the poor. What now appears as an

almost certain cessation of revenue sharing is an even greater setback than was contemplated last summer.

The vigor which some cities and many States and communities are evidencing in assuming more responsibility in meeting the housing crisis for disadvantaged segments of the population needs to be recognized and encouraged. Already, it has produced more cooperation between States, local, private foundations, and businesses. It has also produced new approaches and a number of successful undertakings.

Increasingly, however, the greatest advances seem to be the realm of making housing affordable for upwardly mobile low-income and more affluent families. Although this is a significant accomplishment which strengthens the economic base of the city at the same time that it upgrades the housing supply, there is little evidence that locally generated revenues will be adequate to meet the housing needs of very low income families or the elderly on limited pensions or other forms of restricted income.

Those concerned with the plight of the black elderly recognize the new "movers and doers" in housing at the local level can and are doing much to upgrade the qualitative aspects of housing for segments of the population. They are, however, limited in dealing with the quantitative aspects especially for the poor. If there is adequate housing subsidy, their activities will, I believe, greatly improve the resulting shelter for all who need it.

Thank you.

Mr. FORD. Thank you very much, Mr. Weaver.

Mr. FORD. Now the committee will recognize Ms. Ellis.

STATEMENT OF ELOISE ELLIS

Ms. ELLIS. Good morning, Chairman Ford, other members of the Congressional Black Caucus, ladies and gentlemen. I am Eloise Ellis, chairperson of the D.C. State Legislative Committee on behalf of the American Association of Retired Persons. Mr. Larry White, legislative representative of AARP, is accompanying me. I am also an assessment nurse with the case management team of the Multi-Service Senior Center of Greater Southeast Washington.

Accordingly, I believe that I have firsthand knowledge concerning the status of low-income minority persons. The association, with over 23 million members, is pleased to have this opportunity to present its views concerning the economic status of older black Americans and the impact of Federal budget cuts.

Although AARP is also concerned about the health care, employment and social service needs of older black Americans, our summary presentation will focus primarily upon the economic status of older black Americans. We are, of course, simply concerned about the status of other minorities. Today, over 20 years since antipoverty programs of the Great Society, older blacks remain the most disadvantaged of Americans: poorer, less employed, less healthy, less educated, and less able to provide for themselves.

The so-called golden retirement years for black elderly are frequently anything but golden. Elderly black persons are three times more likely to live in poverty as compared to older white persons. The sources of elderly black income are primarily Social Security

and supplemental security income. Wages earned from employment and money from accrued assets such as savings and pensions are not substantial sources of income and security for elderly blacks.

However, among the elderly who earn wages, those wages are far more critical sources of income for blacks than whites because other sources are limited. Yet many blacks are not working despite their desire to do so, because they are disabled. Almost twice as many blacks as whites do not work because of illness or disability. Older blacks who work generally work longer than do older whites, perhaps due to their greater need for adequate retirement income. If adequate retirement income is attributable to factors such as lower levels of education, limited job access or tenure, lower salary levels, disability and frequently long periods of unemployment, these factors correlate to poor earning records and commensurate lower levels of Social Security or private pension benefits.

The monthly Social Security benefit for blacks is lower than whites due to the poor earning record of many blacks. Similarly, unsupplemented SSI benefits do not even provide a poverty-level income.

Mr. Chairman, one of the primary budget concerns for older Americans relates to Social Security, Medicare, Medicaid, and SSI. Budget politics is an important concern for black elderly persons because we generally rely disproportionately upon entitlement programs. Entitlement programs are 46 percent of Federal spending for 1987, and benefits for the elderly comprise 60 percent of those funds, with Social Security alone accounting for an average of 50 percent of total household income for black elderly persons.

The importance of adequate periodic cost-of-living adjustments is clear. The picture becomes bleaker when one considers that with the exception of two States and the District of Columbia, the average yearly combined benefit of Social Security and SSI for elderly black persons does not produce a poverty standard of income.

Analyses by the CBO and other Federal agencies reveal that cuts in Federal programs affecting the elderly, and the black elderly more so, have totaled $57 billion since 1981. For 1986 alone, $21 billion more would have been spent on programs benefiting the elderly, were it not for legislative budget reductions. However, the true impact of some program cuts such as housing assistance are not felt until many years later. This is frightening, since almost half of elderly households in public housing are occupied by minority persons. Further cuts threatened under Gramm-Rudman make the budget of even greater concern for older black Americans.

Huge fiscal year 1986 cuts in SSBG funds, Medicare-provided payments and low-income energy assistance funds threaten to be even higher in fiscal year 1987. Recommended solutions—solutions to problems of economic status of older black persons involve responses beyond the economic concerns raised above. However, some recommended solutions include: raise the Social Security and supplemental security income benefits to insure at least Federal poverty-level income; alternately, provide incentives to States to increase their supplemental payments; expand outreach programs serving elderly persons; establish liaison with minority community organizations assisting the elderly; expand employment and training pro-

grams for the elderly, including those with disabilities; make added cost-of-living adjustments.

The Congress should carefully consider the impact of today's decisions concerning health care, education and employment upon the economic status and well-being of tomorrow's minority elderly.

The association has also participated with NCBA at other hearings and forums around the country on subjects other than economics. Because of the importance of those discussions, executive summaries of AARP statements have been appended to today's testimony. That concludes my report. Thank you, Mr. Chairman.

Thank you, Ms. Ellis. Thanks to the members of the panel.

[The prepared statement of Ms. Ellis follows:]

PREPARED STATEMENT OF ELOISE ELLIS

EXECUTIVE SUMMARY

The American Association of Retired Persons (AARP) is pleased for the opportunity to present its views concerning the economic status of older black Americans. Although AARP is concerned about the economic well being of other minorities (that are also in jeopardy) our focus here is the elderly black population.

Today, over 20 years since the antipoverty programs, older blacks still remain the most disadvantaged of Americans: poorer, less employed, less educated, less healthy, and less able to provide for themselves. Sources of income during retirement years for elderly blacks are few and inadequate for their level of need.

Budget politics is an important concern for the black elderly because of their disproportionately high dependence on entitlement programs. Entitlement programs are 46% of federal spending for 1987 and benefits for the elderly comprise 60% of entitlement funds. With Social Security accounting for an average of 50% of elderly black household total income, while being less that 40% for whites, the impact of the budget is obvious.

The cuts in Federal programs affecting the elderly (and the black elderly moreso) have totaled $57 billion less than what would have been spent since 1981 under pre-Reagan policies. For 1986 alone, $21 billion more would have been spent were it not for legislated budget reductions. The true impact of some program cuts, such as housing assistance, are not felt until many years later. Further cuts threatened under Gramm-Rudman-Hollings Amendments only exacerbate the need for the budget to be a salient concern on behalf of all elderly persons, but especially elderly blacks.

Some recommended solutions include: (1) raising SSI benefits or supplemental benefits to ensure at least federal poverty level; (2) enforce requirements to expand outreach in programs serving minority elderly persons; (3) liaison with minority community organizations assisting the elderly; (4) adequate cost of living adjustments; (5) expanded employment and training programs, and (6) more attention to the long-range impact of budget and policy decisions.

The Association has also participated in other hearings and forums around the country with the National Caucus and Center on Black Aged. Because of the importance of those discussions, executive summaries of AARP's comments on subjects other than economics have been appended to today's testimony.

TESTIMONY BEFORE THE U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON AGING
REGARDING
INCOME, EMPLOYMENT AND BUDGET ISSUES
AFFECTING OLDER BLACKS

The American Association of Retired Persons, with over 23 million members age fifty and older, is pleased for the opportunity to present our views concerning the economic status of older black Americans.

Although our statement today will focus on older black Americans, AARP is also concerned that the economic well-being of other minorities is also in jeopardy, given greater demands upon, and less funding for social safety net programs. Similarly, we are concerned about how decisions made today will affect the economic security of tomorrow's elderly minorities.

Today, over twenty years since the antipoverty programs of the Great Society, and over ten years since the promise of the SSI Program, older black Americans are still among the most disadvantaged Americans: poorer, chronically unemployed, less educated, less healthy, and less able to provide for themselves a secure retirement, as compared to white Americans. All of this should come as no surprise to most of us here today.

I. Basic Demographics

The number of older black Americans is increasing. Living longer does not mean living better. Poor health, especially hypertension, and the possibility of being single, divorced, or widowed results in greater vulnerability. Longer life expectancy, although still less than for whites, and the higher birth rate among blacks as compared to the nation as a whole mean that the number of black elderly will continue to increase in future decades. (See Table 1)

II. Principal Sources of Retirement Income

Retirement income is linked to an individual's earlier earnings record. A retiree's earnings record is affected by such factors as education, job access and tenure, pay levels, disability, and history of employment. In comparison to the majority of older Americans today, elderly blacks generally receive lower retirement benefits because of poor earnings records that result from a history of lower paying jobs, limited educational opportunity, high illiteracy, disability, unemployment, discrimination in job access, and late coverage or noncoverage by Social Security and private pensions.

The illiteracy rate for older blacks, age 60 and above is 22 percent. Thus, it is apparent that decisions we make today regarding education and employment affect retirement security, the same way that policy decisions made in the 1920's and 1930's, (which limited opportunities for blacks) have affected the economic status of elderly blacks today. Unless we learn from the mistakes of the short sighted and sometimes prejudiced policies toward minorities of the 1920's and 1930's, we fear that tomorrow's minority elderly will be as bad off or worse given the deterioration in their health, education, training, and employment history. For example, black unemployment in August 1986 at 14.6% was over twice the rate for whites at 5.8%; black college enrollment has declined since it peaked in 1976 and 1977 for males and females respectively; and illiteracy among blacks aged 20 to 39 is the same high 22% rate that it is for today's black elderly.

Despite limitations on earning power during their working years which adversely affected retirement income, elderly black Americans rely most heavily upon Social Security benefits as the sole or principal source of household income. Although Social Security constitutes 40 percent of household income for all elderly households, social security provides 50 percent of total income for elderly black households. In addition, the average monthly benefits received by elderly blacks is lower than for whites. This average yearly benefit amount for black recipients is also below the poverty level. Thus, the availability of cost of living adjustments is particularly important to black Social Security beneficiaries.

Another source of income for elderly black Americans is the SSI program. Older blacks constitute approximately 22 percent of all SSI recipients despite the fact that blacks consitute only about 8 percent of all elderly persons. In 1985 unsupplemented federal SSI benefits totalled a maximum of $3,900 for individuals and $5,856 for couples, on an annual basis. These benefits are well below the 1985 federal poverty levels of $5,156 and $6,503 for individuals and couples, respectively. In the 22 states and the District of Columbia where there is the highest concentration of black elderly persons, SSI state supplements (1984 figures) range from a low of $24.30 to a high of $163 per month for individuals, and from a low of $23.28 to a high of $420.20 per month for couples. For individuals, only California and the District of Columbia provide supplements sufficient to bring recipients to or slightly above the annual poverty level; for couples, only California, the District of Columbia, and Oklahoma provide such supplements. Thus, black elderly persons who are eligible for SSI are particularly in need of either an increased federal SSI benefit or an increased state supplement, in order to ensure income at least at the poverty level.

Older black Americans are also less likely to have access to other sources of retirement income. In 1981, for example, 8 percent of older blacks living alone and 5 percent of elderly households derived money from accrued assets. Among all elderly persons and households, the comparable figures are 21% and 23% respectively. Similarly only 10 percent of black elderly (both individuals and households) received income from pensions as contrasted to 13 percent for all elderly individuals and 12 percent for all elderly households.

