DOCUMENT RESUME

ED 140 012 CE 011 175

TITLE Education and Training in Aging; Hearings before the Select Committee on Aging, House of Representatives, Ninety-Fourth Congress, Second Session. March 3-4, 1976.
INSTITUTION Congress of the U.S., Washington, D.C. House Select Committee on Aging.
PUB DATE Mar 76
NOTE 85p.; Some parts may be marginally legible due to small print

EDRS PRICE MF-$0.83 HC-$4.67 Plus Postage.
DESCRIPTORS *Educational Needs; Educational Programs; Federal Aid; *Federal Legislation; *Gerontology; Health Needs; *Health Services; Higher Education; Mental Health; *Older Adults; *Professional Training; Training
IDENTIFIERS National Institute of Mental Health; National Institute on Aging

ABSTRACT

Hearings before the House Select Committee on Aging were held to examine programs, purposes, and needs related to education and training of personnel in all aspects of care and services to the elderly population. Statements and discussions included a review of National Institute on Aging programs into medical aspects of aging; a review of the National Institute of Mental Health's studies on mental health aspects of aging, with application of research findings to particular elderly populations; and testimony by various university representatives on higher education in aging, assessment of joint State and university aging education programs, and discussion of programs related to gerontology education and training. The appendix contains a list of Federal departments and agencies supporting research on aging with fiscal year 1975 funds. (MF)

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EDUCATION AND TRAINING IN AGING

HEARINGS

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

MARCH 3 and 4, 1976

Printed for the use of the Select Committee on Aging

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EDUCATION AND TRAINING IN AGING

WEDNESDAY, MARCH 3, 1976

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 1302, Longworth House Office Building, Hon. Wm. J. Randall (chairman) presiding.

Committee members present: Representatives Randall of Missouri, Spark M. Matsunaga of Hawaii, Don Bonker of Washington, William J. Hughes of New Jersey, William C. Wampler of Virginia, William S. Cohen of Maine, William F. Walsh of New York, and Charles E. Grassley of Iowa.

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

This is a meeting of the full committee rather than a subcommittee proceeding. Under the rules of the committee we cannot commence pending the arrival of others as well as a quorum of at least two.

Now, I observe the attendance of our distinguished representative from the State of Washington.

This is the first of a two-part hearing on the subject of education and training in aging. The committee will hear witnesses today from two Federal institutes that support training and research programs in aging, the National Institute of Aging (NIA) and then the National Institute of Mental Health (NIMH).

Tomorrow will be a very interesting day because representatives from major university gerontology programs and the director of the Virginia Office on Aging will testify on the progress made in aging fields under title IV of the Older Americans Act.

The academicians who will be testifying tomorrow are those professors, department heads and others who will be in the city for a conference conducted by the Association of Gerontology in Higher Education.

We are grateful that the association has agreed for some of its members to testify before us. We are grateful because of their expertise, and they will be able to tell us of the shortcomings and failures in funding in their various institutes. We also are grateful to them for saving the committee a lot of money, if I may interject a note of levity here.

The Chair, of course, states now and will note later in the record, that we are most anxious to hear these witnesses tomorrow. However, I have a commitment to chair the full committee field hearings in Alabama. Our distinguished colleague, Mr. Pepper, will chair the hearings.

We are going to be called upon to make a report to the House Administration Committee of the activities of this past year.

One of the major concerns at this moment is whether there is sufficient funding made available for the continuation of several Older Americans Act programs, and arrangements have been made for the Subcommittee on Appropriations for Labor, Health, Education, and Welfare to hear our plea for the restoration of funds cut in the field of aging.

So, what we are talking about is systematical funding for the continuation of this research and training in the field of aging.

Our first witness today is Dr. Richard Greulich, Acting Director of the National Institute on Aging, who will acquaint the committee with the Institute's progress in support of career training in aging.

Our second witness is the Director of the newly established Center for Studies of Mental Health of the Aging at the National Institute of Mental Health, Dr. Gene Cohen. He will discuss the Institute's research priorities in the field of the mental health problems of the elderly.

My first question to Dr. Greulich is, are you the Acting Director or is Dr. Butler?

Dr. GREULICH. Dr. Butler is the director-designate of the Institute and should be on board in April.

Mr. RANDALL. He has been confirmed or no confirmation is necessary?

Dr. GREULICH. Confirmation is necessary, only in terms of some of the issues surrounding his recommissioning in the Public Health Service Commissioned Corps.

Mr. RANDALL. I asked that only because the doctor has appeared as a witness. Will you be good enough to proceed? We are honored to have you as a witness this morning.

Dr. GREULICH. Thank you.

Mr. Chairman, I do have a formal opening statement that I wish to read for the record, if I may.

Mr. RANDALL. Proceed, sir.

STATEMENT OF RICHARD GREULICH, ACTING DIRECTOR, NATIONAL INSTITUTE ON AGING, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. GREULICH. Mr. Chairman and members of the committee, it is a privilege to appear before you today to describe the National Institute on Aging (NIA), recently created to be the national focus of leadership for research relating to the aging process and the health of of the elderly. The National Institute on Aging is the newest Institute of the National Institutes of Health, having been established by the Research on Aging Act—Public Law 93-296—in May of 1974.

I would like to begin my testimony by providing a brief explanation of what we mean by "aging research." Aging is a natural phenomenon which, as far as is known, affects all higher forms of life and perhaps all living things. No matter how aging is defined, its implications for man and his society are profound. Twenty-two million Americans, 10 percent of our population, are now over 65 years old. In 50 more years, 40 million persons may be that old. Two-thirds of the Federal money spent on health in this country goes for persons over 65.

The obvious need for tangible and immediate improvement in the quality of life for the aged has shifted research away from its exclusive disease orientation, with its study of the sick and institutionalized, to a broader inquiry into normal physiological changes with age, the behavioral constitution of the aged and the social, cultural, and economic environment in which the elderly live. It is this expanded concept of aging research which will dictate the direction of the aging research program in future years, and provides the context for any discussion of research training relevant to aging and the aged.

I am happy to report that the NIA is beginning to function as an independent organization within NIH. A permanent director has been selected and will be in place by early April. Relevant organizational components of the National Institute of Child Health and Human Development, formerly the focal point for aging research at NIH, were transferred to the new Institute in July 1975. These include the Adult Development and Aging Branch, responsible for extramural grants and contracts, and the intramural research programs of the Gerontology Research Center (GRC), physically located in Baltimore, in conjunction with the Baltimore City Hospitals. In addition, a core staff, which will provide direction to and administrative support for the Institute's programs, has now been assembled.

Although 1976 can best be described as a year of planning and organizational development, the ongoing programs of the Institute did produce advances in several areas of research. These promising areas are scheduled for expansion in 1977, and I thought you might be interested in hearing a little bit about that.

The ability of the body to protect itself against disease—immune function—decreases with age. Discoveries in recent years have confirmed the importance of this loss, while at the same time pointing to the possibility that this process can be delayed by experimental intervention. This year, for example, NIA scientists in the laboratory of cellular and comparative physiology, in our intramural program in Baltimore, showed that certain strains of old mice can be returned to a state of youthful immune function by infusion of lymphatic stem cells derived from young donors. Certain chemical reducing agents also seem to rejuvenate the older animal's immune function.

At the University of California, Los Angeles, an NIA grantee found that by restricting the number of calories or the protein content of an otherwise balanced diet of laboratory mice, he was able to prolong life span by 15 to 40 percent, to lower the incidence and growth of spontaneous and transplanted tumors, and to increase resistance to some viral infections. Such regulated animals were shown to possess an immune system which remained or acted younger longer than the immune systems of animals on an unlimited diet. Additional studies to delineate the relationship between diet and age are now in progress.

One of the most disturbing aspects of aging is the state of progressive mental deterioration of the elderly called senility. Although generally known by this single name, the condition is probably a composite result of disease-derived changes coupled with more subtle and less well understood deteriorative changes which are intrinsic to the aging brain. Even though this phenomenon is not well understood,

there is a method of treating the patients affected by it. For example, NIA scientists found recently that a classical technique used to improve memory (mnemonics) can be taught to elderly people. Once learned, this technique can be used in a variety of ways to improve a person's memory of recent events. This simple method proved to be easily learned by older subjects and was quite effective in helping them store and recall information. This area of study appears to have immediate prospects for application.

Previous studies in the Gerontology Research Center have shown that age is normally associated with an alteration in the relaxation phase of the rhythmic contractions in isolated heart muscle of the rat. Other studies have indicated that a similar alteration in muscle relaxation may also occur in man. This research has now been extended to studies in men participating in the Baltimore Longitudinal Study, about which I will speak later, and will continue to be supported in 1977.

An estimated 19 million Americans 45 years of age or older are victims of hypertension, more commonly known as high blood pressure. The magnitude of this problem in middle-aged and older adults makes it imperative that more be learned about high blood pressure and the most effective ways to treat it. Using a technique known as operant conditioning, scientists at Gerontology Research Center have succeeded in teaching patients with hypertension to control their own blood pressures. This technique is one that warrants further investigation in this important health problem often associated with aging.

Turning now to several programs planned in the coming year—several new programs are planned in the clinical, behavioral, and societal aspects of aging.

The Gerontology Research Center began a longitudinal study of aging in 1958, which now has 650 men actively participating; women will be added to this study in 1978 to provide greater validity with respect to the general population. I might note that in 1977 we will undertake the necessary planning so that women can be added to the population study in 1978.

Another important area of concern is the finding that certain classes of therapeutic drugs elicit unexpected responses when administered to elderly patients. Such paradoxical reactions as they are called are frequently opposite to the response which would normally be anticipated. In view of the frequency of these occurrences and the growing number of elderly patients receiving drugs, NIA will begin in 1977 a systematic research effort to determine the cause of change in drug sensitivity and response as a function of increasing patient age.

To date a limited number of studies supported by the Institute have dealt with individual adjustments to the problems of aging, but little is known about the relationship between social factors and the health of the aged. For example, a major problem of the elderly is social, economic, and physical dependency. In order for the NIA to help keep elderly people independent and functioning members of society it must conduct research on such factors as the effect of mandatory retirement, the problem of transportation to community and medical care facilities, and the stigma attached to old age.

The prevention or amelioration of the debilitating effects of old age is another area of concern to the NIA. Research findings to date indi-

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cate that changes in behavior early in life may have the effect of warding off some of the adverse consequences of the normal aging process. For example, the longitudinal study conducted by the Gerontology Research Center suggests that exercise may lead to a longer life. There are, of course, numerous other factors that require study in order to make similar determinations concerning current behavior and subsequent health.

With respect to the resources needed for the aging research, the present research program of the NIA focuses heavily on the biological process of aging. Although this research is extremely important, the Institute must expand its horizons if the many health problems of the aging are to be solved. Thus, in 1977, the Institute will move to develop adequate resources for future research efforts, and will begin new programs in the clinical, behavioral, and societal aspects of aging.

Animal Resources: One of the major obstacles to the study of the aging process has been the absence of suitable laboratory animals on which scientists could either perform their experiments or systematically observe the aging process. Until recently, investigators throughout the country were unable to acquire supplies of shorter-lived species of common laboratory animals, notably rats and mice, in a fashion which would provide adequate numbers of all age levels. A significant contribution by NIA to the advancement of basic studies of the aging process is the establishment and maintenance, through contract, of a germ-free colony of laboratory rats and mice, of known genetics or genealogy, at different ages, and in numbers sufficient for aging research. We look forward to an expansion of this program in coming years.

Turning now to the primary thrust of this committee, I would like to speak about research manpower. A primary concern of the NIA is to insure the availability of adequate manpower to perform aging research. Because the field of gerontology is not well established in some of our Nation's medical institutions, there is a shortage of adequately trained research manpower. At the same time, the number of young investigators interested in the field of aging, but unable to find funding for their research, is increasing. For these reasons, we especially appreciate the opportunity to discuss this area in greater depth today.

It should be recalled that, prior to the establishment of the National Institute on Aging, research relating to the health status of the aging and the elderly was an integral facet of the overall programs of the National Institute of Child Health and Human Development at NIH. Subsequent to the legislative mandate of the Research on Aging Act, those programs of the NICHHD became core elements of the new National Institute on Aging. Thus, existing fellowship and training grant holdings relating to gerontological research were transferred to NIA, along with relevant holdings of research grants, research contracts, and a modest intramural component of laboratory and clinical research, that being the GRC in Baltimore.

Let me emphasize that the training activities supported by NICHHD were totally oriented toward research rather than service, and remain so today under NIA's aegis. Our funds are expended in support either of individuals, directly through the research fellowship mechanism, or of groups of individuals, through the mechanism of the

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institutional research training grant. In either case, the settings in which the training is undertaken are almost exclusively university graduate schools and health centers. The intent of this support has been and will continue to be that of developing highly skilled young people for research careers responsive to the needs of the aging and the elderly. Our Institute anticipates that this type of training will continue as an essential programmatic thrust in progressing toward the alleviation of many of those health and related social problems which impact on our older citizens.