One important source of income for elderly persons is earnings. Older black households are more likely to have wages as a source of income (28 percent) as compared to 25 percent for all elderly households. Unfortunately, elderly black persons are more likely to be disabled. Significant numbers of elderly persons are prevented from looking for work because they are disabled. Among blacks they number 47%; for whites, only 28%. Despite their having a higher incidence of illness and disability as compared to all elderly persons, the proportion of black elderly working past age 70 is greater, probably because of greater need.
Elderly blacks are also less likely to participate in programs which can stretch their retirement dollars. Minority participation in the nutrition and supportive services programs authorized by the Older Americans Act is quite low compared to the level of need. This is due in large part to inadequate outreach to minority communities or services which are inappropriate for particular minority groups. Monority elderly participation in the food stamp program similarly does not reflect the level of need for much the same reason.

III. Older Blacks in Poverty

The number of black elderly persons living in poverty or near poverty remains unacceptably high. This remains true whether compared to the poverty or near poverty status among all blacks, all elderly over age sixty-five, or the population as a whole. The number of black elderly in poverty has fluctuated since 1959 from a low of .71 million, to .65 million in 1975, to .72 million in 1985. Although the poverty rate between 1959 and 1985 for black elderly persons dropped from 62.5 percent to 31.5 percent (largely due to the Social Security and SSI programs), the proportion of black elderly living in poverty today is slightly greater than that of all blacks. It is 2.5 times greater than the proportion of all persons aged sixty-five and older, and 2.25 times greater than the proportion of all Americans living in poverty.

For elderly black females, the figures are even more staggering. In 1959 aged black females with no husband present numbered 240,000 and 410,000 in 1985. These older black women constituted 19.5 percent of all aged women living in poverty. this is a rate twice that of white older women, and 1.25 times greater than the poverty rate for all American women.

In the near poverty category (i.e., 125 percent of poverty), the number of elderly black persons has increased from .854 million in 1970 to 1.021 million in 1985. Although the 125 percent poverty rate among black elderly decreased from 60.1 percent to 44.9 percent during the same period, the proportion of black aged who are at this poverty level is more than twice that of all persons sixty-five years of age and older, and 2.4 times greater than that of all Americans living at the 125 percent poverty level. The conclusion here is that while the rate of elderly black persons living in poverty or near poverty has declined from 1959 levels, the actual number of older black persons in those categories has increased.

IV. The Budget and Benefits for Aged Minority Persons
As you know, Mr. Chairman, the main stake of the aged in budget politics is in the entitlement programs, particularly Social Security, Medicare and Medicaid, and SSI. Entitlements will account for 46 percent of all federal spending in 1987; benefits for the aged comprise three-fifths of all entitlement outlays. These programs comprise the backbone of the existence of the black elderly as stated earlier. In addition, housing, energy and social service programs provide vital support to many low income older persons, especially the black elderly.

V. Past Reductions in Federal Spending for the Aged

A compilation of analyses by CBO and other federal agencies, reveals that spending reductions since 1981 in aged benefits, compared to the spending that would have occurred under pre-Reagan policies will total $57 billion in this 5 year period. In 1986 alone, spending for the aged would have been higher by $21 billion were it not for legislated reductions in spending.

The reductions in benefits between 1981 and 1986 were concentrated in the two programs most essential to the lives of elderly black persons; Medicare and Social Security. Most of the changes were included in the Omnibus Budget Reconciliation Act of 1981 (OBRA) and the Social Security Amendments of 1983. Additional Medicare changes were enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA). These reductions include Medicare provider reimbursement changes. There is growing concern about the impact these reductions are having on beneficiary access and quality of care. The negative consequences for older blacks is greater than for any other older group in America because their income is lowest.

Large cuts, given program size, also occurred in Federal social services programs. For example, federal spending for the aged under the Social Services block grant (formerly Title XX) has been lowered by approximately $150 million (25 percent) in 1986 due to prior year legislation.

Moreover, the reductions in outlays for housing assistance do not reflect the major reductions to date. A 1983 CBO study showed that 42% of elderly households in public housing (nearly half) were occupied by elderly minority persons. Because funds for housing programs are committed but not actually spent until later years, the true effects of reduction in federal support for housing assistance as reflected in budget authority will not be realized for several years. The conclusion to be drawn from this is that the housing crisis will get worse for lower-income families, especially the black elderly.

VI. Gramm-Rudman-Hollings Reductions

Over and above reductions made through the regular legislative process, further reductions have been, and are again threatened, under the Gramm-Rudman-Hollings Balanced Budget amendments. While Social Security benefits and several vital low-income programs are protected under Gramm-Rudman-Hollings, many programs crucial to the well-being of low-income elderly are not. For example, the Social Services (Title XX) Block Grant was cut by $109 million in FY 1986 and would be reduced another $190 million in 1987 if the pending Gramm-Rudman-Hollings across the board cuts were implemented. Similarly, Medicare payments to providers were reduced by $375 million in FY 1986 and would be cut another $1.2 billion in FY 1987. Low income Energy Assistance was reduced by $81 million in FY 1986 and would be cut $137 million in FY 1987.

We urge that Congress and the President adopt a fair and balanced budget reconciliation package rather than impose another round of ill-considered reductions.

VII. Some Suggested Solutions

Solutions to the problem of the economic status of older black persons involve a variety of responses beyond the budget concerns raised above. The federal SSI benefit for individuals and couples should be raised to at least the federal poverty level, or alternatively, states should be given incentives to raise their SSI supplements to insure that recipients will receive at least a poverty level income. Congress has already directed the Social Security Administration to improve its outreach efforts regarding the SSI program. We recommend that these outreach efforts should include effective liaison with minority community organizations. In addition, because older black Americans rely so heavily upon Social Security benefits as their principal source of household income, Congress should insure the continued availability of an adequate, periodic cost of living adjustment.

Funding for such programs as the Job Training Partnership Act and the Community Services Employment Program, which employ disadvantaged persons, should be expanded. Other employment demonstration projects designed to explore employment options for older minority persons (including those with disabilities) should be pursued.

Greater outreach and funding are also needed in noncash benefit programs which have impact upon minority persons, such as the nutrition and supportive services programs of the Older Americans Act, and the food stamp program.

To summarize, we must not overlook the plight of today's younger minorities who will be the elderly citizens of the 21st Century. We implore the Congress to be mindful of the long-term impact of its decisions. As we attempt to reduce the federal deficit, we must not be so short sighted as to make decisions today that will haunt us tomorrow. The proven ingredients of an adequate retirement income are adequate education, health, training, and employment opportunities.

Finally, AARP has participated in several forums and hearings around the country with the National Caucus and Center on Black Aged. Because we feel that these forums have addressed some critical areas of concern for older blacks, we have appended copies of the executive summaries for each of those not addressed in the Association's testimony above.

Thank you Mr. Chairman.

APPENDIX 1

STATEMENT OF GEORGE L. FREEMAN ON BEHALF OF
THE AMERICAN ASSOCIATION OF RETIRED PERSONS
REGARDING
HOME HEALTH CARE
May 19, 1986

EXECUTIVE SUMMARY

The demand for home health care is growing rapidly for two reasons: the size of the frail, chronically ill, and disabled population is increasing and Medicare beneficiaries are leaving hospitals quicker and sicker under Medicare's prospective pricing system still needing transition care at home.

A. Medicare does cover post-acute care, but beneficiaries are experiencing significant problems in satisfying stringent eligibility criteria. And, the scope of covered benefits is being reduced through regulatory initiatives intended to curtail growth in the use of the home health benefit under Medicare.

B. The need for home health care by older, chronically ill Americans and their families poses the greatest threat of

catastrophic costs. To obtain long term care services for chronic conditions, older Americans must spend down in order to satisfy Medicaid eligibility rules. And, Medicaid reimbursement favors institutional, rather than home care. Insurance against the high out of pocket costs for long term care is generally unavailable.

C. Besides high costs, consumers face the lack of uniform and effective reguletion of the quality of care offered by home care agencies. Consumer protections are generally weak or nonexistent.

The American Association of Retired Persons recommends the following responces to these problems:

1. Existing regulatory efforts by HCFA and its intermediaries to arbitrarily and capriciously deny Medicare beneficiaries access to home health benefits must be stopped. Eligibility standards and scope of services should be broadened and clarified to meet the growing needs of beneficiaries for post-acute care. Patient eligibility for post acute care services should be determined prior to hospital discharge and should be binding on Medicare's fiscal intermediaries.

2. Chronically ill, disabled, frail and mentally ill persons need access to a broad range of coordinated and affordable long term care services. A prospectively paid case managed system could provide these essential linkages between medical and social services in a variety of settings.

3. American families need protection from the catastrophic costs associated with long term home health care services. Some combination of private and public long term care insurance must be developed to end the forced pauperization of American families needing chronic care services.

In sum, Medicare beneficiaries need protection against premature hospital discharge into a no-care or inadequate care zone. They need improved access to home based care for post-acute and chronic conditions. They need insurance protection against the financial cost of long term care. And, they need protection against substandard home health care.

APPENDIX 2

STATEMENT OF REBECCA McCLOTHEN ON BEHALF OF
THE AMERICAN ASSOCIATION OF RETIRED PERSONS
REGARDING
CRIME AND THE ELDERLY
August 18, 1986

EXECUTIVE SUMMARY

The American Association of Retired Persons has developed programs designed to deal with the tremendous problem of crime and its effects on older persons in large and small communities. Because crime has a unique and exaggerated effect upon the lifestyles and emotional well-being of older victims, it has consistently been cited by older Americans of all races and income levels as one of their major concerns.

In 1982, AARP instituted its Criminal Justice Service (CJS) which studies problems of crime and the elderly in conjunction with programs aimed at reducing criminal opportunity. In addition to violent crimes, older persons are favored and hence principal victims of crimes such as criminal fraud, strong-arm robbery, purse snatching, theft of checks from mailboxes, vandalism, and harassing phone calls.

Being old not only increases the chance of being a victim, it can magnify the effect, even for those who have not been direct victims. They frequently become prisoners in their own homes due to fear of being on the street, especially older females. One successful CJS program was an instruction course for peace officers and sheriffs on how to respond to the special needs of older persons and using them as community crime prevention volunteers. AARP volunteers also work with law enforcement departments to set up public services like residential security serveys, crime prevention seminars, telephone lifelines, and other police support roles. AARP volunteer groups have also conducted seminars informing older persons how to best prevent crime (both personal and community), as well as establishing working rapport with legal organizations, legislative bodies, and law enforcement institutions. Finally, AARP publishes pamphlets and books on crime issues of concern to older persons, and has developed resources and information used by federal, state, and local officials.

The Association's CJS recognizes and has begun to focus on the fact that urban crime has the most severe impact on minorities. CJS is emphasizing training at police academies with high percentages of blacks and other minorities, including women. However, we need more information and education on how our resources can best serve urban and minority communities. AARP welcomes the opportunity to learn from and work with other groups and government officials interested in combatting the great problem of crime and older Americans, especially older minorities.

APPENDIX 3

STATEMENT OF MARY SHIELDS ON BEHALF OF
THE AMERICAN ASSOCIATION OF RETIRED PERSONS
REGARDING THE
OLDER AMERICANS ACT REAUTHORIZATION AND SUPPORTIVE SERVICES:
A BLACK ELDERLY PERSPECTIVE
September 19, 1986

EXECUTIVE SUMMARY

The American Association of Retired Persons (AARP) strongly supports reauthorization of the Older Americans Act (OAA). Although many elderly persons enjoy a better quality of life today because of services provided under the Act, we can do better--especially regarding older blacks and other minorities. As funding for social service programs declines in the face of increasing demand, the OAA becomes a more critical focal point for disadvantaged, vulnerable, and minority senior citizens. The aging services network should be strengthened to ensure that each component is able to effectively execute its mandated functions. This means that the Act should continue to target services to special populations like older minorities and the vulnerable elderly while allowing sufficient state and local flexibility to meet needs. AARP wishes to respond to existing proposals on OAA reauthorization and also recommend improvements that would better serve all of the nations elderly population. The Association will also comment on other older American volunteer and supportive services programs.

A. In view of declining participation by minorities in Title III programs, AARP believes the OAA should state affirmatively that older minorities are a priority group for receiving services, and that those services should be provided on the basis of need for those services rather than on proportion of the total population. Similarly, we urge federal, state, and local offices on aging to take affirmative steps to promote minority participation in service planning, training, administration, and contracted delivery.

B. The Association does not support raising the age threshold for allocating funds from age 60 to 70 under Section 303. This change in the allocation formula threatens support for the real health, nutritional, and social needs of those persons in their sixties who are presently served, especially minorities who are in greater need than non-minorities but disproportionately do not live to age 70.

C. AARP also supports retention of the requirement to spend "an adequate proportion" on supportive services and continuation of Legal Services as a priority service. Because many AAA's provide only de minimus funding for legal services (20% provide no funding), AARP recommends requiring at least 6% of the amount alloted to the AAA for Part B to be expended for each priority service.

D. The Association opposes consolidation of Title III nutrition and supportive services. Sufficient flexibility currently exists to shift funds between programs to meet varying local need.

E. AARP supports better coordination of services to Older Native Americans by eliminating overlap and administrative complications in Titles III and VI.

F. The Association opposes consolidation of Title IV into a single pool of monies because of its support for a broad approach to improving service, planning, and management under the Act. We further recommend awarding capacity-building grants that enable minority organizations to better compete for Title IV awards rather than granting preferential set-asides.

G. AARP recommends raising the administrative cap on Title V (Senior Community Service Employment Program, which has disproportionate minority participation) from 13.5% to 15% to ensure continued unsubsidized placement and expand job development activities.

H. The Association supports emphasis on serving the "vulnerable elderly" when such targeting is not at the expense of disadvantaged persons with great service needs but not technically within the definition of "vulnerable."

I. With resurgence of interest in voluntarism and increased opportunities, older blacks have given generously of their time and talents. The Older American Volunteer Programs (OAVP) administrated by ACTION includes Retired Senior Volunteer Program (RSVP), the Senior Companion Program (SCP), and Foster Grandparents Program (FGP). Black participation in FGP equaled that of whites at 42.4%. In SCP, blacks are 65.2% versus 30.4% for whites. However, in RSVP, blacks are 12% compared to 85% for whites. The popularity of FGP and SCP over RSVP is because they make volunteering affordable by providing a $2.00/hr. stipend, transportation assistance, meals while serving, insurance benefits, and an annual physical examination. RSVP participants only get reimbursement for out-of-pocket expenses while volunteering. The Association supports the current emphasis on participation by stipended volunteers as was the original intent when these programs were enacted.

J. The Community Services Block Grant (CSBG), formerly Community Action Program has served as a critical source of funding for programs to assist low-income persons. Block granting has meant reduced funding for many community programs including those aimed at poor older minorities. Currently CSBG funds defray administrative costs for programs like weatherization, energy assistance, and outreach. However, other programs serving poor elderly blacks such as Community Care and Development Services have gone out of business. Fixed funding levels do not take into account increased service needs thereby resulting in a net loss of services. AARP feels there should be reporting requirements (now eliminated under the block grant) on participation in programs provided or supported by the CSBG.

Conclusion

The Association reaffirms its support for reauthorization of the Older Americans Act and urges prompt action on this important legislation. We further support continuation of Older American Volunteer programs under their original mandate, particularly paid stipends. Finally, we urge more support for programs benefitting older low income citizens through the Community Services Block Grant.

APPENDIX 4

STATEMENT OF FRED BELL

On Behalf of

The American Association of Retired Persons

Regarding:

Health and Longterm Care Concerns of Older Black Americans

September 26, 1986

Executive Summary

The American Association of Retired Persons is concerned that the health and longterm care needs of older black Americans are not being adequately met by this nation's health care delivery system. Statistics indicate that older black Americans have lower average incomes and suffer from a higher incidence of chronic diseases and disability as compared to older whites. Thus, Medicare's gaps in coverage and cost sharing provisions may have a disproportionately negative effect upon older black persons.

Blacks generally receive less health care services (and correspondingly lower reimbursements) under the Medicare system. They visit a doctor or dentist less often as compared to older white individuals. The system also penalizes the poor and near poor because it reimburses primarily for acute care, and excludes from coverage such items as routine physical examinations, prescription drugs, vision or dental care. These gaps in coverage result in substantial out-of-pocket cost to low income beneficiaries who may simply be forced to go without such services. In addition, increasing deductibles as well as insurance copayments impact heavily on older black Americans, a substantial percentage of whom do not carry Medicare supplement insurance.

Data is also needed to assess the effects of the Medicare prospective payment pricing system upon minority individuals. Variations between states relative to the treatment provided for particular conditions or symptoms also need to be analyzed.

The Medicaid system, which is the primary payor for nursing home care has also underserved older black persons. Although blacks are more dependent upon the Medicaid system than are older whites because of their high poverty rates, approximately 70% of Medicaid reimbursements are made for nursing home care (principally for older, white widows). Additional data is also needed regarding the racial impact of Medicaid eligibility rules and the extent to which minorities are adequately served by community-based health care programs such as those authorized by the Older Americans Act.

Mr. FORD. At this time the Chair will recognize Mr. Saxton.

Mr. SAXTON. Thank you, Mr. Chairman.

Let me suggest to you at least that I appreciate very much the very vivid description and the way in which you have outlined the problem which faces minority members of the elderly community, particularly in the case of Dr. Manuel and Dr. Butler, and the other two witnesses as well, whose personal experience in not only study but in practical application of treatment of older Americans, both minority and nonminority members, were very, very enlightening, to say the least.

I am wondering, through your experience—and I would like to direct this question to Dr. Manuel and Dr. Butler and certainly Mr. Weaver and Ms. Ellis can comment as well—through your studies and through your personal experience in dealing with the problems of the black elderly, have you come across any situations in certain areas of the country or in certain cities or certain programs that you feel have been most beneficial to minority members of the older American community, perhaps in terms of a regional effort that has been put forth by a municipal, or State government or a special program that has been most effective through the Federal Government?

And if you could answer the question in the sense that perhaps we could use that as a springboard to develop other programs which might be more beneficial, perhaps, than things we are doing now. If you could respond, I would appreciate it.

Dr. MANUEL. On the basis of looking at some of the data, as far as region, if we can say that programs have had an impact, I would say that regions other than the South. When you portion out or control under region of the country, the South still comes in as an area where you get some of the major discrepancies between the conditions of older blacks and whites.

In terms of programs, my own opinion is that the programs have as a unit certainly—you can look at the statistics over time and see that they have in an absolute sense reduced the problems of the minority and nonminority elderly. The problem is that over time the gap has widened, so that one way of looking at this is that you have greater and greater numbers of impoverished older blacks who are increasing the disadvantaged black group and therefore accentuating the problem.

This is why I emphasize the greater numbers, because the more you have and the problems relative to such as the older population is going to become more dispersed. I would say that the impact in an absolute sense has made a difference in terms of reducing the gap. I don't see a great deal of evidence of that.

Mr. SAXTON. Before Dr. Butler answers, let me give you a specific that I happen to be familiar with, which I think has been fairly successful in my home State. A number of years ago our State constitution in New Jersey was amended to permit casino gambling in Atlantic City. And when that program was instituted, all the funds which the State benefits from through that program were dedicated to programs of benefit to senior citizens, without regard to race or color.

Through that program we have been able to institute lower property tax for senior citizens and low-income groups who qualify,

drug prescription programs to provide drug prescriptions for low-income senior citizens who qualify, a program called the Lifeline Program to help for utility costs for low-income seniors who qualify.

To me, that has been a successful approach. It was a unique source of revenue, I admit, but I am curious to know whether other States have adopted those types of programs or whether you know of anything we could do on a national level to provide services such as that.

Dr. BUTLER. I am not personally familiar with such. In response to your question, I have a few thoughts that I might share, that we should not underestimate the profound importance of Medicare and Medicaid to enhancing the health care of older people. Since 1965 there has been a dramatic increase in life expectancy. With the increased deductibles and the cutbacks in Medicare, we are beginning to see increased infant mortality rates, some decline in average life expectancy, and there are data to suggest an increasing rate of suicide among older Americans.

It is not well understood that over 20 to 25 percent of suicides committed in this country are committed by people over 65. The value of home care, the home attendant program in New York City, the Visiting Nursing Service and other examples throughout the State of New York illustrate how valuable home care can be.

In response to your question about various novel programs in New York State, we have the Nursing Homes Without Walls, which is a means by which persons who might otherwise have had to be institutionalized can remain at home through provision of in-home services. It has been marvelous for me as a teacher to see home conditions of older people, to see the medicine in the medicine cabinet and their food in the refrigerator.

I mentioned in my earlier remarks the Commonwealth Fund, the foundation's efforts, the competition of America's 100 cities with concentration of older people to participate in these awards of the Living at Home Program—it drew out a number of hard-working coordinating service agencies both for minority and nonminority throughout the cities of our country in trying to create conditions to help people stay at home, and our hope is that we will be able to pull together that information, much as Dr. Manuel has been doing, and make it available.

I think in that there may be some success stories, which I think you are looking for, because we do have to profit from success, as well as lament ineffective programs.

Mr. SAXTON. With regard to Medicare and in particular home health care, it is my understanding that the legislation authorizing Medicare does make a provision for reimbursement for home health care; is that correct?

Dr. BUTLER. Yes; but what has happened is there has been severe capping and cutbacks within the administration, so at the very moment that prospective payment has been introduced to help people move out of hospitals faster; there is less after-care service. We do have entitlements under Medicare for home health services.

Mr. SAXTON. Would it be more efficient to provide home health care rather than to find an individual who may be ready to leave the hospital but not quite ready to go home, who ends up with a

stay of some length in a nursing home; wouldn't it be more efficient for the system to make a better utilization of the home health care opportunity?

Dr. BUTLER. In a general sense. We must not only think of cost but also the quality of life issue. But you are on the right track, the importance of the choice being able in the individual situation by the figures, the social worker and the patient and family. For example, I have long thought that if we had a kind of circuit-breaker mechanism we might be able to make a jump beyond the fear that is obviously prevalent within the health and human resources department, that if we were to provide home health care we would break the Treasury. Realistically, there are patients whose needs become so enormous that to maintain them at home is not realistic.

On the other hand, there are those who, unrealistically, are kept in hospitals or institutions, so if we had a means of signaling at some point, like when the cost of home care reaches 75 percent of the prevailing cost for institutional care, that there will be an assessment and valuation. Your idea would be applicable, that one would make major judgments in individual cases as to what is in the best interest of the patient and the family, in this instance to go home or not.