Such research training support presently involves young people at both the pre- and postdoctoral levels, in such diverse areas as biology, medical science, psychology, and social science—primarily as they relate to questions of health and illness. With the transfer of fellowship and training grant holdings from NICHHD in July 1975, the National Institute on Aging assumed sponsorship of 121 predoctoral trainees or fellows and 44 postdoctoral trainees or fellows. The dollar level of support of these individuals transferred to NIA from NICHHD was slightly less than $2 million. Currently, the status of training efforts of this Institute, as well as those of the overall NIH, are in a state of transition. Until 1974, the statutory authority underlying NIH support of training at either the pre- or postdoctoral level resided in section 301 of the Public Health Service Act. During several years prior to 1974, however, searching assessments of both the needs for and the economic basis of such training support were undertaken, first within the executive branch, and subsequently by the Congress. New legislation, the National Research Service Award Act of 1974, emerged from this dual process.

Implementation of this new authority requires that traineeships and fellowships under the old authority be phased out with all deliberate speed; that is, that no new training commitments be made under the old authority. This Institute is currently supporting 81 fellows and trainees under section 301 of the PHS Act. These commitments will be fulfilled and phased out by 1979. For example, during fiscal year 1977, only 47 individuals will be receiving support under the old authority as compared to the 81 presently.

Simultaneously, we look forward to the growth of our training programs within the authority of the National Research Service Act. A strong case can be made that an urgent need exists for increased numbers of well trained researchers in virtually every aspect of science relating to aging and the aged. Currently, under the NRSA authority and the continuing resolution we are able to support a total of 17 trainees and 7 fellows, and in the context of the President's budget for fiscal year 1977, look forward to increasing this commitment by 19 additional fellowship opportunities.

Now, I am aware that among your concerns relating to gerontological training programs is that pertaining to the definition and maintenance of minimum standards of quality. Accordingly, I thought it would be appropriate to comment on the technique long employed by the National Institutes of Health in assuring high quality in their selection of research trainees and fellows: namely, the "peer review" process. Competitive applications, and I emphasize the word "competitive," from individuals for research fellowships, as well as appli-

cations from academic institutions for institutional training programs, pass through a dual process of review and approval.

Depending on the Institute involved, initial quality assessment is undertaken either by one of the study sections of NIH's Division of Research Grants or by an analogous standing review committee established by the Institute. Such initial review committees are comprised of at least 12 individuals, selected from outside of the Government on the basis of their scientific expertise in research relative either to the study section's area of concern or to the categorical Institute's research mission. In either case, they evaluate such proposals comparatively solely on the criterion of scientific merit.

The second level of review is provided by that National Advisory Research Council advisory to the specific categorical NIH Institute which will finance the training activity. This evaluation is also comparative, but takes into account not only inherent scientific merit but also the degree of relevance a particular proposal has to that Institute's mission and manpower needs.

It may also be of interest to you that an assessment has been made—and will continue to be made—concerning the effectiveness of aging research training programs in creating a more extensive body of active research, teaching, and other forms of gerontological activity in this country. In 1973, for example, a retrospective study was made of the group of predoctoral trainees in the aging area who had been supported by what was then NICHHD programs, and who had received their doctorates by 1970. Of the 175 individuals so identified, 97 had been trained in the social-behavioral sciences and 78 in the biological sciences. Of this group, 85 percent (148 out of 175) were found in 1973 to be engaged in career activities involving substantial work in aging or in other academic areas pertaining to human development.

A similarly high degree of effectiveness was evident in a comparable assessment of postdoctoral training wherein 77 percent (20 of 26 individuals) were actively pursuing research immediately germane to human development and aging. I suggest, therefore, that the quality of the training activities we support is maximized prospectively by the peer review process; and retrospectively by the ultimate involvement of the vast majority of our trainees and fellows in research pursuits responsive to gerontological needs.

While there seems to be no question as to the need for additional research personnel, trained from the outset in gerontological and geriatric concepts, NIA also intends to increase research in the field during the coming fiscal year through a mechanism called the special research grant program. We propose to earmark approximately $1 million in next year in order to initiate modest levels of grant support for as many as 75 young scientists. These are people who have already acquired their professional research training, but whose long-term career commitments are still uncertain.

It is our belief that such individuals might well be directed toward gerontological research careers as a consequence of competing successfully for this kind of initial research support. I may add that analogous research grant programs have already been used effectively, and for comparable reasons, by several other Institutes within the National Institutes of Health.

Finally, I would like to touch briefly on the longer term projections of the need for trained research personnel. As I am sure you are aware, the Research on Aging Act of 1974 directed that the Secretary, HEW, submit a comprehensive research plan on aging detailing precisely what opportunities exist for research relating to our older citizens' needs, and how the Department proposes to approach them. Stemming from the research plan, which is due to be submitted for congressional consideration by May 31 of this year, there should emerge a far clearer picture of both overall and specific requirements for additional research manpower.

Pending the submission and acceptance of this plan, the NIA proposes to continue its support of research training primarily in the areas of biomedicine and the social and behavioral sciences. Currently, these are the areas with which we have the greatest familiarity. Clearly, there also continue to be critical shortage areas with respect to research manpower. The Research on Aging Act of 1974 provides what to my mind at least is inferential direction that NIA might ultimately become involved in research and training relating to educational and economic aspects of aging.

The degree to which NIA does, in fact, acquire added responsibility for these areas will, I believe, depend on the final judgments made concerning our proper role as compared to that of several other agencies within the Department, whose missions are equally ones of continued commitment to the solution of the myriad problems facing our older citizens.

I thank you for your courtesy in permitting me to present this statement, and I would welcome any questions you may have.

Mr. RANDALL. Dr. Greulich, I have listened with interest and full attention to your statement, and it is an excellent one.

Dr. GREULICH. Thank you, sir.

Mr. RANDALL. I guess the preliminary question, is what kind of shop do you have out there? What kind of manpower and management do you have?

Now, all of these fellowships and programs are fine in view of your good record in the field, which is excellent, but I don't recall or find any statistics on where you stand.

You call this the National Institute on Aging?

Dr. GREULICH. Yes, sir.

Mr. RANDALL. NIA/NIH?

Dr. GREULICH. Correct. When the NIA was established, an identification was made of existing programs relating to aging research at NIH, then residing within the National Institute of Child Health and Human Development——

Mr. RANDALL. Over at the old Public Health?

Dr. GREULICH. No, sir, NICHD is another one of the NIH institutes. At the time the National Institute on Aging was set up, the first order of business was simply the identification of those programs and those people within the National Institute of Child Health who were concerned with aging and the aged.

As of last July these programs and people were transferred to form the corpus of the new Institute on Aging.

Mr. RANDALL. Let me understand here. We picked our people from those involved in child health for the aging?

Dr. GREULICH. Not entirely. Let me be clear. Formerly, aging research was carried on as a part of the mandate of the National Institute of Child Health and Human Development. All that has happened to date is that the components relating to aging research from the NICHD were moved administratively to form the operational corpus of the new Institute.

Mr. RANDALL. Thank you. It is a management field then?

Well, then let us go back to our original question. You moved this child health group which had management expertise, and now where are we as far as any kind of corpus of a structure out there. We fail to find any reference to that in your testimony.

What is the composition of your present staff? Who is responsible for administration and how many will you have when Dr. Butler gets there?

Dr. GREULICH. At the moment we have 176 people; 150 of these are intramural research scientists who work at the facility in Baltimore that I mentioned in my statement.

Mr. RANDALL. They are all over in Baltimore then?

Dr. GREULICH. Yes, sir. The remainder are on the Bethesda/NIH reservation. These 26 people have the responsibility for the programing and ultimate management of the research grants and research contracts, as well as overall management of the Aging Institute.

Mr. RANDALL. Now, we are trying to get down to figures.

Actually, all these folks over there are scientists who are working on projects. These are the in-house people and the other fellows—the fellowships, that is—the figure I was attempting to obtain.

Dr. GREULICH. Those are the grants and contracts management people then. There is the central administrative apparatus which currently has 12 people.

Mr. RANDALL. Administrative, and it has 12 people?

Dr. GREULICH. These would be jobs, like that which I now occupy. There is the budget officer, the personnel officer, and so forth.

Mr. RANDALL. That seems fairly modest.

Dr. GREULICH. It is modest, but it is a beginning, and one with which we are at the moment able to work. We certainly look forward, however, to being able to develop a stronger capacity in this regard.

Mr. RANDALL. Specifically, you referred to GRC physically being located in Baltimore.

What is the history of it? Where did that start? Where did it come from? How is it managed? How was it managed before it went into NIH?

Dr. GREULICH. I can give you a very brief history that I think will be responsive.

Mr. RANDALL. You obviously picked it up and managed it. Now what was the history?

Dr. GREULICH. The history of it is that before there even was the National Institute of Child Health and Human Development at the National Institutes of Health, there was a commitment made to the need for the study of aging—the biological and social processes underlying aging. Initially that aging activity was with the National Heart Institute.

Mr. RANDALL. Do you mean the GRC?

Our time has expired, but finish your question. We can come back to GRC. Was that under the Heart Institute?

Dr. GREULICH. Aging research activity was originally under the Heart Institute. With the creation of the NICHHD, it was determined that research on the full sweep of human development should fall within the Child Health Institute. The aging activity then was moved from the Heart Institute to Child Health.

With the recent advent of the Aging Institute, aging activities have been moved from the Child Health to the Aging Institute.

GRC was established in 1968. A determination was made that the NIH Clinical Center on the Bethesda campus would not be the best site for doing normative research on aging individuals. An aging research facility closely connected to a general hospital seemed a much more desirable arrangement. Thus, the GRC was established at Baltimore in conjunction with the Baltimore City hospitals. Up until the time that the GRC was transferred to NIA, it was considered a field station of NICHHD's intramural activities.

Mr. RANDALL. I will recognize the gentleman from Maine.

Mr. COHEN. Thank you, Mr. Chairman.

You indicated that you are finding some unexpected results or reactions from various therapeutic drugs. For example, what are you referring to?

Dr. GREULICH. Perhaps one of the most commonly recognized is the reaction to barbiturates. For younger people, as you would probably realize, barbiturates tend to have a depressing or calming effect. For a rather alarming number of older people, however, the effect of barbiturates is exactly the opposite, causing agitation and excitement.

Mr. COHEN. Have you followed that up with research on amphetamines?

Dr. GREULICH. I don't know of any research on amphetamines in aged.

Mr. COHEN. I think that you also indicated in your statement that you would like to have NIA conduct research in the field of mandatory retirement, transportation, economic dependency. The question that I have is if NIA is the appropriate institute for directing more research efforts in these problem areas?

Dr. GREULICH. I think my answer to that will have to be marginally responsive. We all perceive the need for this kind of research, but it is not clear yet whether this should be our purview. Until the Secretary's research plan on aging has passed from the Department to the Congress, and the Department itself has thereby sorted out how it wants to do its business, we will have to defer a decision in this matter. As far as the impact of retirement on health, I think personally that such research should be a part of our mandate.

Mr. COHEN. Well, perhaps you could explain the distinction between the type of research supported by NIA and title IV of the Older Americans Act, which is supported by AOA. What is the difference?

Dr. GREULICH. The critical difference relates to the fact that nowhere in the Older Americans Act is there a mandate to the Administration on Aging to do research in health. Traditionally, the NIH and NIMH have been the primary agencies for health-related research.

Mr. COHEN. Do you not agree that NIH is basically—or more basic—experimental as opposed to that of AOA, which is more policy oriented?

Dr. GREULICH. I would agree that this has been the pattern.

Mr. COHEN. But you are suggesting that you should also be involved in more policy, economic and social?

Dr. GREULICH. I think there are aspects relating to the health status of the elderly which are in a sense economic and social and which are so health related that we would be remiss if we did not give at least very careful thought of getting into those areas. It would not be a departure as you are suggesting, if I hear you correctly, from the traditional stance at NIH with its approach to research.

Mr. COHEN. You are also indicating that you think there is some immediate prospect for the application of research in the area of mnemonics and mental deterioration. Could you explain that in some detail and perhaps some specific application?

Dr. GREULICH. Of course. The word "mnemonics"—it comes from the Greek, a memory aid—is commonly used by students to learn long lists of new information usually.

In our medical schools, for example, there are any number of mnemonic sentences. The initial letter of each word in the sentence is used as a key to whatever the information is.

For many older people, it is frequently almost as difficult to learn and recall complex mnemonic sentences as to remember whatever new information they are trying to master.

Let us use a grocery list, a mundane but quite real example. The technique here is to teach an individual to take an imaginary walk through his house from one room to another, starting perhaps in the vestibule, going to the living room, the bedroom, and so on. The secret of the mnemonic is to take that walk in an orderly fashion, one which is readily familiar and recallable. The new information is recalled room by room. If they have to get bananas, for example, that may be the bedroom.

Mr. COHEN. I know that my time has run out, but it seems that that is exactly the process Mr. Lucas used in his book called "Memory Book", which was an old technique used by the Greek orators.