Mr. SAXTON. You mentioned something which Congresswoman Bentley and I were discussing briefly just before she left with regard to the length of stays in hospitals. The new DRG system has certainly shortened those lengths of stay and I don't have to describe to you what that means. The "quicker and sicker" release has been overused many, many times.

But with regard to that, is there any difference [illegible] in the consideration given by HHS to an elderly person and the length of stay an elderly person might need to become well from an illness as opposed to a younger person? Does HHS make that distinction in the DRG system at all?

Dr. BUTLER. Not to my satisfaction, which is one of the reasons that I recommended in my recommendations the creation of a special index of severity or complexity. When you get to be 75 and above, unfortunately, you frequently have four or five diseases, not just one. So to be paid for just one makes you very unattractive to a hospital either on admission or for more rapid discharge.

If we had a measure of complexity and severity that would be protective of patients, then we would have a real indication from the Department of Health and Human Services of their concern, not just oral expressions of concern. So I think we need such an index as part of the DRG process itself as a direct protection to patients and families.

Mr. SAXTON. Thank you very much, Doctor.

Mr. Chairman, thank you.

Mr. FORD. Dr. Butler, let me continue on the line of questions from Mr. Saxton. You have often stressed that Medicare appears to be designed more for doctors and other health care professionals, but Medicare lacks an effective approach to the response of long-term care at least for older Americans. I happen to serve on the House Ways and Means Committee, with a portion of the jurisdiction of the Medicare Program. As a matter of fact, we have a

scheduled meeting this morning on reconciliation dealing with part A and part B of the Medicare Program.

If you were to design a comprehensive long-term care program of benefit under the Medicare Program, how would you structure this program? I am going, I guess, beyond the Aging Committee here, but as one member of the Tax Committee with jurisdiction over the Medicare Program, certain portions of it at least from the revenue side of it, I would like to know how would you structure that.

We have the AMA and the physicians all riding the doors of our committee rooms today wanting us to make sure that we protect the providers and all, and they really want us to protect the physicians. I would like to know, how should we, even from the Aging Committee, make recommendations to committees like the Ways and Means as well as the Commerce Committee, the other part of the jurisdiction of the Medicare Program?

Dr. BUTLER. First I would say that my view is that the restructure of Medicare cannot be handled by financing alone; that is to say, we really have to have a vision what we as a society want, and what we want for our present-day elders, and for our future older people, which is everybody in this room. I have in mind the fact that we have to structure a program that places doctors in a little different perspective. As you get older, you are not just—I am not just a collection of organs and body parts. We are a totality.

We have nursing needs and we are depressed over what is happening to us. We are looking forward to a granddaughter's wedding. All of these things relate to the way we are as human beings and it is not medicine alone that can serve those needs, so we have to have a meaningful comprehensive system with an egalitarian relationship between the providers.

The next question is how can we afford to have this kind of effective comprehensive system. It is my view that we have a lot of money that goes into the health care system.

Mr. FORD. How do we structure a plan that the providers are not dominant factors over the long-term care program? How do we focus to the beneficiary versus to the provider?

Dr. BUTLER. It is not going to be easy, but I think we have to have a strong cost containment which does not find its way ultimately to the disadvantaged or to the consumer, but does control the way we as physicians function. We generate 70 percent of the costs, even though our income doesn't derive from that, per se. I could go through a line-by-line discussion of cognitive payments versus procedures. If I had a procedure, I would get a specific amount of money each time and reimbursement for doing it.

If I spend time with elderly people for a careful comprehensive assessment and follow that patient over time, referred to as management, the reimbursement is extraordinarily modest compared to procedures without any new money being put into the system. There is no reason we can't move toward paraprofessionals doing the procedures. We are going to have to, without any new dollars in the system shift to a care approach that speaks to the team, that pays the team as a whole, including the nurse and social worker, and that is oriented toward care as much as cure, and which begins to tighten the ropes around the extent to which surgical and procedural specialty medicine and high technology medicine is operated.

I have great respect for those branches of medicine but I am saying there are ways to control those costs. I am not sure I will get out of this room alive——

Mr. FORD. Is that getting close to HMO's?

Dr. BUTLER. My worry about HMO's is that it can become very important to save money again. I am not disrespectful—I grew up in the depression, so I have a lot of respect for how important the dollar is. On the other hand, with the advance of business into medicine, including the business profit-oriented HMO's as well as the nonprofit, something like 8 to 10 percent of the money is going to come out of the system, not to providers and patients, but to corporate shareholders. So I think we have very real problems with HMO's as well as other innovations, as to how they will ultimately be conducted.

Mr. FORD. Dr. Manuel, Hispanics often complain that the Census Bureau counts understate their numbers and the extent of poverty among Hispanics. Would you say that the undercounting is a problem among the elderly blacks, and, if so, what impact, if any, would it have to the poverty figures of elderly blacks; not only I guess with Hispanics, we have heard that from other ethnic groups as well.

Dr. MANUEL. There is an undercount, as evidenced by the Census Bureau itself, not only the Hispanic population but other minority populations. My reading of the impact would be because the numbers and the types of rather descriptive statistics that we are using to talk about the poverty rate, and some of the other summary measures that we make in order to characterize the status of the black population, because of the numbers, the magnitude of the numbers, my own opinion is that it is doubtful that there would be much change in our overall conclusions because minor changes in those numbers—sure, there is an undercount, but when you are talking about magnitude of numbers in terms of size of this population, I don't think they are really going to affect our basic conclusion.

Mr. FORD. You don't think that would impact the basic conclusion of those numbers?

Dr. MANUEL. No; for pure statistical reasons.

Mr. FORD. How does it impact the black elderly population in general as it relates to programs in general?

Dr. BUTLER. Since Federal funding is based upon population, wouldn't any underestimation have some profound effects——

Mr. FORD. If the undercount is there, what is the impact of that? Because when we see the Federal agencies and you see the Federal programs in many instances it does in fact interface, impact it directly, oftentimes, on the number.

Mr. WEAVER. I think two things should be said in that connection. The undercount of the black community is somewhat different in its cause and its nature from that in the Hispanic. Hispanic, it is a matter of definition. Up until 1930 we didn't have any Hispanics. All Hispanics were white--at least that is what the Census said. Then it was found out that they weren't, and there was a change, and they began to ask to be counted. Then there is a definition of what is a Hispanic, and many Hispanics count themselves as white,

services to acquaint and help the elderly find resources that are available. Volunteers could be trained to work with the elderly in given communities. In this same vain, churches could create senior citizens clubs that could have recreational, cultural, and entertainment components.

In the third place, there is a vast need to decrease the loneliness and isolation of thousands of Black elderly people. Here again, church volunteers could provide companionship in rest homes, hospitals, and private homes by reading to, and writing for elderly people. An "adopt a grandparent" program has been helpful in some churches around the country.

Finally, churches need to recognize more and more that many older people have talents that are unused, and have the ability to do many creative things. In all too many instances, and because of inattention, the fine talents of many older people are never utilized.

The words of Hubert Humphrey have an eternal meaning. "The greatness of a nation is determined by its treatment of its underprivileged, its youth, and its elderly."

Mr. FORD. Thank you very much, Reverend Kilgore.

Mr. McGee, you are recognized.

Mr. MCGEE. Thank you, Mr. Chairman. I would respectfully request the written testimony of my president be entered into the record.

Mr. FORD. The testimony of Mr. White will be entered into the record.

Let me say for the record the Chair would like to announce that this is a formal full committee, Select Committee on Aging public hearing, therefore, during that process will not entertain questions from the audience to witnesses.

But the Chair will, in fact, adjourn this session and also ask Mr. Simmons of the National Center of the Black Aged to Chair the workshop, to entertain questions from those who would have questions to the panel or those who would like to make statements.

In the past, we have had non-full-committee joint hearings with the Congressional Black Caucus. We are trying to keep within the House rules and guidelines to make it formal.

I am very delighted to have this opportunity—I see the chairman of the full Committee on Aging has just entered the committee hearing room, and I would like to say that without his leadership, without his foresight and without his commitment in the areas of the plight of the black elderly, the crisis in black America, and without his vision as chairman of this committee, one that has offered the leadership in the past and one that I am confident that will continue to offer the leadership and continue to bring the critical issues of the elderly, and especially the black elderly to the House floor, and to the attention of our colleagues in the Congress, as well as to the American people.

I am just happy and delighted to bring to you at this time my dear friend, a great American and chairman of this Aging Committee, Chairman Roybal.

The CHAIRMAN. Thank you, Mr. Chairman.

I will not take the time of the committee to read a prepared statement. I ask unanimous consent that the statement be considered as read and placed in the record.

Mr. FORD. It will be made part of the record.

The CHAIRMAN. I would like to compliment our distinguished chairman for holding this hearing and at the same time apologize for being late. I was on the floor of the House due to the fact that just last week we were able to defeat a so-called immigration reform bill, but a bill that in effect is designed to bring a steady flow of cheap labor into the United States.

We feel that that is one way of exploiting a large segment of our population. We feel it is discriminatory, that it would result in discrimination against not only those who come into the United States illegally or legally, but against those of us who were born here, are American citizens and once discrimination starts with any particular group—it does not matter what group it is—it will finally get to us and get to other groups.

One has to stop it somewhere. So I stayed on the floor because I felt that they would bring it in with some kind of gimmick and they did not. We were able to have an hour's discussion on the subject matter.

The gentleman from Texas, Mr. Gonzalez, asked for an hour's time, which he got. We discussed the entire problem. We were satisfied that no more action would be taken.

That is the reason why I am late. But I want you to know that I understand and I am quite sympathetic with what the Congressional Black Caucus is doing.

We work very closely together. We work closely together because what affects the black community of the United States will affect the Hispanic community and every other so-called minority in this Nation.

Again, I think that we have to do a great deal more about the concentrated effort in working closer together, not necessarily being so involved that we lose sight of one another's mission, but making that particular mission a target for both the Hispanic and the Black Caucus, that each caucus works separately and independently toward that same goal and cooperate when we have a hearing such as this where we possibly can be sure that we let one another know that we are working together toward the same objective and that we are going to prevail.

I thank the gentleman for this time.

Mr. FORD. Thank you, Mr. Chairman.

Thank you, once again, for your very able leadership in the area of aging and especially for the black elderly.

Thank you very much.

I would like to pose one or two questions, I guess. I do have to leave myself. The conferees on the budget reconciliation of Ways and Means and the Senate Finance Committee is in session now. I see my tax counselor over there looking at me real funny.

I am going to try to stay put. I am going to, when I finish recognizing the members and a couple of questions, adjourn the official formal session and at that point ask Mr. Simmons to come to take over the Chair and let us have a dialog with the participants who are here so we can have a continuation of this session with other questions and other information that is needed to be said and talked about at this legislative weekend.

Dr. Henry, you know, you talked about—I missed the first part of it—but you talked about those hogs that are in a group and you would think they were all gathering around each other to keep warm and you mentioned each individual hog is there, you know, to protect himself.

But in today's world, is it possible for advocates for the disadvantaged to form coalitions with better-healed interest groups that are somewhat successful or are we in a world where interest groups look out for their own interests or risking a risk suffering budgetary problems or defeat for themselves?