Dr. GREULICH. Cicero was among the first to recommend mnemonics as aiding memory.

Mr. COHEN. But even prior to Cicero you had some Greek orators who could not write it all down, so they started by going through the entrance of the building and identifying various objects.

Dr. GREULICH. It is an old technique.

Mr. RANDALL. Thank you very much, gentlemen.

I recognize the gentleman from Washington, Mr. Bonker.

Mr. BONKER. You stated 1976 is a year of planning or organizing of your 172 member staff. What percentage of time and commitment would you estimate was on pure research as opposed to organization or development?

Dr. GREULICH. I cannot give you that exactly, but I will give you a fairly accurate estimate.

Of the 150 people at the Gerontology Research Center, which is a substantial part of our organization now, certainly, 130 were engaged full time in research.

Mr. BONKER. How can you say that 1976 can best be described as organization and development? It seems to me that if 150 people were committed to full-time research, the organizational plans and development would be fairly minor, a fairly minor objective in your agency.

Dr. GREULICH. I tried to indicate that we have not left research alone by any means—particularly at the GRC. I would point out that because NIA is a new Institute, we have the same problems pending which would face any new agency just beginning to establish itself. In addition to that is the task of developing a research plan on aging for which we are the lead agency. It was really in the context of getting the new organization off the ground, getting it ready to become participatorily independent from NIH, and also the preparation of the research plan that I used the words about "organization and planning."

Mr. BONKER. In your statement you mention areas of ongoing research, and under it "comparative physiology." You made reference to some testing where you use older mice and return them to a stage of being youthful, I mean, deter the aging process in older mice by the infusion of lymphatic cells derived from younger donors.

Could you expound on that and maybe explain how you would apply that to senior citizens or to humans?

Dr. GREULICH. Over the past 10 years, or thereabouts, it has become clear that much of what we call resistance to disease—to infection—resides in the lymphatic system of the body. The two primary organs are the thymus and the bone marrow. It is the lymphatic system which seems to control to a large extent the degree of defense that the body can put up against some sort of challenge.

It has been well documented that with time, with age, the capacity of these cells diminishes in the sense of being able to react appropriately to an external challenge—whether it be to a bacterium or a virus or what-have-you. No one understands exactly what goes on in this process of gradual decline. However, it was a surprise in a sense, to find that by using matched genetic strains of mice we could take the bone marrow and lymphatic cells from the young donor mouse and infuse the older animal with its cells and thus confer on the older animal a much more youthful capacity to defend itself.

Mr. BONKER. What effect would that have on the youthful donor?

Dr. GREULICH. The youthful donor is pretty prompt in making up the losses. In this case the animals were sacrificed in the process to get sufficient cells, but in theory it would be quite possible to keep the animals alive. They regenerate their stem cells quite readily when they are young.

Mr. BONKER. Do you see the day when this can be applied to humans?

Dr. GREULICH. I think that is a long way from any real potential for application, primarily because of the genetic problems.

Mr. RANDALL. The gentleman may proceed for 5 minutes. The Chair will stay with you.

Mr. BONKER. Thank you, sir.

You also mentioned that controlling the protein content and calories in the diet of mice could prolong life by 15 to 40 percent. Do you see that as realistically applied to humans?

Dr. GREULICH. I think that it probably will, but that is my own professional judgment. It is going to take time to find out what factors are really involved. The information I provided you would suggest that somehow caloric-protein restriction in early life in these laboratory animals enhances the effectiveness of their immune system.

We do not know about human beings in this respect. It would be nice to just simply say that if you could keep your kids from eating too much as youngsters, that maybe the same kind of effect would be evidenced when they reached maturity. I think that out of our longitudinal study of normal people will come some information bearing on this whole issue. In the study, we are looking very carefully at the eating habits of the GRC's longitudinal group.

This is the group that I mentioned: the 650 people ranging in age from 20 to 93, who come back every other year for 2½ days of extremely rigorous physical examination and tests. They do this on a voluntary basis. We have followed some of them since 1958.

The problem of extrapolating animal information directly to man, as I am sure you are aware, is very, very profound. The longitudinal approach, however, would probably give us the kind of information that you are asking about.

Mr. BONKER. Euthanasia is becoming a controversial issue. Is the Institute involved in a study of it? What are you doing about the issue? Are you considering whether or not scientifically and medically we should be working toward artificially prolonging life?

Dr. GREULICH. In direct answer to your question, we are doing nothing in this area. I regret that answer in many respects, because I think that preparation for death and its realities is an extremely important concomitant of human education.

I would hasten to assure you that the issue of euthanasia does not enter into our perception of what we are about. Our primary interest is in making life as personally and socially rewarding as it can be for as long a period of time as is possible. The extension of lifespan is not one of our primary goals at this moment, largely because we would not have the first notion of how to go about it, and because there is also the philosophical issue of how society could deal with people if they live longer.

It is a very broad and deep area. Obviously, at this point, we want to make life better, not longer.

Mr. BONKER. I appreciate that. Thank you.

Mr. RANDALL. Thank you, Mr. Bonker.

Doctor, we will try to go back and go through your testimony. Mr. Bonker has covered the lymphatic infusion. I know that on that same page you touched very briefly on the eating habits of the young. You say that the University of California along with the others, has done some studies about the number of calories and particularly protein content.

Is there some indication of too much protein consumption?

Dr. GREULICH. One could draw that inference, but I think that it would be premature to do so. The issue of restricted diet and its effect on longevity is not of itself a new finding. As a matter of fact, it was originally made some 40 years ago by Dr. C. M. McCay, a very famous American nutritionist. The newer data suggest that the effect of restriction of diet may be mediated by somehow keeping the immune system going better. It makes the system more resistant to challenges from without, such as infections, tumors, and so on. We think we are getting a handle on why caloric restriction or protein restriction has this effect.

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Now, what is wrong with proteins? I do not think anyone would care to say at this point. There is no information available. Indeed, it may turn out that there is nothing wrong with proteins per se. It may be more a question of dietary balance.

Mr. RANDALL. You are speaking of proteins, you are getting very close to certain religious groups and others who believe we should not eat meat.

I believe they say it prolongs life. There is the vegetarian system in our own district, quite a large religious group, and that is the central part of their thinking.

Dr. GREULICH. Yes, sir. The Seventh Day Adventist Church, of course, does not believe in consuming meat or meat products. There have been a number of studies made of their health status, and, on the whole, I believe Adventists do appear to have some advantage over the general population with respect to longevity and freedom from some diseases.

Mr. RANDALL. And you say the study is of the Seventh Day Adventists?

Dr. GREULICH. Yes, sir. However, comparable studies and findings have also obtained for the Church of the Latter Day Saints—the Mormons—whose religious preferences relate to abstention from stimulants such as coffee and alcohol, but whose protein intake is derived largely from meat and related animal products. Consequently, the general applicability of these studies is still a matter to be determined by additional research. These are directions, but they are not final and definitive findings by any means.

Mr. RANDALL. So, there will not be any lack of quality on the record, the church group that we are referring to is the Unity. Their world headquarters is in our district, and they have some dishes that they prepare there containing soy products and different types of vegetables. You honestly believe you are eating meat, however, and they are totally meatless. Our home city is also the world headquarters of the reorganized Church of the Latter Day Saints, and you are so right when you say they have rather definite dietary planning that they advise their members to use.

The gentleman from Washington.

Mr. BONKER. I have no further questions.

Mr. RANDALL. Thank you.

I believe, we have Dr. Cohen also and we have a lot of questions to ask.

Now, Dr. Greulich, this is a most interesting subject. I am sure we all want to live longer, even the doctor, and we also want to live in a condition that we have our possessive sensibilities, and want to avoid senility. Now, there is a lot of fascinating work going on in the full committee and the subcommittee brought some folks down from Minneapolis last year.[1] At the hearing, they spoke of wanting a surgeon there to perform, I believe, it is carotid artery operations, literally scraping out the carotid artery. I note that you made no indication of a study in that area, but then there are equally fascinating developments going on in the city of Chicago, and it is now available, we understand, for

[1] Reference is to the hearing, "Innovative Alternatives to Institutionalization (Minneapolis Age and Opportunity Center, Inc.)," held July 8, 1975, by Subcommittee No. 2 of the Select Committee on Aging.

those of means. It may cost as much as a thousand dollars for a series of treatments for elderly patients. It is a very high concentration of oxygen for a series of days that literally clean out the accumulation of the hardening process in the brain. It really is fascinating. We know that all over Europe there are several countries, some behind the Iron Curtain, that perform this fascinating procedure. Is your Institute doing anything about it? Are you on top of the situation in Chicago? Do you know what they are doing out there?

Dr. GREULICH. We are aware of what is going on in these areas. I would point out that problems of vascular supply to the brain fall within the purview of the National Heart and Lung Institute and that of the National Institute of Neurological and Communicative Disorders and Stroke. This is the matter of turf that you are getting into.

Mr. RANDALL. Turf? We are at the racetrack now.

Dr. GREULICH. Yes. Those Institutes at NIH have much more firm and clear-cut mandates to do research in those areas. We stay abreast of what is going on, of course. As you are finding out, it is an integral part in many instances of the aging process. After all, any number of older people do not have hardening of the arteries, nor do they need hyperbaric oxygen, which is the technique you are referring to. We are probably a little more concerned with aging in the broader context than with something such as the issue of whether the vascular or nervous system is intact or not.

Mr. RANDALL. That is the point. It is, as we understand it, the therapy or the treatment for the avoidance or the correction, of senility. That is what it is, hyperbaric, and it is this carotid artery. You are engaged at NIA in the broader study rather than the specifics. Is that what you are saying to me? Are you showing this committee that other research is going forward in HEW? What branch of NIH is that now?

Dr. GREULICH. In the National Heart and Lung Institute. It is going on as well in the National Institute of Neurological and Communicative Disorders and Stroke.

Mr. RANDALL. Doctor, I think we need to have you draw us a chart in all that goes on across the street. They have a beautiful campus out there. We have been out there. We know all about the operation of it, but I think you need to meet with our staff here and do sort of a work chart of who was doing what. Maybe we need to talk to some others, other than yourself.

Dr. GREULICH. We can provide such information for the record if that is acceptable.[1]

Mr. RANDALL. We are asking you to do that if you would, please.

Doctor, I was noticing that you repeated again and again throughout your testimony the words "Longitudinal study." Would you explain longitudinal study for us?

Dr. GREULICH. There are two ways of comparing the aging process. You can take a group of people that are 80 years old and measure several aspects of their function and then you can take a group that are only 40 and compare or measure the same functional attributes in them. That is a cross-sectional study. Then you can take a chance, really, and set it out that the differences between the two groups is

[1] The information provided appears in the appendix, pp. 79–82.

because of age. That is dangerous because the people who are 40 years old have had different backgrounds, different life experiences and different environmental exposures than those who are 80. It becomes somewhat risky to do these cross-sectional studies.

The longitudinal study, on the other hand, is a much slower and much more expensive procedure which examines the same person, year after year, to find out what he or she was like at age 40 as compared to what he or she will be like at the age of 80. This is the most rigorous way of testing out what aging is at an individual level. I hope I have not confused you.

Mr. RANDALL. Not completely or totally. We are trying to catch on here. Does this have anything to do with this group that you brought over that has been returning since 1958 who are somewhere between age 20 and somewhere up to what age?

Dr. GREULICH. Age 93.

Mr. RANDALL. And they have been going over there and coming back every year since 1958?

Dr. GREULICH. Correct.

Mr. RANDALL. I think I notice on page 4 that you finally spell it out. You call it the longitudinal study. What do you mean by paradoxical reactions to drugs? Is that what we call a side effect or adverse effect? We know what a paradoxical reaction is, and then you refer to drugs.

Dr. GREULICH. In essence, it means that the effect of the drug is virtually the opposite of what one would expect it to be. That is the paradox.

Mr. RANDALL. Are either of our colleagues ready for questions or do you want to wait a few more minutes? The gentleman from New Jersey or the gentleman from New York, do you want to defer for a moment?

Mr. HUGHES. I have no questions, Mr. Chairman.

Mr. WALSH. Yes, Mr. Chairman. I am very sorry that I am late.

Mr. RANDALL. It is good of you to be here.

Mr. WALSH. There was a meeting of the Public Works Committee and the Veterans Committee, and I am on both of them. They were off at 10 this morning and I can generally be at two places at once, Mr. Chairman, but I have not figured out how to be at three.

In reading over some of the material in the folder, you talk about research in aging, Doctor, and in the year 1975, there is the statement in here on the concept of the blood level of alcohol when deferring to intoxications. I am wondering if it may need to be adjusted to allow for the age differences in the alcoholic effect.

Dr. GREULICH. It may have a profound impact on that whole issue. The study of the effects of alcohol as a function of age is again a product of the Gerontology Research Center in Baltimore. It utilizes the longitudinal study group. These people received very carefully controlled doses of alcohol intravenously. The various psychological and physiological testing that was done on them demonstrated amongst other things that loss of function was greater in older persons. That is not perhaps too surprising but the rather difficult part of it was that the older people were less aware of their reactions than were the younger ones. So they did not feel high. They did not feel as though they had any impairment of their judgmental processes at all. It was the same dose which would cause the younger person to

say, in effect, "Boy, that really hit me and I am not fully up to par in terms of my ability to react." There are some implications here which need to be studied further, obviously, and perhaps even taken over by one of the other Institutes.

Mr. WALSH. In connection with the injection, you say, the alcohol was injected intravenously?

Dr. GREULICH. Yes.

Mr. WALSH. Has it been established that there has been the same effect or more of an effect than in taking the alcohol orally?

Dr. GREULICH. It has a much more rapid effect, but the ultimate level of intoxication is about the same. It is just absorbed that much more rapidly, so that, in the vernacular, it hits more quickly.

Mr. WALSH. So in determining whether or not the level of alcohol in the bloodstream that we use to determine whether a person is driving while intoxicated may need some change then, I would assume, because it is absorbed more rapidly, and you could really question whether or not this would be a valid study in changing the law with respect to drunken driving while intoxicated.

Dr. GREULICH. It could not possibly be applied immediately because of the route of administration utilized in the studies I have reported. One would have to repeat them giving oral doses. The reason we did not choose to use the oral route is that alcohol effects are highly variable in terms of what people may have eaten, or of the general state of their digestive system. We wished to avoid these variables. We wanted to get the same level of alcohol into the blood at the same speed in these various individuals. Obviously, we have a lot more work to do in this area.

Mr. RANDALL. Gentlemen, we shall proceed.

Mr. WALSH. *Just one or maybe two more questions, Mr. Chairman.* I would appreciate the time.

Mr. RANDALL. You certainly may have it.

Mr. WALSH. In connection with the whole field of dietary studies, Doctor, that are you pursuing at Baltimore on the effects of some of the foods, have you been able to draw real conclusions yet with respect to the effect of the diet on the aging process?

Dr. GREULICH. I will answer the second question first. The answer is no. We have not been able to draw any conclusions, but we perceive even more clearly the need to know far more than is currently known about the impact of dietary habits—the food levels of vitamins, minerals, and so forth that people take in—on life expectancy. This is another aspect of that longitudinal study. We are keeping a very careful dietary record on people engaged in that study.

Mr. WALSH. I am concerned about the whole field of diet for aging and its relation to health, because I noticed, and you may have too, that we are proceeding rather rapidly in the development of some dietary foods in this country. What is disturbing about it is that in the case where they bring out new dietary foods, and they simplify the refining process, the canning process or the freezing process; they may remove something that appears to be deleterious to health, but the price of the product increases. I guess, the best example is the use of salt in some of the products that we have. They merely take the salt out, yet the cost increases about one-third. They take sugar out of a

soft drink and the price goes up. They even take some of the nutrients out of beer and the prices jump about 30 percent. I do not know if this is your prerogative, but I wish you'd make some suggestions as to the level of government or agency of government I could turn to for suggestions in this field.

Dr. GREULICH. I hate to be nonresponsive, but I have no real information about where in the Government that should be addressed. At the moment it is not in our immediate capacity for exploration, but it certainly is a part of what we have in mind with respect to learning more about the nutritional needs of the elderly.

Mr. WALSH. Thank you very much, Dr. Greulich. I have no further questions.

Mr. RANDALL. Thank you, gentlemen. The gentleman from New Jersey, do you have some questions at this point?

Mr. HUGHES. I am going to apologize for a conflict in my schedule. The Judiciary Committee, on which I serve, is conducting an extremely important hearing at this time.

Mr. RANDALL. I want to go on the record and say that you have been a faithful member of this committee, not only in terms of the hearings here in Washington, but in the field. He was present at one of the finest field hearings we have ever attended. We are all grateful.

Mr. HUGHES. I will have a question of Dr. Cohen. I am interested in knowing a little about the environmental conditions and factors that seem to contribute to the mental impairment of residents in nursing homes. I think that you cite some statistics in your testimony, and I wonder if you can describe to us what the factors are in your judgment that contribute to this impairment.

Dr. COHEN. I have not had an opportunity yet to give my general opening statement.

Mr. RANDALL. The doctor has not had an opportunity to testify.

Dr. COHEN. I would be happy to respond.

Mr. RANDALL. I believe that the gentleman from New Jersey would rather listen to Dr. Cohen at this time, but we have not reached a conclusion of the questioning of Dr. Gruelich. I want to say to you, sir, that the Chair has studied all of your statement very carefully during the time our colleagues have been questioning you. I want to commend you and compliment you. You used the word "modest." I suggest that you have done a very good job and we believe that you have done a very good job in retaining these folks. In other words; it is one thing to select them, but you have proven to us that you have done a good job in the selection of your fellowships, your graduate students and your contracts, but particularly as to these persons who have gone through the training. You have a very commending row of figures that 85 percent are going on into careers in aging. In conclusion, I simply want to compliment you.

Now, we have with us Dr. Cohen, and our time is fleeting. Dr. Cohen is the Director of the newly established center for the studies in mental health of the aging out at NIMH.

Dr. Gene Cohen is going to discuss with us the institute's research priorities and mental health problems of the elderly. Just proceed, Doctor. You do have a statement, I believe.

STATEMENT OF GENE D. COHEN, M.D., CHIEF, CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING, DIVISION OF SPECIAL MENTAL HEALTH PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH

Dr. COHEN. Mr. Chairman and members of the committee: I am pleased to appear before you today to present our views on the Center for Studies of the Mental Health of the Aging.

The mandate given the National Institute of Mental Health is to conduct a program of research, training, and services for the prevention and treatment of mental illness and for the maintenance and improvement of the mental health of the Nation. Since persons 65 years of age and older now constitute approximately 10 percent of the population, or 21.8 million citizens, it follows that a significant portion of the NIMH effort should be directed toward the mental health problems and needs of this group. The fact that the aging constitute a population defined here only by chronological age, provides some indication of the size and variety of problems that are encountered. Included in this group are persons from all social and economic levels, all racial and ethnic groups, from every region of the country, representing every occupational and educational background, and displaying the widest possible range of mental health problems and needs. The high incidence of poverty, increased susceptibility to debilitating physical disease, the loss of status in a youth-oriented society, and personal losses, such as death of spouse, that increase with advancing age, are all factors that contribute to the vulnerability of this age group and to the pressing mental health problems that they experience.

The enormous implications for mental health posed by this segment of the population are reflected by the fact that psychopathology in general and depression in particular rise with age to the point that the highest incidence of new cases of psychopathology of all types is found in the population 65 years of age or older, as reported by the World Health Organization. Their survey found that in the 65-plus group, there occurred 236.1 new cases a year per 100,000 population, or 2½ times the rate found in the next highest age group. Suicide also increases with age and attains its zenith in elder white males. In fact, 25 percent of all suicides in this country occur in the 65-and-over group, despite this group representing only 10 percent of the population. Of the more than 1 million persons over 65 who live in nursing and personal care homes, it is estimated that more than one-half display a significant degree of mental impairment while over 40 percent evidence symptoms of depression, anxiety, or psychosis severe enough to justify psychiatric intervention. Though it is more difficult to obtain precise data for community residents, it is estimated that from 10 to 25 percent of the elderly in the community are suffering from significant mental impairment and that the incidence of depression is almost as high as that found in the residents of institutions for the aging. Some measure of the lack of attention given the aging by mental health professionals is reflected in a recent NIMH conducted study which showed that more than 60 percent of the elderly admitted to State mental hospitals have received no previous psychiatric care; that is,

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the State hospital is the first mode of mental health intervention for them. Moreover, fewer than 4 percent of persons seen at public or private mental health clinics are over age 65. This age group represents more than 10 percent of the population and yet it has a greater prevalence of mental disorder than experienced by any other age group.

Faced with a mental health problem of this magnitude, the NIMH has attempted to mobilize its resources to maintain and, if possible, to improve the mental health of this segment of the population. By the active support of research, the development of innovative and more effective methods of delivering mental health services, and the education and training of appropriate manpower, the NIMH is seeking to provide increased and precise knowledge of the factors associated with mental health and mental disorder in later life, to devise means for preventing mental disorder and maintaining the psychosocial functioning of older persons, and to stimulate greater interest and more adequate programs for the elderly on the part of various public and private agencies and institutions responsible for the mental health and welfare of the American public.

In recognition of the importance of the problem and of the need for a greater concentration of NIMH resources to meet it, the Director of NIMH during the past year announced the formation of a Center for Studies of the Mental Health of the Aging, thus moving the aging program to a higher status within NIMH. The primary purpose of the Center is to centralize the Institute's efforts on behalf of the mental health of aging persons. The Center coordinates NIMH programs affecting aging persons in the areas of research, training, and services. It collaborates with other governmental agencies, in particular, the Administration on Aging and the National Institute on Aging. It also relates to other public and private agencies at the national, regional, State, and local levels. Its goals are carried out through technical assistance and its efforts are directed toward stimulating and encouraging:

(1) Research into areas in which knowledge is needed;

(2) Incorporation of mental health considerations in programs for the aging in which mental health components have been neglected;

(3) Development and evaluation of innovative programs for the delivery of mental health services to the elderly;

(4) Development and evaluation of innovative mental health training programs to enhance skills for working with older persons; and

(5) Development and dissemination of information about the mental health and mental illness of the aging.

The technical assistance offered by the Center is carried out through dissemination of information, consultation, participation in conferences, meetings, institutes, and workshops. In this first year of the Center's existence, three conferences have been planned in the major areas of research, services, and training. Participants attending will be leading experts in each of these fields and members of NIMH staff who relate to these areas. The purpose of these meetings is to intensively study issues, needs, and gaps with regard to research, services, and training, and to come up with well-thought-out perspectives for rational planning and implementation of programs in these areas as they relate to mental health and aging.

Around the time the new Aging Center at NIMH was developed, the Director of NIMH established a research advisory group to assist

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him in the setting of the Institute's research policies. This group devoted several of its first weekly meetings to consideration of the NIMH research program in aging, with t e aim of defining the areas of research most appropriate to the Institute. The following three categories emerged:

(1) Etiology, diagnosis, and treatment of mental disorders;
(2) Development and delivery of mental health services;
(3) The prevention of mental disorders.

In each category, there are a number of more specific areas designated as proper responsibilities of NIMH. This report has been widely circulated, both as a means of public information and to stimulate research interest and studies appropriate to the mission of NIMH. Examination of the research projects supported by NIMH during the past fiscal year, as well as in previous years, reveals that the research previously supported, also fits quite well into these three categories. During the past fiscal year, 55 research projects were funded by NIMH which are of relevance to the mental health of the aging and which can be placed into the three categories mentioned above. Specific information about the kinds of activities which are being carried out in these categories is given below.

THE ETIOLOGY, DIAGNOSIS, AND TREATMENT OF MENTAL DISORDERS

This category contains the largest number of projects supported during the past year. Included in it are a wide range of studies dealing with biomedical and psychosocial processes with important mental health implications, a number of studies having to do with the effect and appropriate use of the various psychoactive drugs, clinical studies of mental diseases, particularly chronic brain syndrome and depression, and studies into the epidemeology and demography of mental illness in the elderly. The need for further and more precise knowledge of the nature of mental illness in the elderly is emphasized by a study conducted at the Research Foundation for Mental Hygiene in Albany, N.Y. This study, which has been going on for several years, is now focusing on geriatric patients with special reference to distinction between and prognosis for organic disorders. The study is of a cross-national character, in which the same diagnostic procedures are applied to populations of older people in the United States and the United Kingdom. It is of interest that nearly 80 percent of the first admissions to mental hospitals of persons 65 years of age and over in the United States are diagnosed as organic disorder, while in the United Kingdom only 46 percent who were admitted in this age group are so diagnosed. Such a dramatic difference demands further investigation and study since it has important implications for the treatment of mentally ill older people.

DEVELOPMENT AND DELIVERY OF MENTAL HEALTH SERVICES

A number of innovative experiments in this area have been supported during fiscal year 1975. They have ranged from studies of the effect of various architectural arrangements on mentally impaired older persons in institutions, through the study of a new and more effective program for persons resident in nursing homes and retirement homes to the need of providing mental health support and treat-

ment for older persons living in very deprived circumstances in welfare hotels in large cities. Typical of these projects is the one being conducted by the Ebenezer Society in Minneapolis, Minn. In this project, a home for the aging serves as the focal point for a wide range of institutional and community activities designed to maintain the current level of functioning of older persons, slow down deterioration, and reduce and possibly halt deterioration often associated with chronic brain syndrome. The program has been quite successful, not only in the treatment of the subjects included in it, but in mobilizing a variety of community resources and focusing their efforts upon providing more appropriate therapeutic and supportive services for older persons who are at high risk of being permanently institutionalized.