Is it possible now—I am using, I guess, the story that you told about the hogs—but is it still possible for those interests and advocate groups——

Dr. HENRY. I think so. For some one to look out for his own interests in that activity, he looks out for other people's interests. It is almost impossible to take care of yourself without providing a service for other people.

If we look at it from that standpoint, I certainly think it is.

Mr. FORD. I want to agree with you because there are so many things we are doing and I think Mrs. Dorothy Height talked about it and touched upon it earlier.

You know, the things that we are working with in welfare reform and the issues that you have been in the forefront on children, having children, you know all impact us at one point or another. I guess like Dr. Henry said earlier, you really have only one alternative to being elderly, unless you are willing to give up that life and die young.

I think what we have been focusing on, whether it is the teenage pregnancy problem or the welfare reform issues that is before the Congress, all impact us at some given point and I think that coalition of those advocacy groups should, in fact, work tirelessly on behalf of the issues that we know that we are confronted with, because if god continues to give all of that strength, those of us who have not reached that age, at some point we are going to be there unless that unfortunate thing happens that is called death.

Dr. HENRY. Let the church say amen.

Mr. FORD. Mr. Kilgore, what can be done in terms of public policy to make it more attractive for black institutions, institutions such as the black church that you have so eloquently talked about here today, to understand that? What else can they do to undertake a lot of the service programs for the elderly and institute those programs throughout our community and make sure that we tap all of the resources that are now available to the elderly that oftentimes you will find it very true that our communities have been late in receiving the information and oftentimes when we learn the process and think that we are ready to be participants within the program of the game itself, oftentimes programs are dismantled or eliminated.

So how can we be strong advocates from institutions like the black church and other community-based organizations that we can stay in the forefront?

Reverend KILGORE. I think we have got to remember first we are all in the same bag, so to speak, and we are all on the same team.

Dr. Abernathy gave an illustration years ago in this line. He said there was a man that had some excellent fighting cocks and he got them all together to take to a place where there was going to be a contest with another person that had fighting cocks, put them all in the same cage. But on the way there they created differences between themselves and started fighting and when they got there to put them against the others they had knocked each other out.

He said he just stood there and looked at them and said they forgot they were all on the same team. I think we have got to understand we are on the same team, the Federal Government, the churches, the social institutions, the health care institutions.

I think we are all on the same team in America. We have got to be able to generate the kind of connections that will help to alleviate these problems. In some areas we have done it.

It has been done better with children. The church that I have recently retired from 20 years ago established a child care program sponsored at that time by the Social Security Department and the Agriculture Department.

Now, it is sponsored by the State department of education where it puts into that place where we take care of about 110 children, $500,000 a year.

It has made a difference. We have tracked some of those children all the way from that place into college. We have got to begin to form these kind of connections where we do not violate the separation of church and state—in a sense, we ought to separate it, but I understand the legal terms there—but we have got to begin to do that so there can be partnerships between the Federal Government and clusters of churches or church organizations and other kinds of community organizations in solving the problems of our community.

That is the reason I say that we in the church must lobby, must deal with you in the Federal Government and others in the State government until we can see that we are all on the same team and we must preserve and take care of our elderly people like we take care of our children and other people in this country.

Mr. FORD. Thank you very much.

I don't want to rush to conclude this session, but Mr. Chairman, I have other commitments and I think the audience would like to participate. I would like to personally, on behalf of the Select Committee on Aging and on behalf of our distinguished chairman of the full committee, thank all of the witnesses who have testified in responding to questions from the committee.

I would like to thank all of my colleagues who have participated on the select committee session today and also all of the participants for the 16th annual legislative weekend of the Congressional Black Caucus for coming to the Nation's Capital, being a participant on this aging session today and would like to close out at this time formally the select committee.

As acting chairman of the committee today, I would like to adjourn the session and turn this over to Mr. Simmons at this time to continue the session itself, not the aging committee, but the Congressional Black Caucus workshop.

So at this time the Select Committee on Aging has adjourned.

[Whereupon, at 11:45 a.m. the hearing was adjourned.]

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APPENDIX

PREPARED STATEMENT OF LOUIS W. SULLIVAN, MD, PRESIDENT AND DEAN THE MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA, ON BEHALF OF THE NATIONAL HEALTH COALITION FOR MINORITIES AND THE POOR

Mr. Chairman and Members of the Committee, thank you for the opportunity to offer our comments on a devastating problem encountered by many of our nation's black elderly individuals.

I am Dr. Louis W. Sullivan, President of the Morehouse School of Medicine in Atlanta, Georgia, Vice President of the Association of Minority Health Professions Schools, and Coordinator of the National Health Coalition for Minorities and the Poor. This national health coalition was formed by the Association of Minority Health Professions Schools and a number of other organizations deeply concerned with the problem of inadequate, or in many cases, inaccessible health care for our nation's poor and minority citizens. The serious lack of medical treatment provided to our society's black elderly individuals is a problem with which the Coalition is all too familiar. We believe that many Americans are unaware of the vast dimensions of this problem. To us, there seems to be no other explanation for why so many citizens who have so much to contribute to our society, should be living their lives without adequate medical care.

In August 1985, a Task Force appointed by the Secretary of the Department of Health and Human Services reported a significant gap in health status among the nation's blacks and other minorities when compared to the nation's white population. The Secretary's Task Force reported that annually in the black community, almost 60,000 excess deaths occur because of the disparity in health status. Evidence also indicates that the problem is growing, not getting better. Unfortunately, in the face of this widening disparity, Medicaid and Medicare cost-cutting maneuvers have resulted in reduced access to care for many black elderly individuals.

Today, this problem of reduced access to medical treatment

is further exacerbated by the growing problem of hunger among the elderly in our society. For example, it has been estimated that at least 65% of the elderly persons admitted to hospitals have serious nutritional deficiencies. Weight loss, dehydration, and malnutrition are only a few of the many problems resulting from inadequate food in-take. For instance, hepatic failure, chronic infections and a number of other diseases are associated with an insufficient food supply. Medical care and treatment becomes extremely costly in that nutritional deficiencies, and the diseases associated with these deficiencies, require weeks and sometimes months to remedy. Consequently, tha National Health Coalition for Minorities and the Poor urges that funding for Medicare and Medicaid programs be increased, or at the very least, funded at their current FY1986 levels. Furthermore, the Coalition urges increased funding and support for nutrition assistance programs, such as those contained in the Food Security Act. In addition to improving the quality of life for many Americans, these programs are cost-effective because they minimize the need for recurrent treatment and hospitalization due to illness and disease associated with nutritional deficiencies.

Only by increasing access to medical treatment and nutrition assistance program, for our nation's black elderly, can we hope to solve this tragic crisis of malnutrition and inadequate health care among our nation's elderly black citizens.

Thank you Mr. Chairman, for this opportunity to present our views, and we applaud you for holding this important hearing.

PREPARED STATEMENT OF DENNIS H. JACKSON, GENERAL MANAGER,
DEPARTMENT OF AGING, LOS ANGELES, CA

Honorable Congressman Ford, Members of the Committee, I am Dennis H. Jackson, General Manager, Dept. of Aging, City of Los Angeles—an area agency on aging. It is indeed a pleasure for me to participate in the festivity of the Congressional Black Caucus and to address the "Plight of Black Elderly".

During the course of these proceedings you will hear various revelations that portray the plight of black elderly. These will take various formats—anecdotal presentations, personal experiences, vignettes of a time gone by, attacks on the administration, and countless others.

Because of this, I would prefer to offer you a different perspective of the plight of black elderly. I would like to talk about the perpetuation of discrimination against older black persons by legal, legislative, and executive manipulation of an effort to free all Americans regardless of race, creed, color, national origin, sex, or age.

Some twenty years ago, your colleagues, the Congress of the United States, in its infinite wisdom, saw fit to insure and assure the right of older Americans to live out the remainder of their years with dignity and independence. The culmination of their deliberation was the Older Americans Act of 1965. The language of the original enactment talked about all older Americans. It talked about the need for a conscious awareness of the plight of those who got us where we are now. As the older Americans Act evolved through triangle amendments, it began to address the special needs of "ethnic minority, those in greatest social or economic need, and low income minority seniors." The worlds of the Older American Act ring out with the resonance of the Star Spangled Banner, The Gettysburg Address, Martin Luther King's I Have A Dream, and even the Pledge of Allegiance and the Preamble to the Constitution. But Mr. Ford, those words of the Older American's Act are only solace to black elderly while they are black young. As they begin to age, the words of the Older American Act become more difficult to eat as the grinders lose their sharpness; the words become more difficult to see through the dimming windows of life; more difficult to hear because of the external noise pollution of political rhetoric.

You see, the black elderly are sensing the absence of the necessary ingredient in the Older American's Act to give it real sustenance—follow through by the Congress.

As we languish here today and talk about our past accomplishment through the Older American's Act, the state legislative and administrative bodies are methodically and systematically eroding, prostituting, and even

bastardizing those words. My state, the golden state of California, has enacted legislation to insure "preference to those in greatest social or economic need, including low-income minorities"--provided those without social or economic need are not harmed. It's referred to as "Hold Harmless Clause".

The result of this grammatical contradiction is that over half of the state's minority elderly are denied equitable access to this Congress's intent that they live out their lives with dignity and independence. Clearly, California's Hold Harmless Clause, in its intra-state funding formula for the elderly is not in either the spirit, intent, or letter of the Older American's Act.

So that you will not mistake my concern as one localized Californian, let me provide some revelance. In a mysterious, phantom-like white paper (appropriately disclaimed by everyone), it is proposed that the age requirement for access to services funded through the Older American's Act be raised from age 60 to age 70. It is my belief in concert with both Congressman Royball and Biaggi, that the paper was authored, leaked, and supported by the Administration.

I further believe that this phantom document is meant to exacerbate the plight of the black elderly. But its sublety is denuded because by now all Americans know that Blacks, Hispanics, and native Americans do not live as long as their white brothers and sisters.

These minority Americans have a relatively significant longevity once they reach age 75. Their most difficult endeavor is to reach age 75.

The Area Agency on Aging in the City of Los Angeles, with the advice and guidance from its City Council and Mayor Tom Bradley, and through its legislative delegation in Sacramento is actively addressing the plight of the elderly in California. However, we fear that the sustenance of the Older American's Act will continue to escape the grasp of older Americans nationwide, unless as concerted an effort as went into its enactment is exerted to make it a reality. To this end, I ask the Congressional Black Caucus to insist on the support of its colleagues in assuring that all older Americans escape the plight of black elderly and provide the follow-through needed to give sustenance to the intent that older Americans may live out their lives with dignity and independence.

In summary, the need is for a cause whose time has come! The opportunity is now! In 1987, you will deliberate the reauthorization of The Older American's Act. Make it the meaningful document you envisioned some twenty odd years ago. Don't let it become obfuscated with terms such as "flexibility, local determination, and private sector commitment." Rather, state your intent in clear, concise and unalterable terms. Provide the means to insure that that intent can be audited and evaluated.

I again thank you and wish you success in your pursuits. Should you wish to ask any questions or pursue my discourse further, I am at your service.

4/12/86

THE RESTRUCTURING OF MEDICARE
An Essay on A Geriatrics-Based Strategy for Change

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This essay was presented originally at the Conference on Societal Impact of Population Aging in the United States and Japan, Feb.13-15, 1986, in Tokyo.

The conference was given jointly by the Aging Society Project of the Carnegie Corporation of New York and the Association of Former Members of Congress.