PREVENTION OF MENTAL DISEASE

This category contains the second largest number of research projects recently funded by NIMH. Since projects in this area are concerned with the wide variety of psychiatric, psychological, and sociological aspects of the older person's life, the studies contained in it similarly reflect a wide range of interesting and important research projects. Studies aimed at developing understanding of the meaning of forced retirement from employment and the value of assisting the older worker to prepare for it, the effects of housing and various living arrangements on the adjustments and satisfaction of older persons, the role that remarriage plays in later life, and the importance of social integration on successful aging have all been topics addressed by these studies.

One of the most crucial problems that is encountered in attemping to provide more adequate mental health services for older people is the scarcity of mental health personnel with training and experience in working with the aging. Through its Division of Manpower and Training, the NIMH is attempting to increase the number of personnel in the traditional mental health disciplines who possess the necessary experience and background to deal effectively and appropriately with the mental health needs of the older population. An example of this effort is a training grant awarded to Duke University Medical Center which is aimed at increasing the numbers of psychiatrists training in community gerontopsychiatry and gerontology, and to prepare them for leadership roles in prevention, treatment, and rehabilitation of the aging. Training includes case studies and supervised therapy of inpatients, as well as of outpatients in retirement homes. A geriatric nursing program includes home visits. There is inservice training of subprofessionals and for professional welfare workers also provided.

The important role that trained social workers play in providing services to the aging is recognized by a grant given to the School of Social Work of the University of Wisconsin. This is a graduate training program in social work in the problems of the aged. Case material is derived from community help-giving agencies. There is individual and group instruction in problems of failing health, social isolation, early retirement, loss of income, use of leisure, and the confinement in nursing homes and homogeneous community housing projects. Frequent contact with aged people is maintained.

It has been recognized for a number of years that persons with no previous training in mental health or gerontology who are motivated

to work in a helping relationship with older people can be a valuable mental health resource provided that appropriate training is given to them. A number of projects aimed at training such paraprofessional personnel are being supported by the NIMH. One such project is being carried out by the University of Notre Dame in which paraprofessional training is designed for individuals and a mental health outreach program to provide mental health services to aged persons, who, for various reasons, do not avail themselves of such services from regular, public or private programs. Emphasis is on a broad base of problem understanding, problem solution, and patient rehabilitation. Trainees are chosen from middle-aged and elderly groups on the basis of health factors, motivation, personal adjustment, and capabilities, rather than on previous educational background or sex.

An important factor in improving the level of care afforded to the residents of homes for the aging and nursing homes is the provision of a pool of well-trained ancillary nursing personnel to provide direct service to the residents of such institutions. This fact has been recognized by the NIMH, and a number of projects have been undertaken to train such personnel. This has taken the form both of inservice training in such institutions and of university-based training programs for persons intending to work in these homes.

Further training activities relate largely to providing grants to educational institutions to conduct programs of continuing education designed to improve the skills in working with the aging of mental health professionals, as well as other persons concerned with the welfare of the elderly, such as public welfare workers, clergymen, and physicians in general medical practice.

Also during the year, the new Aging Center at NIMH was created; Congress enacted Public Law 94-63, title III of which is the Community Mental Health Centers Amendments of 1975. Presently, CMHC's number more than 600, covering catchment areas in which some 90 million persons reside. Of major importance, though, for older people, is the fact that this legislation requires that CMHC's provide services directed at the mental health needs of the elderly. Specifically, CMHC's must provide "a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services." Staff of the Center for Studies of the Mental Health of the Aging have been actively involved in this effort, both in the development of guidelines and regulations for such programs, and in providing consultation and technical assistance to directors and staff of CMHC's in various parts of the country. During the past year, staff of the Center have participated in conferences and workshops for groups of mental health center personnel, and it is anticipated that this effort will receive even more attention during the coming year. Indeed, NIMH is planning a major effort to assist CMHC services to the elderly through the identification and development of model services, service delivery mechanisms and staff training approaches that will significantly enhance the development of effective mental health care for the elderly.

This effort has also been furthered over the years through publications in the area of aging and mental health developed by NIMH through contracts. These publications have focused on the continuum from the community to the State hospital to the nursing home or other

long-term care facility. For example, these publications have included a guide for program development for aged persons for the use of CMHC staff, a guide for long-term care facilities staff of how to care for the mentally impaired aged patient, a social work guide for long-term care facilities, results of a study of retirement and its predictive variables, summaries of NIMH-supported research into the mental health of the aging, and the results of a longitudinal study of human aging. During the past year the new Aging Center at NIMH sponsored the development of a guide for staff of long-term care facilities on the maintenance of familial relationships of patients. Other publications are being planned for the immediate future, including summaries of NIMH research relevant to aging persons updated to cover the years 1961 to 1975; a primer on psychotherapy with the aged; proceedings of the Center's three planning conferences on research, training, and services; and a comprehensive clinical textbook on aging and mental health which should represent a landmark publication.

A further very important recent development is the Secretary of HEW's Committee on Mental Health and Illness of the Elderly, which Congress also mandated last year in Public Law 94-63. This committee, in close collaboration with NIMH and the Center for Studies of the Mental Health of the Aging, will be examining and making recommendations about future needs as they relate to mental health research, manpower, training, and services. In addition, institutions and alternatives to institutionalization will be scrutinized. The committee's work should provide a highly significant complement to the efforts of the Center for Studies of the Mental Health of the Aging in looking at needs, gaps, and potential new directions that could greatly impact on the mental health of the elderly in this Nation.

Mr. RANDALL. Thank you very much, Doctor. Your subject matter is just as interesting and just as fascinating as that of Dr. Gruelich. Unfortunately, the chairman has to make an apology that not only because of the subcommittees and some full committees, but so many panels we now have to chair, that I did not get a chance to review your testimony before you came before us. I have jotted down some notes as you were going along.

You are heading a Center out there that is within the National Institutes of Health. All of us are in support of the National Institutes of Health, and you have set up a unit within a unit out there, so to speak, which you head. In other words, you call your center the Center for the Study of Mental Health of the Aging, and this is a special mental health program. I am trying to compartmentalize the background just as we go along.

Doctor, how many do you have?

Dr. COHEN. We have 4½ ongoing professional positions.

Mr. RANDALL. What do you do with that other half?

Dr. COHEN. That is for a person who is there halftime, and we have in addition, on a temporary basis, a person on a special assignment from the Minority Center who will be with our center for 3 months. This person will focus special attention on minorities and issues as they relate to aging and mental health.

Mr. RANDALL. Let me get this in perspective. What do you have altogether? Now, you might not be the best witness for this, but out at

NIH we have got quite a complex out there. Now, we get down to the National Institute of Mental Health. How many do you have?

Dr. COHEN. I do not know exactly. I think it is in the vicinity of 900 people, but I would hesitate to give an exact figure.

[Information later supplied by Dr. Cohen: "Permanent positions number approximately 900."]

Mr. RANDALL. You also mentioned that there were other categories, other special categories. I assume that these are children and youth and so forth.

Dr. COHEN. The Center for Studies for Child and Family Mental Health.

Mr. RANDALL. Family, child: these are also centers?

Dr. COHEN. Yes, they are. The bulk of the focus of the Institute is around research, training, and services.

Now, in conjunction with that structure there is a Division of Special Mental Health Programs at the National Institute of Mental Health, and this includes the center that I am with on aging.

There is the Family and Child Center and the Minorities Center. There are also centers on metropolitan problems, crime and delinquency, disaster, and there will be a new center examining the problem of rape.

Mr. RANDALL. I am sure that you appreciate the thrust of our questions.

Out of the 900 we have 4.5 working on the mental health of the aged. You probably have more working on it, but that is all generally in your center right now.

Dr. COHEN. Yes; the nature of our Center at this point is one of coordination. If we had direct funds, then that would, of course, necessitate a larger staff. We are working in conjunction with the rest of the Institute through the divisions of research, training, and services. We will collaborate with individuals in those divisions and try to focus on the areas which are deficient in terms of attention to aging. We will be addressing needs and gaps relating to research, to manpower and training, to the development of necessary services, and to improvement in the delivery of services.

In this capacity we consult very closely with several other parts of the Institute.

Mr. RANDALL. The gentleman from New York.

Mr. WALSH. I have a couple of questions, Mr. Chairman.

Doctor, as I understand it, the Committee on Mental Health and Illness of the Elderly was established by Public Law 94-63 in 1975. It requires you to make a report to the Committee on Interstate and Foreign Commerce. It is also my understanding that there was some delay in appointing this committee and getting it started, and that you may need some more time in which to make that report; is that correct?

Dr. COHEN. Yes, sir, that is correct.

Mr. WALSH. How much more time do you need, Doctor?

Dr. COHEN. Essentially, we are hoping that we will have 1 year from the time that the committee has its first meeting. I think that the committee will probably begin work sometime in the late spring or summer. We are hoping that we would have 1 year from that point

so that we can do a responsible job in terms of areas that the committee will be focusing on.

Mr. WALSH. It seems to me, Mr. Chairman, that this is a valid request. The committee was late in getting organized. They have not had a meeting as of yet.

Dr. COHEN. No, they have not. The members have not been appointed.

Mr. WALSH. So this is something we may want to recommend to the Interstate and Foreign Commerce Committee, Mr. Chairman. This committee has sufficient time with which to complete its requirements under the law and they probably will need an extension until the spring of 1977, I would assume.

When was it organized?

Dr. COHEN. July 29, 1975. It was supposed to have its final report in on July 29, 1976. Essentially, we are hoping for 1 year from that point.

Mr. RANDALL. The Chair will respond to the gentleman from New York. The point is well taken. It is a project that the staff should be able to handle.

I am grateful for the gentleman's interest and we commend you for it. You will work with our staff; I will assign the gentleman. I think it is a point well taken.

Mr. WALSH. Thank you, Mr. Chairman.

Just one other question. I understand that you do have some problems with the grant procedure and that you would rather see direct funding to the Mental Health Center of NIH, is that correct?

Dr. COHEN. That relates to the present structure where, as I mentioned, we are called the coordinating center in terms of working with the rest of the Institute where the funds are administered.

My own feeling is that it would be a more effective approach with some direct funds. This gets around a lot of redtape. It also facilitates increased opportunities for shared funding. That is not only among different parts of NIMH, but also among different parts of the Federal Government in general. Some of the earlier questions related to areas that perhaps overlap the mandate of AOA or NIA or NIMH.

The area of retirement is an example where more than one institute or agency would have an interest. With direct funds we could better coordinate research in this area.

On occasion shared funding is the only way certain projects might be funded at all. This would greatly facilitate our ability to carry out our mission and perhaps increase the efficiency and the quality of the mental health in the aging area. Ideally, direct funding would not be at the expense of other NIMH programs, but brought about through additional targeted funds.

Mr. WALSH. And I assume that there is a cross-pollinization of ideas of mental health and the agency working just in the health field.

Dr. COHEN. Yes, we feel that it is extremely important in this area because we are looking at a group—that is the elderly—where the interplay among biomedical, psychological, and social factors is greater than with any other group. It would be a serious mistake for the varied elements of Government not to have dialog with each other.

We have established sizable task forces and groups through which we have very frequently collaborated with many parts of Government that have components in the area of aging. We are also very interested in collaborating with HUD because housing for the elderly has a very profound impact on their well-being.

We have also collaborated with the Department of Transportation, et cetera. I think that any of those areas where the impact would be on the psychosocial well-being of the elderly would be of particular concern for us. I think that it is an area where it is useful to have these working relationships if we are to realize the essence of a successful program.

Mr. WALSH. Essentially what you are looking for is a team approach?

Dr. COHEN. Yes.

Mr. WALSH. This brings me down to a question that I am concerned about. I discovered that under one of the provisions—I believe it is the Home Health Care Act—occupational therapy is not permitted in the homes. It is not authorized and I am introducing legislation that would permit that to occur.

It seems to me that this is one of the very necessary therapeutic measures for the elderly in their homes. I would think that there would be some type of occupational therapy in the home. I would hope that your organization, if it is asked, would support this type of approach.

Dr. COHEN. What you are describing is consistent with the growing focus on outreach efforts—an area where there is considerable opportunity not only to keep people out of institutions, but also to increase their very basic well-being and dignity. I think it is an area that it very promising for profound advances in the future.

Mr. WALSH. I think you have summed it up, and it would be the hope of any committee working in the area of aging to cut down the hospital care and keep them in the home and out of the hospital setting much longer than they do.

I hope that the real goal that you have to seek in this whole area of the aging program is the program that we are setting up.

Dr. COHEN. In that regard, it is a curious field in the sense that we have much more knowledge in terms of working with older people than many people relize. The problem is one in terms of delivering that knowledge. In the example that you gave, we know that occupational therapy works, but if you do not have access to people who can make use of it, it is irrelevant.

You see, this is a basic historical problem that goes back to Ponce de Leon, who was looking for the "Fountain of Youth," and many are still looking for it. Such a search is important in the sense of looking for new technique, for new drugs, and it can also be at the expense of not looking at present approaches and finding ways of how to maximize their utilization.

Not to improve the application of present knowledge would be a serious error. I think the point that you are making focuses very strongly on making use of present knowledge, and that is a major concern that we have.