INTRODUCTION

This essay embodies a geriatrics-based critique of Medicare. This is a rarity. (1) The program, which has benefited many older Americans and their families, generally is evaluated in terms of insurance and social insurance principles, procedures, objectives, and cost evaluations. These approaches are not to be disparaged but they are dangerously incomplete in an America with a rapidly growing population of the very old.

The absence of a geriatrics point of view produces lopsided instruments of health policy for America's aged population of 27 million persons, mostly women. While the total elderly population is growing, the very old group within it is growing faster. It is this group that has heavy needs for geriatric service. There were 10 million Americans aged 75 and older in 1980. Estimates are 13.7 million in 1990, 16.9 million in 2000, 18.9 million in 2010, 21.5 million in 2020, and 30 million in 2030.

It would be a mistake to consider the majority to be seriously disabled; it would be equally mistaken to overlook the fact that morbidity rates rise with age. All of us stand a better and better chance of reaching very old age -- and of needing geriatric care for our future selves and our elders.

The focus on Medicare's inadequacies in geriatric terms is not intended to divert attention from needs for broader changes in American health care. Some 30 to 35 million Americans are uninsured or under-insured for health care. It has been distressingly easy for children to be ignored. A sensitive health-care system, reflecting a sensitive society, should respond to all stages of life. From the professional health viewpoint, the life cycle as a whole is the appropriate subject of a health-care system. National health insurance (NHI), a logical response to these outlooks, was defeated during the Administration of President Harry Truman in the early 1950s.

Medicare was a fallback position for NHI advocates in the 1950s and 1960s. They hoped that once NHI for older people was established the next likely step would be NHI for children (or "Kiddy Care"). (2a) Although NHI was considered an idea whose time had come in the early 1970s, the opportunity was overtaken by general economic conditions and the rapid inflation of Medicare costs within the inflating health-care system.

For issues related to life-cycle concerns and costs of the health-care system, the context for effective redress is some comprehensive approach -- NHI or a national plan of health services. Failing that for the moment, reformers are left to improve the pieces of program and policy at hand, such as Medicare.

I expect that an outgrowth of a true system of geriatric care will be intensified concern for the preceding part of the life cycle. The geriatrics practitioner deals with an individual having problems rooted in earlier life. Research in geriatrics has utility for those interested in health promotion and disease prevention in children, teen-agers, and young adults. Geriatrics research also holds significance for population-wide policy, because old age may reveal the subtle and long-term contributions to disease and disability of occupational, environmental,

psychosocial, nutritional and other conditions.

There are, of course, risks to the U.S. economy in international competition when the prices of goods and services incorporate costs of a system of care that is less effective and efficient than it should be in meeting the needs of an aging population. Without developing this point further, I simply want to suggest why, if not comprehensive reforms, at least the restructuring of Medicare is a topic of broad interest, including leaders of commerce, industry, and finance.

Health care for the elderly population is substantially different from health care of younger adults. A distinguishing characteristic of old age is the likelihood of multiple, simultaneous crises or losses, and they may be superimposed on chronic illness and anxieties about incapacity and dying. Often remarkable, the capacities of an octogenarian to recover or compensate without assistance are compromised. These blows are in the form of disease, accident, bereavement, isolation, immobilization, problems in activities of daily living, hearing loss, and financial stress. In the form of age prejudice (ageism) reactions to the individual can impede recovery or survival. Such a framework, so different from that common in the younger adult, necessarily changes the work of professionals.

Geriatrics embraces health and supportive social services across the entire spectrum of preventive, acute, chronic, and rehabilitative care. This breadth of attention requires the work of a team, not always to effect cure of a disease but to sustain as much of a desired lifestyle as the patient's capacities allow. The patient and family members and friends, if any are available, are part of the team along with professionals. By contrast, illness in the younger adult is usually a temporary departure from full functional capacity.

It is argued here that commercial insurance has not supported, and perhaps cannot support, the service requirements of the U.S. geriatric population. It is predominantly a low-income population (30 percent had an income under $10,000 per year in 1983), all the more so at the oldest ages. The very old

do not form a profitable market under present circumstances. Policymakers would be imprudent to seek a systematic answer to the needs of the very old on the basis of services that are insurable.

The overreliance on insurance policy at the sacrifice of health policy is a serious flaw in the evolution of Medicare and a danger to the frail elderly, notably in the omission of outreach, prevention, and long-term care services.

I believe that Americans probably are paying for a geriatric system -- but aren't getting it. Extravagance in payments for hospital and doctor services has been demonstrated; however, most of the "savings" are not being invested into comprehensive geriatric care.

In the $70+ billion a year spent by Medicare, over $12 billion a year for the poor elderly through Medicaid, and in other federally aided health and social service programs, I believe there is enough to support much of a care system suited to the needs of the 10 million Americans over age 75. New kinds of service delivery, of using allied health professionals, and of supporting and cultivating the natural networks of informal support would enhance effectiveness and affordability of Medicare restructured.

The attempt here is to reconceive the program as a system of financed health and social supportive services, manpower training, research, and development activity.

A. Paradoxes of Progress

Unlike most other industrially advanced countries, the United States has no program of national health insurance. It has maintained health insurance in the private sector, with the overwhelming portion of the population covered through employment. The major exception among contributory programs is Medicare, a federal program primarily for persons aged 65 and above.

The reason for the exception to private coverage is that a retirement population cannot afford the premiums required to cover the actuarially determined expense risks of sickness. (2)

Medicare came into existence in 1965 as a national program because of the inability of private health insurance to serve this population. Nor could State welfare programs (medical assistance) or State-blessed private insurance pools handle the burden of this growing population of elders. These inadequacies meant that many older people -- over 50% were then estimated to be in or near poverty -- had no practical way of avoiding destitution because of expensive illness. Medicare represented the broader social response necessary for resolving the problem: an earmarked payroll tax paid by workers of all ages (for Part A), general revenues (for Part B), and beneficiary payments (premiums for Part B and deductibles and coinsurances in both A and B).

Even Medicare was insufficient for protecting many elderly persons who could not afford Medicare beneficiary payments and Medicare-excluded needs (such as long-term care and outpatient drugs). Medical assistance still had a role, and it had to be extended. In the mid-1960s, more than half the elderly population was in or very near poverty. In 1983, medical assistance was necessary for the 14.1% of America's elderly who were in official poverty and an additional 10% who were close to it.

Health care for the poor is paid for under a noncontributory program, Medicaid, a federal-state government program covering 3.5 million older persons. In 1965 when Medicare was enacted into law as part of the Social Security system, Medicaid also was enacted in another portion of the same legislation. This continued a division in the way the American federal system approached vulnerable populations: social insurance and welfare approaches characterized the original Social Security Act of 1935.

There is yet another distinction to be made between the two programs. Medicare is modeled after private health insurance for the employed. Its strongest protection is against the expenses

of hospitalization for acute illness. Job-based insurance was designed for people of young and middle age when the main threats to financial security arose out of acute illness rather than chronic incapacity. Typically, the private insurers left chronic care expenses to government and philanthropy (such as mental illness and long-term physical disability which were taken care of in nursing homes and large public hospitals).

Similarly, private insurance limited its coverage of physician services to diagnosis and treatment of short-term illness. Whatever the public health value of preventive medicine, mental health services, and long-term care, classic insurance principles seemed to dictate their exclusion from private arrangements. They were too hard to insure.

The political need for conservative votes to assure enactment of the liberal Medicare legislation confined the program to the conventions of private insurance. The insurance industry was mollified with a role as intermediaries. Organized medicine, to avoid the inclusion of physicians in a mandatory program (Part A), accepted coverage of their services in Part B. It did little to control doctor fees.

Medicare did amplify some of the more daring aspects of private insurance, such as coverage of home-health services and the post-hospitalization nursing-home benefit. (In doing so, Medicare executors wrote national standards for the providers of these services.) Architects of Medicare avoided coverage of long-term care out of fear that the additional costs in an untried federal program might play into the hands of opponents. While there was cost and administrative experience with insurance for hospitalization, such experience was absent for "custodial care" in the nursing home. It also was argued that if heavy acute-care expenses were covered, people could afford lesser expenses of custodial care and outpatient drugs. Moreover, improved medical assistance (Medicaid) was intended to serve as back-up protection for the population whose care expenses threatened or produced indigency. Unfortunately, rapid increases

in nursing-home rates and out-of-pocket spending undermined the economic security goals of Medicare.

While Medicare sought to preserve the independence and health of those with acute care expenses, it left chronic care substantially to Medicaid. Unfortunately, Medicaid comes into play after these patients lose their financial and even their functional independence. For example, by the time a sick spouse is eligible for nursing-home care under Medicaid, that person's problems have deepened and the well-being of the mate has been compromised. The slide into poverty -- occurring often for the first time in old age -- may become an overwhelming stress and a barrier to health-protective steps.

The following figures indicate the roles now played by Medicare and Medicaid in care of the elderly: the United States in 1984 spent $4,200 per capita for the elderly population's personal health care, or $120 billion. Medicare paid almost half, other government programs paid $22 billion, private insurance paid $9 billion, and the elderly and families paid $30 billion out of pocket. Because Medicare covers only 45 percent of the total cost of their health care services, two of every t edicare beneficiaries carry private "Medigap" policies, typically, paying the Medicare deductibles and copayments and some additions to hospital and post-hospital care. These policies have been called overpriced for what they offer; anxious elderly purchasers mistakenly believe they acquire long-term care coverage through Medigap.

While Medicare and Medigap virtually ignore preventive medicine, mental illness, dental needs, long-term care, and outpatient drugs, Medicaid -- the federal-state program for the poor -- does not ignore them. The extent to which it effectively offers a full spectrum of service differs among the 50 states and the District of Columbia. Eligibility requirements and benefits vary within limits allowed the states for qualifying for federal aid. (3)

From a geriatric viewpoint, neither public nor private programs deal satisfactorily with maintaining the independence of

the frail elderly person. The Medicaid "deductible" is the individual's financial independence. The geriatric principle of providing care in the least restrictive environment is violated by the institutional emphases in Medicare and private insurance. Home care is one of the most difficult services for conventional insurance to cover, because its use is less under control of the professional. For the hospitalized patient, the "insurable event" is admission to the hospital. What is it for home care? Is its use more under control of the patient than the doctor? The issue is in doubt for the insurer, who must calculate odds on the use of services.

For this reason, home care is most comfortably approached in conventional insurance as a post-hospital benefit. In Medicare, the home-health benefit is hedged against "custodial care," the services needed to maintain the stabilized patient who is not going to be cured or get better. Unfortunately, these insurance considerations are counterproductive. The physician in geriatrics knows that the stabilized patient may easily require acute care and hospitalization unless "custodial" services are given. Such services may be as humdrum as help by a home attendant in getting out of bed, going to the toilet, getting dressed, preparing a meal and taking medications on time. Medicare's statutory exclusion of custodial care is a set up for personal and programmatic turmoil.

American systems of social and private insurance falter on issue of the care of the chronically ill and their medical, nursing, and social service needs. The absence of coverage stymies the development of these services. The fragmentation of other services and their financing often exasperate the practitioner, patient, and family. A weak system of chronic care eventually generates admissions to hospitals and nursing homes, and these costs bedevil Medicare and other third parties.