Mr. WALSH. Thank you very much, Doctor. I have no further questions.

Mr. RANDALL. Thank you.

The gentleman from New Jersey.

Mr. HUGHES. Thank you, Mr. Chairman.

Doctor, I think my questions tie very closely with the other questions just asked by my colleagues. Obviously one major factor of mental health impairment in nursing homes is the fact that they are taken out of their secure environment and placed in an institutional environment.

I would like to know about this, because mental deterioration occurs too often to be coincidental. What other factors do you feel go into this ratio? Would that be a high ratio that you suggest of mental impairment in the institution as compared to the 10 to 25 percent that you find in the community generally?

Dr. COHEN. It is a very serious area, and I think that there are a number of factors. I think the foremost one is that of the people, in the sense that there are profound staffing difficulties in nursing homes. While the magnitude of problems is higher in the nursing home, however the level of expertise and sophistication does not match the problems at hand.

We can see historical counterparts of this with regard to children, where, at the beginning of the century, a number of children were institutionalized, and there was a very high percentage of deaths because of the inadequate ratios of the staff to the children.

In some cases, the death rate for children was as high as 90 percent. Without that interaction between people who are caring, which is a vital role played by families, friends, and neighbors, there is a significant change in the nursing home. It is hard to get such personal investment and I would say that the people environment is a profound issue.

Mr. HUGHES. In my own private practice, I spent a great deal of time in nursing homes visiting residents. It is a depressing sight.

I wonder how much the sickness and deterioration of others affects the lives of so many who are there. One of the complaints that I often received was the fact that there was so much misery around them. At some point, the nonafflicted residents would have to move. It was not unusual for residents to move from one nursing home to another nursing home because of the situation I just described.

They became depressed because they were around people who had mental or other problems. They were not a part of life. They saw few children, relatives, or friends.

Dr. COHEN. I think that is a very profound part of the situation. In fact, they have left the mainstream and this is the problem.

It is furthered even more in terms of problems with regard to the training program. We have this problem not just in nursing homes, but of course across-the-board. There is a very high turnover of staff in nursing homes, and with the elderly, a group that has lost so many significant persons around them, such as family and friends, this further compounds the problem.

It is very difficult to establish the relationships that we feel that the staff members should assume. This is a serious training issue, and it is compounded by the difficulty of having enough staff to facilitate a basic amount of simple interpersonal contact.

Related to this is the deficiency of opportunity for such basic events as simple physical contact, be it the touching of a child or handshake; a basic human element that is absent here.

We see that if we do not exercise in a physical sense, we become rundown. It is a very similar situation in ter .s of the mental and and social activities.

Mr. HUGHES. The opportunity just to laugh is important. There are those nursing homes in my own immediate area that have planned activities and others which have nothing. The residents in some of these nursing homes just sit around all day looking at one another. This is an important problem area. I hope that as we study the problems of the elderly, we give this due attention.

Dr. COHEN. Yes, that is a very significant area since 20 percent of the persons over the age of 65 will spend some time in an institution, a hospital or nursing home. Only 5 percent at a given point in time are in institutions, but 20 percent would spend some time there which is a sizable number of people, and reflects a very high priority area. In this regard, we pay attention to nursing homes and support a number of publications that focus on the training of nursing ho ne staff.

We are also focusing on the techniques of increasing the involvement of the family within the nursing home along with involvement of other significant persons from the informal support system. The informal support system consists of friends, neighbors, and others in the patients' lives who are not part of the professional health team.

Mr. RANDALL. Thank you, sir.

The gentleman from Hawaii.

Mr. MATSUNAGA. Thank you, Mr. Chairman.

Considering the vastness and importance of this program of mental health for the elderly, I am somewhat disturbed that out of the fiscal year 1976 budget for NIMH research of $63,848,000, only 3 percent was designated for aging research. Also, it has been called to my attention that of the $52,172,000 for research for fiscal year 1977, only about 4 percent has been earmarked for aging research. Is that true?

Dr. COHEN. Yes, that is correct. The 3.5 percent has been the figure basically. The reason for the increase in the percentage of 1977 does not actually reflect an increase in money. It is that the total amount of research funds of the Institute have been gradually going down. The amount of money for aging research is stable, but the total amount of NIMH resources is decreasing.

Mr. MATSUNAGA. But it is still a very small percentage, when we are looking at a group that is 10 percent of the total population and constantly increasing, isn't it?

Dr. COHEN. Yes.

Mr. MATSUNAGA. And even though it is increasing in percentage, the actual dollars have been decreased? And why is it that this administration is opposing the increase of these funds? Are you being dictated to as to how much you should be accorded of the total amount?

Dr. COHEN. As far as the total funds for research for the Institute, that is the administration's decision. The factors are obviously multiple, including the general economic climate. As far as the percentage in terms of research for aging is concerned, even more complicated factors are involved.

These factors include the number of proposals that come in, the responsiveness of different parts of the Institute to the area of aging,

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which is a problem that is not just at the level of the Institute, but it is across the culture in the sense of a youth-oriented culture.

So, I would say that it is largely a mixture of those two elements. Part of the reason for the formation of the center was to increase the sensitivity and awareness of the different parts of the Institute to the problems in the area of aging and to emphasize the needs and to try to facilitate further commitment to that area.

It is difficult with diminishing funds.

Mr. MATSUNAGA. Now, moving to another area, is it true that the minority elderly run into bigger problems with relation to adjusting to a social atmosphere, to the point that you find a greater percentage of mentally disturbed among the minority groups?

Dr. COHEN. There is tremendous variation here because of the differences with the minority groups. To better address this area, we have arranged a special assignment with a person from the Minority Center at NIMH, who is going to be spending at least 3 months with us—focusing on those issues.

We are also planning a number of conferences focusing on the different minority groups. There are a lot of variables, as I mentioned earlier.

A quarter of the suicides are over 65 in this country, but the highest amount is with white males. With elderly black males, it is a significantly lower percentage. From that perspective it is a different set of problems, and there are basic explanations for this.

We have just funded a study and conference focusing on retirement issues for the second-generation Japanese Americans. They are experiencing serious problems in later life. Depending on the minority group concerned, there is a tremendous variation. I really cannot make a general statement. But, as you can see, the black/white issue is different from what one might expect in that regard.

Mr. MATSUNAGA. Of course, you know the statistics, the facts as they exist. But is the NIMH minority center working toward solutions to the problems which exist in these areas?

Dr. COHEN. Yes. We are approaching that from several directions. We are trying to identify the different subgroups even within a designated group. There are particular problems in terms of the delivery of services.

One of the problems independent of the clinical difficulties that a minority person might have would be the access of that individual to the health care system. If the case had been delivered earlier, the problem might well have been treated more easily and more extensively.

It is not just a matter of a clinical problem, but the complex deficiencies in the delivery system for elderly people in general.

I mentioned before, that at best, only 4 percent of the patients seen publicly or privately are over the age of 65, despite 10 percent of the population being over the age of 65.

The time these people actually received service would be under 1 percent.

A younger person could come into the mental clinic and be seen weekly over the course of a year, however, an elderly person might be seen only once. We are attempting to find solutions to these problems in our research.

Mr. MATSUNAGA. Thank you very much, Dr. Cohen, and thank you, Mr. Chairman. I wish to apologize for my tardiness. I was testifying

before the Merchant Marine and Fisheries Committee this morning. I am spearheading a movement to extend the authorization of the Sea Grant College program.

Mr. RANDALL. No apology is necessary from our distinguished member from Hawaii. He is a member of the most prestigious Rules Committee. I suppose if we take the membership of the members, 28 members, the obligations and responsibilities, I daresay it would near equal any 28 members in the House.

I thank you for coming.

Mr. Grassley, the gentleman from Iowa, is also someone who shows up during the course of every hearing and we appreciate your attendance.

Mr. GRASSLEY. Pardon me if I run next door to vote on a rollcall, but I particularly wanted to ask you a question on this area.

The University of Iowa in my State used to have a Division of Gerontology 3 or 4 years ago. It did away with it, however, or at least it is a separate institute now. My questions deal generally with the university training program.

Do you feel that universities are adequately preparing professionals to treat specific problems of the mentally ill patient, and how can geriatrics become a more integral part of the medical school curriculum? Do you feel that funding is adequate in the university for gerontology, psychological and geriatrics programs?

Dr. COHEN. In general I would say that training for working with the younger adult population is reasonably adequate, but gross deficiencies occur when it comes to the elderly. Again, it is a very complicated area where the problem lies not only with the institution, but with our culture as a whole.

I can look at my own field of psychiatry. During medical school and durirg my psychiatric residency, perhaps I had one lecture on working with older persons. I think that this is fairly typical in psychiatry and psychology, despite the fact that we are talking about a very sizable part of the population.

There is much reluctance about getting involved with the older person, and this has a bearing on the small amount of time which is devoted to the different curricula. However, this is only one of multiple obstacles.

We are at our center paying very intensive attention to looking at how curricula can be improved and are trying to set the stage for a more responsible program, but there are other contingencies such as funds which play a profound role, Mr. Grassley.

Mr. GRASSLEY. Do you believe there is a necessity for more specialization—or is this a time when we are asking for more generalization in this area?

Dr. COHEN. Your question is a very important one and a very fundamental one. I think it really should be addressed with a fair amount of detail. I will speak to it in the sense that I do not think many would recommend a formation of a specialty in geriatrics at every university. However, several well developed geriatric centers across the country would play an important role in advancing the care of the older population. Such seed programs would eventually facilitate and improve the general training of practitioners as a whole in many universities.

Mr. GRASSLEY. Do you believe funds must come from the Govern-

ERIC

ment, either State or Federal, to accomplish this goal of meeting on the mental health needs of the elderly and the treatment of these needs?

Dr. COHEN. I think that this is a definite road one could follow. Training and successful services go together, but the funding issue is a serious one.

Mr. RANDALL. Proceed.

Mr. GRASSLEY. Thank you very much, Mr. Chairman.

Thank you very much, Dr. Cohen.

Mr. RANDALL. If Mr. Grassley has no more questions, I will pose a few for you, sir.

Mr. Matsunaga started questioning you on part of the percentage earmarked for age research, and I believe you said it was rather small.

Dr. COHEN. Yes.

Mr. RANDALL. I think you said it is 4 percent or 3 percent as the case may be.

Dr. COHEN. Yes; that is correct.

Mr. RANDALL. That is reminiscent of another area of funding that we have had some research on in our own staff. We found out what is close to some $30 billion being spent on revenue-sharing. We find that less than one-half of 1 percent. Whether it is senior citizens or anything else, maybe we are going down a parallel here in this situation.

Now, out of the 63 or 52, whichever you are talking about here, we are down to 3 or 4 percent. Who made that decision?

Dr. COHEN. I do not think it was a decision of any one individual.

Mr. RANDALL. It is slow starting, or just getting started. Is that the reason for it?

Dr. COHEN. In part. There are factors in terms of the numbers and the quality of the proposals that come in. Given the shortage of training programs with a geriatric focus, the numbers of researchers in this area are fewer than what might otherwise be.

In addition to the training issue there is the problem of altered commitment to the area of aging. It is a very complicated factor, involving the cultural orientation to this group, and this applies not only to the public, but I would say to those who are administering programs as well.

Mr. RANDALL. The only answer that would be valid to this point—you say that the research is not available?

Dr. COHEN. That is part of the answer.

Mr. RANDALL. What is the other part?

Dr. COHEN. The other part is the responsiveness on the part of the institutions to allocate more funds.

Mr. RANDALL. Institutions?

Dr. COHEN. Institutes.

That is related as well to the total amount of money that the institute has.

Mr. RANDALL. Yes; but there is someone upstairs. We are not talking about the OMB—it is not that level. You are under the Secretary of HEW, I would assume.

Dr. COHEN. Yes; NIMH is within ADAMHA, an agency in HEW.

Mr. RANDALL. It is the Secretary's office. Dr. Greulich said he was going to get us a structural chart of all this vast arrangement.

You said that only 3 percent or 4 percent is spent on aging research, whereas there has been one figure which we have been repeatedly given: That 10 percent of our population, that is, 22 million. That is the figure that has been alluded to this morning several times.

Well, we are going to do our best to do something about it. We are simply trying to find out who made that decision on the 3 or 4 percent. If you do not have the manpower, you said that somebody had made the decision that it would be only 3 or 4 percent.

Dr. COHEN. I did not say "one individual."

Mr. RANDALL. Then who were the individuals?

Dr. COHEN. I do not think it is a matter of actually pointing your finger to somebody. I think it is more complicated in the sense of the orientation of the various sources from which funds are administered. In turn, there is the matter of awareness of problems. Then there is the matter of priorities and the many factors that influence them. We are trying to provide useful information that will be relevant in the shaping of priorities as they relate to aging and mental health.

Mr. RANDALL. Doctor, I hope you are on the side of the aging, because that was a very astute answer about priorities. We come back to the basic fundamentals that there are 22 million people, 10 percent, and certainly that should have some priority itself. We are simply trying to ferret out and fix the responsibility, and maybe we ought to call somebody. Let us find out, let us call in the Secretary.

We have a new Secretary who is the titular head across the street, who is running the National Institutes of Health, but who is managing that Institute over there?

Dr. COHEN. The National Institute of Mental Health is one of three institutes in ADAMHA, an agency in HEW.

Mr. RANDALL. We need the structure that the good doctor will provide us forthwith, hopefully, because I think we are going to have to pull some folks in from out there to find out what is going on. For those of us in the field it is extremely frustrating to see the magnitude of the problem in one of our Institutes.

We found some good folks leaving because of that frustration—leaving NIH.

Dr. COHEN. My feeling is that there are profound things which can be done, as I tried to point out today. We know that approaches can be taken that can make tremendous differences. That is what makes it more frustrating.

If the knowledge was not there, that would be one thing; but when there is the knowledge, then it is truly a tragedy not to apply it in meaningful programs.

Mr. RANDALL. Well, Doctor, we are just scratching the surface here, just working at the tip of the iceberg, I guess.

We appreciate your appearance. Maybe we can have you back one of these days, you and Dr. Greulich.

In the meantime, Doctor, hopefully you can give us the whole picture out there, and if it is not too much work, it will save a little bird-dogging, if that is the proper word for the staff, you can tell us how to break this down moneywise.

We are going to work a little more closely with the Appropriations Committee. In fact, we have a conference with them next week. It just

seems that there is something in here with this substantial segment of the population that we are talking about and the percentage that we are dealing with.

That is all there is to it. It just does not seem that this is the way it should be.

Thank you very much, Doctor. We have to adjourn now, but we will try to plan this around a future session.

Dr. COHEN. Thank you very much for the opportunity to testify here.

Mr. RANDALL. Thank you, both of you.

The committee will stand in recess until tomorrow morning. The committee will meet in the same room and the Chair repeats again his apology that he must be in another field hearing at that time.

Thank you again.

[Whereupon, at 12:15 p.m., Wednesday, March 3, 1976, the committee recessed, to reconvene at 10 a.m., Thursday March 4, 1976.]

ERIC

EDUCATION AND TRAINING IN AGING

THURSDAY, MARCH 4, 1976

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m. in room 1302, Longworth House Office Building, Hon. Claude Pepper (chairman, Subcommittee on Health and Long-Term Care) presiding.

Committee members present: Representatives Claude Pepper of Florida, Spark M. Matsunaga of Hawaii, Fred B. Rooney of Pennsylvania, William C. Wampler of Virginia, William F. Walsh of New York, and Charles E. Grassley of Iowa.

Mr. PEPPER. The committee will come to order, please. Ladies and gentlemen, we welcome you here this morning to attend the hearing of the House Select Committee on Aging. My distinguished colleague, Mr. Wampler, and I are delighted to have so many of you here as a measure of your interest in the critical question of how we can better serve the elderly people of our country who make up such an important segment of our citizenry.

Our distinguished chairman, Congressman William Randall of Missouri is providing outstanding leadership as chairman of the Select Committee on Aging and was anxious to hear our witnesses today. However, he was committed to chair the full committee field hearings in Alabama, and he asked me to chair the first part of today's hearing.

I am chairman of Subcommittee No. 2 of the House Select Committee on Aging. The jurisdiction of our subcommittee is health maintenance and long-term care. Since I will have to leave for an important Rules Committee meeting at 11, our distinguished colleague from Hawaii, Hon. Spark Matsunaga, will chair the second part of the hearing.

Today's hearing on "Education and Training in the Field of Aging" is being held in conjunction with the second annual meeting of the Association of Gerontology in Higher Education. This is the second of a two-part hearing. Yesterday, the committee heard witnesses from two Federal institutes which support training and research programs in aging.

Today's witnesses include the director of the Virginia State Office of Aging and seven representatives of some of the outstanding university gerontology programs in the Nation. Issues to be discussed include the need for increased and consistent funding of titles IV A, B, and C of the Older Americans Act, which provide for training and research in gerontology and multidisciplinary gerontological centers; second, alternative Federal sources of funding for training and research; and, finally, the need for the development of minimum standards for gerontology training programs.

We are very fortunate to have the benefit of expert testimony on gerontology programs at this time, because the second supplemental appropriations bill will be marked up shortly by the Appropriations Committee and then considered on the floor of the House. Among the items being considered is funding for gerontology programs under the Older Americans Act.

The problems of aging are best solved without regard to partisanship, and members of our committee from both the majority and minority work closely together in attempting to meet the needs of the elderly. At this time, I would like to recognize our good friend, Congressman Wampler of Virginia, and his minority staff, Miss Nancy Hobbs, for the dedicated and high quality work which they placed into these hearings today. By the way, I would also like to introduce the majority staff of subcommittee No. 2, Bob Weiner and his assistant here, the able secretary of our subcommittee, Ms. Kitty Edwards, who used to be in my congressional office. She is a very lovely lady and is doing a very fine job for the committee.

Mr. Wampler, would there be anything you would like to say?

Mr. WAMPLER. Nothing except thank you, Mr. Chairman. I would like to at the appropriate time, introduce Mr. Wood when he presents his testimony.

Mr. PEPPER. Our first witness is Edwin Wood and I will ask Mr. Wampler if he would be good enough to introduce him.

Because of the number of witnesses and so that all members will have the opportunity to ask questions who wish to do so, the committee will operate under the 5-minute rule which allots to the members of the committee 5 minutes to ask questions until a round of questioning for each witness is completed.

Mr. Wampler, will you introduce our first witness?

Mr. WAMPLER. Thank you, Mr. Chairman. It is a pleasure to present to the committee this morning Edwin L. Wood who is the director of the Office on Aging of the Commonwealth of Virginia. Mr. Chairman, I have had the pleasure of working very closely with Mr. Wood. I know him to be a man who is thoroughly dedicated to the problems of aging and with the limited resources that have been made available to him, I feel that he has done an outstanding job in the Commonwealth of Virginia in focusing on the problems of the aging.

Mr. Chairman, I am somewhat embarrassed that in the adjoining room, 1301, there is the full Committee on Agriculture, and as you know, I happen to be the ranking minority member of that committee. We are in the process of marking up a bill on a matter that we have devoted many months of study to. If during the testimony of Mr. Wood or other witnesses I have to excuse myself, I hope that you and those present this morning will understand. I have yet not been able to solve the problem of being two places at once.

Mr. PEPPER. Will the witness please come forward. We are happy to have you. You may proceed.

STATEMENT OF EDWIN L. WOOD, DIRECTOR, OFFICE ON AGING FOR THE COMMONWEALTH OF VIRGINIA

Mr. WOOD. Thank you very much for those kind remarks.

I am Edwin L. Wood, director of the Office on Aging for the Commonwealth of Virginia. It is my great pleasure to be able to speak

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to you today on the current status of, and uses for, funds made available to State agencies on aging for training under title IV–A of the Older Americans Act.

There is little need, except to perhaps refresh your memory, to remind you of the vast influence which the Older Americans Act is having on our Nation. That influence goes beyond those of us employed to work directly under programs sponsored by the act, for as planning, coordination, program development and service implementation activities take place on behalf of older persons we are seeing a citizenry, both public and private, which is beginning to focus more and more attention on the entire concept of aging and the elderly.

What is so often lacking, however, is the very basic knowledge from which to plan and implement programs and services which are responsive to the particular needs of the elderly. That knowledge, in my opinion, must be amalgamated from a number of sources including research into the aging process itself, evaluation and monitoring of existing programs, and the conduct of demonstration projects that could provide either new and innovative methods, or redirection of existing ones. Perhaps most critically of all, the knowledge gained therefrom must be channeled into the education and training of individuals and groups to whom the elderly are of primary concern.

Although educational training programs in gerontology and related fields have been increasing over the last few years, this increase has not been commensurate with the rapid growth of State and local programs which serve older Americans. As a result, the staff of these programs have had limited exposure to basic knowledge about the elderly population they are mandated to serve. Moreover, since many of the agencies and projects under the Older Americans Act are of relatively recent origin, there is an urgent need for training in program management, needs assessment, evaluation, and other agency functions in dealing with this group whose interests and needs span the entire spectrum of our community life.

When in fiscal year 1974 State agencies on aging were, for the first time, provided the opportunity to receive and direct resources into training activities, it was indeed a welcome and most sought-after opportunity. Virginia, and other States as well, was given the opportunity of prioritizing those training activities which we deemed most necessary from the State level. Our own priorities, in terms of those funds available and others which we would hope to tap, included in order: (*a*) The training of State offices on aging staff, (*b*) training of area agencies on aging and nutrition project personnel, (*c*) training for professional and para-professionals in other fields concerned with the aging, and (*d*) the prov n of the opportunity for training of older individuals and volunteers who serve in advisory and other capacities in aging programs. We fulfilled, at least in part, the desperate need for short-term training for our first two priority groups through the use of fiscal year 1974 funds. We are proceeding now with fiscal year 1975 funds toward the provision of appropriate opportunities for the second two priority groups.

I would call to your attention the fact that since late 1973 there has been a rapid development of area agencies on aging and "Title VII: Nutrition Programs for the Elderly" springing up across the country. As a consequence, there has been a rapid influx of staff assuming new responsibilities in the aging service field. There have been,

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of course, some very meaningful training events conducted for these specific groups regarding their roles and duties. I would note, however, that as the Older Americans Act does not designate State agencies, nor area agencies, as direct providers of services, one of our primary duties becomes the promotion and stimulation of services from other resources in many areas. The most critical need, in my opinion, which would necessitate the continuation and even greater increases in funding for training activities, hinges on that responsibility which we have for program development and for highlighting attention to the aging within the existing educational delivery system now in operation. Title IV–A funds have allowed all States to have certain resources at their command in order to perform this duty in the educational and training arena.

As an example of the training provided by State agencies, let me note some specific activities made possible through the use of title IV–A funds in Virginia. We received $75,000 of fiscal year 1974 funds. We have held intensive training of State-level staff in the areas of: (1) Organization analysis techniques; (2) objective setting; (3) short- and long-range goalsetting; and (4) skill building in planning and field operations, including monitoring, evaluation, and technical assistance. The basic objective in this training was to develop a "results oriented" State staff with the expertise to fulfill mandated responsibilities. Further, area agency on aging and nutrition project personnel are benefiting from training, provided through the same grant, in the areas of: (1) Effective citizen participation; (2) evaluation and monitoring; (3) general program management; (4) interagency relationships; (5) outreach; (6) effective advocacy; and (7) accounting, recordkeeping, and financial management. Our objective here, was to provide skill training for the myriad duties assigned to local staffs.

I would not leave you with the impression, however, that State agencies on aging can fulfill all the needs in this particular area with any amount of funding. The job is too great and we have an entire educational system in this country that can, and should, be utilized. However, State agencies can make a critical and direct impact on the short-term training needs of staff working in gerontology as well as fulfilling a planning and advocacy role in the provision of long-term training.

Short-term training is generally geared to the immediate needs of staff dealing directly with Older Americans Act programs. Being of short duration and specific in purpose, it concentrates on both programmatic and management issues and has direct, quickly applied benefits in terms of better services for the elderly—employees have the opportunity for exposure to the process of aging and its implications as it relates to their particular service activity!

Speaking from experience as a member of the Advisory Council for the "Title I: Higher Education Program Act" in Virginia, I can assure you that that Council is deluged with proposals during its annual funding cycle for specialized, mostly short-term, educational projects which would impact the elderly of our Commonwealth. Professionals in the field of adult education are remarking to me constantly of the interest and desire for these types of courses to be offered in areas throughout Virginia. Community college personnel and senior college personnel are responding as best they can to the demands for edu-

cational opportunities in gerontology. The interest is most certainly alive, but the resources are infinitesimal as regards the total need as we see it.

Long-term training should provide that logical sequence of learning experiences throughout the educational process that will prepare and equip individuals for a wide range of vocations. Most of our States are fortunate in having an acceptable climate for the growth of interest in long-term training programs which I feel can best be provided from our institutions of higher education. In my opinion, the role of State agencies on aging should be one of a catalytic nature, encouraging such institutions to channel and direct their resources into this broad field of educational gerontology, while at the same time providing data on manpower and training needs as seen from the practical point of view.

I am sure that this committee will hear today about the needs now existing at the higher education levels and of the efforts being undertaken there. While I have not been asked to address those needs, I would, nevertheless, like to note a recommendation made by the Presidential Task Force on Aging in 1970 which was brought to my attention by Dr. W. W. Morris of Iowa, chairman of the training committee for the National Association of State Units on Aging:

> The Task Force believes that additional Federal research and training monies should be made available and used for: (1) Curriculum development in gerontology in two- and four-year colleges and graduate schools; (2) training and continuing education—including inservice training—for the broad range of manpower—both paid and volunteer—required to provide comprehensive community services for the elderly; (3) special retraining programs for those in their middle and later years to enable them to serve older persons; (4) research support for the basic sciences and in applied gerontology; and (5) gerontological training for educators and researchers to equip them to teach and conduct research in aging. The Task Force also notes the need for funds for development and expansion of centers on aging at major universities.