Nor does insurance reinforce family members, friends, and volunteers who are the principal caregivers of the at-home elderly. Some networks of informal supports would collapse without professional services. Many families exhaust themselves

in attempts to keep the frail person at home. Respite care, counselling, training of the family on how to deal with problems, and provision for nonmedical professional help in the home in crises would support families in avoiding institutionalization. Social services by religious and philanthropic groups, states, counties and municipalities play key roles in sustaining families and the frail elderly.

All the foregoing are elements needed in long-term care systems, and they lie outside Medicare and private insurance as now conceived.

The foregoing analysis suggests the following paradoxes:

1. The Medicare program for the elderly does not cover major geriatric needs. It is not a true geriatric program.

2. If Medicare is non-geriatric, Medicaid is anti-geriatric. The Medicaid program for the poor contains the missing geriatric benefits needed for a comprehensive Medicare program. But Medicaid's heavy emphases on institutionalization and poverty status foster dependency. A major goal of geriatric practice to encourage and promote independent living to the greatest feasible extent.

3. Medicare grows in cost while shrinking as a shield against poverty due to sickness. Now, because of increases in cost-sharing, the elderly are shielding government against Medicare bankruptcy. Result: The program is being repealed, de facto. Beneficiaries are more and more exposed to medical indigency. (4,5) (The bulk of the growth of Medicare expenses is traceable to a variety of causes beyond the control of patients, such as uncontrolled doctor fees ordering of services, cost-plus reimbursement for hospital services, hyperinvestment in acute-care technology.)

4. As the Medicare shield shrinks, more people need expanded protection. The numbers of very old persons are growing dramatically; the number aged 75 and older, now about 10 million, will reach 21.5 million in 2020, and their proportion of all elderly persons will enlarge to 42 percent from 39. Both the rate of spending for care expenses and the rate of indigency rise with age. (In New York State, for example, 1 in 3 persons over age 80 age receive Medicaid benefits.) But both Medicare and Medicaid obstruct the development of an adequate infrastructure (manpower, service systems, and facilities) for geriatric care. Medicare retains an explicit proscription against "custodial care," and Medicaid funding is problematical. Both programs provides no secure flow of funding for community-based services, and there is virtually no private long-term care insurance.

Thus it is that Medicare helps people to survive the acute illnesses, only to fall into poverty in very old age, while Medicaid helps people only after they have lost their financial independence.

Why has the United States lost so much of the forward thrust in developing protections against poverty in old age? Part of the answer of course is money. The economic surge of postwar America faltered in the early 1970s, as it did in many advanced countries. In the remarkable quarter century of growth in wealth and in population (including the baby boom of 1946-1964), the United States could afford to raise living standards for the elderly as living standards rose for the work force. It could also finance foreign aid, the Vietnam war, and the nuclear buildup. The inflation of the 1970s threatened living standards and provoked attacks on the programs whose taxes cut take-home pay. The later 1970s saw almost a complete loss of forward motion and even some retrenchment under a Democratic president, Jimmy Carter.

Amid predictions of Medicare bankruptcy, the Reagan Administration attempted to dismantle Medicare. But it had to

alter course in the face of the program's popularity. The attack shifted to nibbling away at beneficiary protections and taking a strong, prescriptive approach to methods of paying doctors and hospitals. In 1983, a National Commission on Social Security Reform produced a consensus on safeguarding the nonMedicare aspects of the Social Security system. Medicare reform proposals were awaited from other quarters. Meanwhile, owing to legislative and administrative changes in Medicare's payment patterns, the date of the program's "bankruptcy" receded into the mid-1990s from the early 1990s.

Meanwhile, Canada has built a national health insurance program on a flexible federal-provincial basis. It has controlled costs while incorporating long-term care. A clear picture of the evolving efforts of three Canadian provinces is in A Will and A Way: What the United States Can Learn From Us About Caring for the Elderly, by Robert L. Kane and Rosalie A. Kane. (New York: Columbia University Press, 1985.)

The geriatrics-based criticism offered here is intended to remove serious inadequacies from a praiseworthy program whose accomplishment should be acknowledged. Where half the aged had no private health insurance 20 years ago, now virtually all have hospital and doctor coverage. They are in the mainstream of American medicine, not on its margins. To some extent because of improved access to care, mortality rates for the over-65 population have diminished in the 20 years since Medicare was enacted.

Yet it is hardly churlish in the face of Medicare's contribution to the elderly to note that American medicine has made no corresponding major shift to geriatrics. In 1977, an American Medical Association survey showed fewer than 700 of the Nation's 350,000 physicians claiming a practice focus in geriatrics. Only a few medical schools offered an elective in geriatrics and none had a mandatory course. In 1983, virtually nothing of the $1.8 billion Medicare paid hospitals in 1983 for costs related to medical education was earmarked for training in geriatrics. There is only one department of geriatrics in America's 127 medical schools, and that one was established only

two years ago, about 18 years after Medicare's enactment. By this time, however, Medicare's payments for graduate medical education were considered fair game for cutbacks. Some members of Congress proposed preserving some of the money for the development of geriatrics training. This was entirely reasonable, a move indicating a view of the program as a service system supported by manpower training.

Overall, however, Medicare and medicine are out of alignment with population needs.

B. Adapting to the Demographic Revolution

The political/economic environment of the 1980s complicated the case -- fatally, some thought -- for expanding Medicare in the near-term. About the best that could be expected was to continue marking time with "demonstrations" of flexible use of Medicare money for long-term care. Some demonstrations have shown ways of adding at least some long-term care services to the conventional Medicare-benefit list without additional expense to the program.

These results, in addition to the longer record of savings achievable through prepaid group practice, suggested that Medicare funding already was sufficient for major geriatric reforms -- if only policy barriers could be overcome. The barriers included (1) the proscription against custodial care, (2) extravagant methods of paying for hospital and doctor services, (3) resistance to trying new methods of delivering and financing services, (4) ignoring the demographic trends and the cost implications of added years of life.

The growing 75+ population brings with it a high morbidity load. Individuals who, in another era, might have died in their 40s, 50s, and 60s, are surviving into the 70s and 80s -- with partial disabilities. The kinds of services needed by the sick elderly are medical, nursing, and social services for the short-term and long-term.

The well elderly, also a growing subpopulation, are increasingly vulnerable to serious illness as they age. Their service needs lie in the direction of periodic monitoring and preventive care. Other vulnerabilities stem from financial depletion and the loss of supportive spouses and other cohort members.

The elderly and their families must be considered in the context of services, financing and other supports needed to function at home or in the community. To ignore social supportive services and the needs of the principal caretakers is to set the stage for enlarged institutional expense, including acute and custodial care.

The design of a sound system of geriatric care must take into account a variety of demographic characteristics. The problems of an aging population are, foremost, the problems of women. They constitute two-thirds of the elderly. Women tend to outlive their spouses, to live alone, and to command slender incomes. Not surprisingly, they are the majority occupants of nursing homes.

The kinds of services particularly needed by a geriatric population include adult day care, respite services, home attendants or homemakers, chore services (e.g., home repairs), transportation, sheltered or congregate housing (with meal service), hospice programs, and skilled, intermediate and other nursing-home services.

Because the goals of care for the very old focus on minimizing their characteristic vulnerabilities, personnel and facilities must be prepared differently from those directed at the needs of the younger adult. The training of medical, nursing, and social service professionals in geriatrics must relate to the multiple conditions old patients have. These do not occur in a well-spaced series, as often the case with younger adults, but simultaneously, with psychosocial and economic as

well as medical ramifications. The main objective often may not be cure of the disease, for that is not always possible. Rather it is to promote ability to function, to conserve as much of the patient's desired lifestyle and independence as possible.

Professionals must be aware that "disability" describes a relationship between the individual's physical and psychologic capacities to function and the social and physical environment. The home, community and employment environment may facilitate or obstruct the individual's ability to perform and maintain a lifestyle. These factors must be examined for health impact.

The professionals must be taught methods for assessing patient needs and resources and the preparation of a plan of care acceptable to patient and assisting others. The plan may require considerable effort in educating patients and assisting others on the nature of normal aging processes, the early signs of disease or dysfunction, when to contact professionals and what to do before this becomes necessary. It is essential to good geriatric care to incorporate health promotion and disease prevention in the plan of care. This is a tall order, and requires more skills than any single practitioner may provide. The multidimensional nature of geriatric assessment and care implies the use of a medical/nursing/social work team.

To do these things well and to continually improve the efficiency of services, professional education must be placed in the context of research -- health delivery research and basic biomedical and sociobehavioral research. The system of delivering services for the elderly must also be a system of research and education. One tool for this, the teaching hospital, has been joined by the teaching nursing home. To these should be added health maintenance organizations that do research and teach and home care agencies that do research and teach. In all these settings, practitioners must be trained for teamwork.

The significance for cost containment of research and

education cannot be understated. All of us know how research into the nature of poliovirus led to a preventive measure that obviated the need for expensive treatments. This feat demonstrated that research was hardly an expendable item in modern society. Less dramatic but nonetheless important research findings and treatments are needed in an aging society to prevent functional losses from occurring initially, to prevent further losses due to complicating conditions, to rehabilitate, and to compensate for permanent losses. To the extent that individuals can be trained to help themselves and contribute to society, they preserve their autonomy and morale and they free formal and informal providers for other productive activities. This should be the spirit of the system of service/education/research, and service-payments patterns must contribute to this infrastructure.

Similarly, the service system's institutional environments must reflect sound geriatric principles, particularly to facilitate independence. Hospitals must be designed for geriatric patients: color schemes should help guide the cognitively-impaired patient to service areas, sound conditioning should minimize confusing background noise and facilitate speech comprehension, lighting should aid the cataract afflicted by minimizing glare, safety should be designed into furniture, floor coverings, and hallway layouts so as to protect patients with disorders of gait.

The Medicare program cannot be expected to cover the enormous gamut of societal adaptations required for the safety and care of the very old. Medicare's proper theatre of action should be health care and health-related social supportive services. Liaison will have to be built between the new constellation of Medicare services and other services, notably community-based social and housing services, needed for the frail elderly.

I turn now to a framework for applying the foregoing principles.

C. Private or Public Solutions

American policymakers have to engage the question of whether the improvements in services for the elderly should be accomplished in the public or private sector or in both. The most direct, dignified, and socially efficient way to protect old age from poverty due to health-care expenses is through social insurance, with contributions from those to benefit spread across the working years. Since virtually everyone can expect to live at least into the 70s and has an older relative, mandatory coverage of the U.S. population through a contributory plan is an entirely reasonable proposition. Contributions, starting long before the individual reaches old age, would be the basis for meeting expenses for the individual's future self years hence.

Various pathways to achieving this through a private/public partnership could be imagined. For example, every American could be required by law to purchase private insurance to extend Medicare. There would have to be national standards for extended benefits and for administrative integrity and cost. Probably, to assure payout years hence, funds would have to be federally insured.

One might also envisaion a "social utility" approach; service would be provided by a highly regulated private organization that is insulated from competition in order to achieve stability, economy, and satisfy unprofitable but desirable social purposes. These approaches could be elaborated further. But suffice it to say that the attempt to avoid a social insurance approach would surely entail considerable governmental intervention and higher costs of administration than achievable through the Social Security system.

That is why I view the basic response to the demographic imperative to be the restructuring of Medicare.

The new Medicare should expand its current benefit structure to include long-term care (including institutional and community-based health services and health-related social services), mental and dental services, outpatient drugs, hearing and vision aides, health promotion, disease prevention, and casefinding services. It will then be transformed into a sound geriatric program.

Operationally, this means: (1) geriatric assessment and reassessment at regular intervals; (2) development of plans of care to promote capacity to function, based on the recent assessment; (3) emphasis on care at home and in the community; (4) assistance to families for support of the patient at home, such as counselling, respite service, chore service, and home attendants. Entitlement to specific benefits in home-care and institutional programs would depend on the plan of caree, implemented with the aid of a professidonal coordinator through approved service providers. would depend on the findings and recommendations of the assessment team in a plan of care.

To maintain quality and to control costs, providers of geriatric services must meet eligibility standards (e.g., training in geriatrics), standards of quality assurance, and accept financial risk (e.g., furnishing services at a fixed prospective payment, sharing in loss or surplus).

The foregoing elements-- comprising a complete range of short- and long-term care with cost and quality controls -- can be realized in various types of organized care. One of the more promising is the social and health maintenance organization S/HMO). Four S/HMOs are being tested in the United States under different auspices (such as a nursing home, a health maintenance organization, a continuing care community). Through waivers of certain Medicare and Medicaid requirements, they receive an average per capita payment. It may be used to suppliment regular benefits. This makes it possible for Medicare beneficiaries to receive preventive services; these services are in the interest

of the S/HMO to provide on the assumption that costs are avoided if acute care episodes are avoided. Custodial care for Medicare beneficiaries is provided for a limited period in a nursing home under a supplimentary private policy.

Because of fragility of their economic support, standards of living as well as health, very old people should be excused from copayments and deductibles. These devices for sharing costs between program and beneficiaries are counterproductive in poor populations: they deter coming forward for needed care. A geriatric system, recognizing the fragility of these people, goes out to find and serve them. Eligibility for services should be established through assessment of need and plan of care, confirmed by periodic reassessment. This process should establish not only the needs of patient and family for service but also their ability and commitment to provide care.

Estimates of the cost of Geriatric Medicare can and should be developed. Estimates should be presented to show the net cost of expansion above current spending through Medicaid and other programs the expansion would displace. These estimates may shape the timing and extent of the expansion but not the certainty of the commitment for substantial Medicare expansion. To withhold this commitment would not abate the suffering, anxiety and expense of preventable and minimizable incapacity. Moreover, the price of the commitment may force consideration of new kinds of economies and efficiencies. Because Medicare costs were not well controlled in the past, there is reason to believe that an expanded set of benefits as suggested above might be financed substantially out of prudent economies. A number of strategies are possible to balance Medicare's benefit structure by intra-program savings or by absorbing the funds as well as the functions of such other programs as Title 20 and Medicaid.

Nonetheless, if more funding is needed for additional benefits despite economies and if U.S. society is serious about the quality of late life, consideration would have to be given to income-based premiums and/or tax policy. I think the American public would be willing to weigh these possibility with others.

In the abstract, Americans object to tax-and-spend approaches. They are not keen to have government intervention. But history shows they are willing to support taxes earmarked for purposes they value.

Americans today are paying a smaller proportion of gross national product in federal taxes than in recent past. For example, pre-Reagan federal taxes were about 19 or 20% of gross national product; in 1984, they dropped to 18.5%. Meanwhile, federal spending rose from 21 or 22% of GNP to 24%, largely to accommodate defense policy. The gap between revenue and expenditures produced a $200 billion annual deficit and deepened resistance to federal spending for existing domestic programs, let alone any expansion.

The needs for restructuring Medicare are urgent. Where economies fall short of freeing enough funds for comprehensive geriatric services, the benefit expansions should be financed by new, earmarked taxes. The tax base should be income from whatever source -- investments as well as earnings. The new tax approach should support research and training of the kind mentioned above. Other revenue sources might be increased taxes on tobacco and alcohol and dedicating them to Medicare; this raises an ethical issue if the program becomes dependent on unhealthy behavior.

Other possibilities include taxing employer contributions for health and life insurance, and surcharges on corporation as well as individual income taxes. (6)

At the same time as new taxes are raised, the entire Medicare program must be run as prudently as possible. Since Medicare is embedded in the health care system, its economical operation depends on system-wide reforms. The United States is witnessing enormous changes in the financing and organization of care, notably in the commercialization of services, the proliferation of health maintenance organizations, the combining of providers of services of various types under one administration, and the

combining of providers and insurers. The new conglomerates are organized often as venture capital enterprises. Employers are reshaping health insurance policies to require more cost sharing by beneficiaries. It remains to be seen whether these changes will improve the quantity and quality of coverage substantially or make way for profits without effecting major reductions in costs of the entire system.

Medicare has taken the lead in altering payment arrangements for hospitals. Medicare has shifted from cost-based reimbursement determined retrospectively to per case prices based on about 470 diagnosis-related groups.

This classification scheme has drawbacks from a geriatric point of view, since it is difficult to classify and receive adequate payment for the patient with multiple diagnoses and varying severity of illness. (The system pays somewhat more for people over age 69 or for one co-morbidity; these allowances, however, do not truly cover severity and complexity of many geriatric cases, especially the most frail.) The method provides incentives to avoid the more difficult cases covered by a DRG and to discharge patients as early as possible; however, the DRG system does not control for quality of care nor does it recognize that a patient who may no longer need hospital services still may not be be discharged safely to his or her home or cannot be discharged to a nursing home because no bed is available. The new Medicare payment system appears to assume the existence of long-term care services and circumstances that may, in fact, not exist.

The extension of DRGs to office practice has been proposed but seems unworkable. At the moment, Medicare reimbursement for physician services copies the private system by favoring procedures. While this benefits the cardiologist and the surgeon, for example, it underpays primary care physicians for time and effort in diagnosis and treatment. This is a barrier to geriatric practice.

No payment system by itself will assure proper consideration

of the patient's needs. That must come from the professionalism of the practitioners and managers of the system and the wisdom of its financiers. Unfortunately, the bulk of American physicians and hospitals have taken advantage of the trust accorded them by Medicare and other third-party systems. Their incomes have risen sharply; services have been overutilized; resources have been extravagantly consumed. In reaction to this, American employers and the Medicare administration may have gone overboard in emphasizing economy at the sacrifice of access to services and their quality.

It may be too much to expect any formulas to produce automatically an equitable system of service. Negotiation among fair-minded parties may be a cliche, but may be the safest approach to resolving cost, access, and quality issues.

There remains the need for coordinating the new Medicare with programs providing social services and other supports necessary for the survival and quality of life of the Medicare patient. Coordination is required among Medicare, Medicaid, Older Americans' Act programs, Title 20 (social service) programs, Veterans Administration programs, and housing, transportation, and legal services. The reformed Medicare program should absorb some of these programs. In particular, it should lead to the elimination of Medicaid insofar as it applies to the aged.

The establishment of a true health policy for an aging America needs the greatest wisdom the Nation can find. I have proposed establishing a National Commission on Long-Term Care composed of leading lay persons with no close connection to the health services field. The commission would conduct its own investigations and studies to produce a report and recommendations in a limited period of time. The panel's scope would cover benefits, financing, delivery organization, research, education, facilities, and health and social services. The commission would consider which functions would be best provided by the public sector and the private sector. Its views may expedite the adaptation of major institutions of our society to the needs of the growing elderly population.

D. Conclusion

This paper has argued for the restructuring of Medicare as a necessary adaptation of our society to the growth of a very old population. The approaches offered have these goals:

1. Completion of the protections against impoverishment in old age for reasons related to sickness

2. Promotion of service benefits, practitioner training and delivery systems suited to the geriatric needs of patients and families

3. Recognition that life in America is, on average, a long life for which we do not now allocate sufficient financial and service support.

4. Assurance to taxpaying adult children that their incomes will be protected against major expenses of parental health care.

5. Affirmation of the dignity and value of very old people, by providing a humane system of comprehensive geriatric care.

6. Efficiency and effectiveness in meeting the needs.

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FOOTNOTES

Footnote 1: Notable is the work of Professor Anne R. Somers. See her special article, Long-Term Care for the Elderly and Disabled. NEJM 307:221-226, 1982. She proposes eliminating Medicare's statutory bar against custodial care benefits, consolidation of certain Medicaid, Title 20 and other public funds, cost-sharing for long-term benefits, and a new federal, state, and community program to coordinate long-term care.

Footnote 2a: Medicare was extended to cover persons with end-stage renal disease, whether elderly or not; this is a precedent for a disease-by-disease extension of Medicare,

which I consider ill-advised. Preferable would be coverage of individuals of any age with incapacitating chronic illness and other functional disabilities, such as nonelderly patients with Alzheimer's disease.

Footnote 2: In 1984, the actuarial value of Medicare was $2,210 a year, about one-third of the median income of elderly persons; the American Association of Retired Persons has estimated the cost of comparable private insurance to be $3,400 a year. Source: Aiken LH and Bays KD. The Medicare Debate: Round 1. NEJM 311:1196-1200, 1984.

Footnote 3: As with other public assistance, Medicaid programs set a limit on income and assets the individual or family may hold and be eligible for coverage. An owned home is excluded in the counting of assets.) About 3.5 million elders are in Medicaid as well as Medicare.

Footnote 4: In 1985, older Americans are spending an even higher proportion of their income on health care than they did before enactment of Medicare (15%). Despite the improvement in Social Security cash benefits for retirees, incomes of the elderly are more likely to hover about the poverty line than are the younger-adult incomes. Nonetheless, the program's hospitalization deductible has doubled to $400 in the last four years; and there is continued exposure to inflationary expenses in the nursing home. An estimated one-third of Medicare patients who enter nursing homes for long-term care are officially poor within six months. In New York State, annual nursing-home expense can reach $40,000.

Footnote 5: Medicare costs have risen rapidly, about 15 percent a year. The inflation not only eroded the financial protection goals embodied in the original set of benefits but also blocked any addition of benefits for long-term care, outpatient drug and preventive care. Between 1976 and 1981, Medicare beneficiaries experienced an 80% increase in out-of-pocket liabilities for noncovered services and products. In their search for security,

elderly persons bought private "Medigap" insurance, which, while covering the Medicare deductibles and coinsurances, did not cover long-term care, outpatient drugs, or preventive care.

Footnote 6: Former Social Security Commissioner Robert Ball provides a reasonable strategy of cost containment and increased revenues. He takes note of the large deficit in the federal budget and the subsidies given to Part B (supplementary medical insurance, largely physician coverage) from federal general revenues. He wisely points out that Medicare cannot effectively control its costs independently of the rest of the health care sector of the U.S. economy. An all-payers system, in which a state government regulates the payments that any third-party payer can make to institutions, has been effective in New York State; it held inflation in hospital prices below the national average for several years. Such a system is embodied in a proposed bill in Congress (Kennedy-Gephardt); under it, state programs that meet federal standards would receive federal aid, very much in the style of the Canadian national health insurance. (Incidentally, this model would have been proposed as part of the 1935 Social Security Act had not President Roosevelt feared the political influence of the American Medical Association in defeating the entire measure.)

For new revenues, Mr. Ball's suggestions include (1) raising taxes on cigarets and alcohol, dedicating the increased income to Meldicare; (2) extending Social Security coverage to certain state employees (now exempted) and shift their contributions to Medicare; (3) expanding the Social Security tax base by counting employer contributions to group health and life insurance and diverting this income to Medicare. By such measures, enough money would be raised to eliminate the Part B subsidies and permit expansion. (Ball RM. Medicare: A Strategy for Protecting and Improving It. Generations, Summer 1985.)

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