This broadly based recommendation addressed a variety of activities which could be tackled either individually or jointly by State Agencies on Aging and institutions of higher education. While we have made some progress in these areas, there is a continuing need to support efforts on behalf of both groups.

Mr. Chairman and members of the committee, there is one major problem area that I would like to point out to you specifically and that is the uncertainty in the title IV–A program. I have discussed this particular problem with Dr. Louise Gerrard of West Virginia, president of the National Association of State Units on Aging, and with several other State executives on aging and I think that I can speak on behalf of all of us receiving funds under this part of the act. No new venture should be undertaken without a degree of commitment and that commitment must be great enough to allow the fulfillment of the desired goal. I am sure that 200 years ago there existed great uncertainty on behalf of the Colonies which banded together to declare their independence. Yet the commitment to that goal was there and we today are living proof that that commitment is being fulfilled.

The funds made available to us in the fiscal year 1974 budget were in actuality expended during fiscal year 1975 and the same is true with fiscal year 1975 funds being expended in the current fiscal year. As a member of the government structure, I can understand and appreciate

the reasons for these delayed expenditures but, in my opinion, State agencies are in a most critical time in their development. We cannot afford to have undertaken the efforts of prioritization and of short- and long-range planning in the educational area if we are to face continuing uncertainty regarding the maintenance or expansion of services in this area.

The uncertainty of funding is augmented with the fact that there seems to be an increasing national prioritization process for the expenditure of funds that we are receiving. At the present time, the national priorities in training have coincided almost perfectly with our priorities in Virginia. I trust that is also true in other States. Yet, I would become increasingly pessimistic about our own long-range educational planning if greater efforts are made from the national level in prioritization for these limited funds.

Let me take this brief opportunity, however, to note that so far as Virginia is concerned, we have found the Administration on Aging to be extremely helpful and cognizant of our training efforts. Our State office on aging emerged as a new State agency, separate and distinct, and on an equal plane with other major departments in July of 1974. With that new status came also a new commitment and a new direction for the programs which were being undertaken at that point in time. The Administration on Aging has been conscious of this development in Virginia and I do appreciate their understanding of our priorities as seen in our Commonwealth.

One final point which I would like to make is that the funds under title IV–A have served Virginia, and other States as well, as seed money for training and educational opportunities. We are, of course, aware of certain other types of program funding that could be directed towards our short-term training efforts such as title I of the Higher Education Act, and funds available through continuing and adult education. However, title IV–A funds are, at this time, the mainstay of our activities for immediate training needs and I would continue to urge your most careful deliberations to insure their continuity.

The thought that I would leave with you would be that as the elderly population increases, as new programs and services are begun at all levels of government and within individual communities, and as further opportunities are developed for older people to participate in community life, there will be a continuing need for training and education. As aging is inevitable, we can and must prepare for it in a meaningful way.

Mr. Chairman, may I express to you and the committee, and especially to Congressman Wampler, my appreciation for this opportunity to appear before you.

I will be happy to answer any question.

Mr. PEPPER. Mr. Wood, we thank you for your very able statement. We are pleased to have it and it will make a valuable contribution. Mr. Wampler, would you like to ask any questions?

Mr. WAMPLER. I want to thank you for a very fine statement. What role do you hope Virginia community colleges will play in the training of persons for employment in the delivery of service to the elderly?

Mr. WOOD. I think that we are indeed fortunate in having an opportunity to utilize our community college structure, which is a State-

wide system in the Commonwealth. We are developing at the present time some very basic educational training programs. Hopefully courses in the introduction to gerontology, with the cooperation of other educational institutions, could be offered in areas throughout Virginia.

The community colleges are in the localities where people work, therefore, we would hope that some basic courses in gerontology could be offered through the community college system.

Mr. WAMPLER. Mr. Wood, you note that Virginia had received $75,000 in fiscal year 1974 appropriations for title IV–A funds. Would you care to comment on that?

Mr. WOOD. Yes, sir, I would be delighted. As you may be aware, sir, the Administration within the latitude that the law gives them, took approximately half of the appropriation last year under title IV–A and allocations were made to State agencies on aging. Approximately half of those allocations were made to about 85 colleges and universities for gerontological programs.

We in Virginia of course have made a number of applications for senior institutional educational programs in gerontology. We have not been fortunate enough at this particular point in time to have received any funds under that. But I would certainly hope, Mr. Wampler, that if further funds were made available and since it is my understanding that a majority of States do have some institutions therein who are receiving funds, that there would be an opportunity for the expansion of these types of programs from the Administration's point of view.

Mr. WAMPLER. I would urge you to persist in your efforts.

With regards to title IV–A training, what role do you see for the paraprofessionals to play in the delivery of services to the elderly?

Mr. WOOD. There is certainly a need for training of paraprofessionals and I think there are a very wide range of possibilities for their input into service for the elderly. We are looking at some opportunities now for paraprofessionals to work in the legal field. They may provide services that don't necessarily require an attorney, but will be under the supervision of an attorney aiding older persons to qualify for or fill out the appropriate forms for State, local, and Federal benefits that are available.

I think, too, that there is a desperate need to see that these types of individuals receive some very basic educational instruction in gerontology. As long as they are going to be working with the older persons, they need as much training as those of us who are full-time professionals in the field.

Mr. WAMPLER. Mr. Wood, the Committee on Agriculture has been undertaking a food stamp program and there are a number of reform bills at the present time before our committee. The Administration has taken action, at least from their point of view, to shore up some of the inadequacies and abuses of the system.

As part of our hearings it is rather obvious to me, that a great effort has been made in the field of nutritional education and obviously there is a great deal that remains to be done. This applies not only to the elderly, but I think to everyone, the poor and the working poor.

Do you feel that there is a need for additional emphasis in the field of nutritional education, particularly as it applies to the elderly?

Mr. Wood. I certainly do, Congressman. I think our nutrition projects, as you noted, are now doing some things in this area. However, with the funding we have, we are only capable of serving about 3,500 meals a day in Virginia. However, we have approximately 603,000 people in Virginia 60 and older. I think it would certainly be appropriate if there were funds for those other 600,000 people to have the benefits of nutrition, as well as education and training.

Mr. Wampler. Thank you, Mr. Chairman.

Mr. Pepper. Mr. Walsh.

Mr. Walsh. I have no questions at this point.

Mr. Pepper. I was very much interested in your statement that as the elderly population increases, and I believe we now have over 22 million elderly, new programs and services must be begun, and as further opportunities are developed for older people to participate in community life, there will be a continued need for training and education.

Do you have any statistics as to the projected need for gerontological training and education?

Mr. Wood. Mr. Chairman, while I do not have the specific data in that regard, the impression that I shall leave you with is that in many areas training in gerontology is almost nonexistent. While there are differing opinions as to the actual manpower projections, I can assure you I think that there would be a need in every community college and every institution of higher education in all of our States for gerontological education.

Mr. Pepper. Thank you very much, Mr. Wood. Are there any other questions by members of the committee? If not, we thank you for the valuable contribution you have made to our hearing this morning.

Our next witness will be Dr. Carter Osterbind. Dr. Osterbind is director of the University of Florida, Center for Gerontological Studies and Programs. He is past chairman of the Florida Commission on Aging and past member of the National Planning Board for the 1971 White House Conference on Aging and chairman of the Florida delegation.

On February 10 and 11, there was a conference on gerontology at the University of Florida hosted by the center which Dr. Osterbind heads. At that time, they had a distinguished panel of participants on this subject. I was invited to attend, but unfortunately, I was unable to be there because of legislative demands here. I do wish to thank him for the kindness that was exhibited to me in making me one of the honorees that received an award during that conference. I am very grateful.

We are very pleased to have Dr. Osterbind here today.

STATEMENT OF CARTER OSTERBIND, DIRECTOR, CENTER FOR GERONTOLOGICAL STUDIES AND PROGRAMS, UNIVERSITY OF FLORIDA

Mr. Osterbind. Chairman Randall and members of the committee, I am Carter Osterbind, director of the Center for Gerontological Studies and Programs at the University of Florida. I join with my associates in testifying as a representative of the Association for Gerontology in Higher Education. I, like them, am a member of the association because the educational institution with which I am associated

sees the need to establish a better basis for communication, in the field of gerontology, with other universities and colleges, with governmental agencies at all levels of government, and with the Congress where so many of our programs have seen their genesis. We in the universities and colleges of the Nation also see the need for a forum through which we can present the viewpoints of our educational institutions.

Because it has relevance to my testimony, I would like to cite briefly some of the activities of the interdisciplinary center which I direct. At the University of Florida we have for many years had a concern about aging and older people because of the large number of older people migrating to our State. Because of this concern, we established the institute for gerontology over 25 years ago to create within the university an organizational unit through which members of the university community from many diverse fields and professions might examine educational, research, and public service needs in the field of aging. Members of the university became involved in many different types of activities: teaching, research, community programs, and in work with local, State and Federal governments in the development of many types of programs related to elderly people. Recently we have incorporated the institute of gerontology into a broader program of the Center for Gerontological Studies and Programs.

This new center has a much broader goal than the previous institute of gerontology. It is expanding its programs in graduate, undergraduate and continuing education and in research. This means that on one campus the Center for Gerontological Studies and Programs is drawing on existing resources in the Institute of Food and Agricultural Sciences; the Health Center which embraces the colleges of medicine, of dentistry, of health related professions, and nursing; in the college of arts and sciences; in the college of law; in the college of communications and journalism; in the college of architecture; and in the college of business administration. I mention all of these educational areas because all of these colleges have ongoing established educational programs and research programs in some aspect of gerontology. The object of the center has been to bring together and commit existing resources within the university, along with other resources that might be obtained, to a broad diversified program of activity. This process continually involves an assessment of educational and research needs as indicated by developing programs and activities in the public and private sector of our State. It is within the context of the operation of this center that I have been able to discern the kinds of problems one encounters in moving forward a broad interdisciplinary program that relates to significant social problems of our country.

Those of us in the educational field were delighted when Speaker Albert, in February 1975, appointed this 28-member House Select Committee on Aging. We feel that the responsibilities of your committee as specified in the House rules makes it incumbent on us in the educational field to fully apprise this committee of the educational needs and opportunities in the field of aging, especially as viewed by the educational institutions in our country that have joined together in this Association for Gerontology in Higher Education to further develop and present our views. To administer an educational program in the field of gerontology, as in any field that is interdisciplinary in nature, an educational institution must efficiently deal with many vari-

ables if it is to provide the educational services and utilize its resources effectively. Because these matters are so closely linked to the programs that are funded by the Congress, I wish to comment on them briefly.

Through AGHE we have surveyed and in various ways gathered information about educational programs in all types of educational institutions throughout this country. While our major purpose has been to assess the scope and variety of programs and to uncover innovative approaches and roles of different types of educational institutions, we have also discovered that programs in different communities and States are conditioned and patterned differently because of differences in the institutions themselves and the educational needs and the priorities in these respective areas. While there are many differences in programs, it is evident that much has been accomplished, and is in the process of being accomplished under title IV–A of the Older Americans Act. I have personally examined many programs and discussed them with educators in almost every type of educational institution—large universities, 4-year and community colleges—also in many professional areas and disciplines, and in types of programs such as continuing education, vocational education, adult education, and even on-the-job education in cases where educational institutions have been involved.

In carrying out these various educational missions, educational institutions have had to carefully examine the alternative uses of educational resources. They look at the qualifications and quality of their teaching and research staff and of their graduate and undergraduate students, and at training needs as evidenced by evolving social programs and try to assess the priorities that should be established by the university or by the college in terms of the interrelationship of human and physical resources, of the educational training of their staff, and the students available for training. This is a continuing process in a world of continuing and dynamic change. I will illustrate this by commenting on the kinds of things that we undertake in a center like the one with which I am associated.

With my focus on educational needs in gerontology, I seek to learn, in consultation with leaders throughout the State, the kinds of needs that they see that can be met through educational and research programs. For example, we discover that in the design and planning of all types of residential facilities for older people there is a need for architects who are sensitive to not only importance of the artistic and structural features of buildings, but who make use of the body of knowledge that has been developed by sociologists, psychologists, and economists. Architects must be sensitive to the environmental needs of older people and the things that bear upon the need of the elderly to live in a safe and appropriate environment throughout their life span.

If programs like this are to be carried out, they must have a steady source of funding. The programs, the qualities of the programs must be viewed by an appropriate peer group that can make an assessment of their quality and review the importance of the continuance and need for these programs. It is very wasteful, as any of us can see, to involve a young professional or professor in a college of architecture, in extensive study, travel and research; and to develop programs that can contribute greatly to the improvement and design of all types of living facilities for older people; and then to abandon such programs

so that it becomes necessary for these well-trained people, and the resources they have committed to their endeavor to be abandoned so that they must turn to other things. It is not only wasteful of their time, but it results in our losing some valuable resources that our society so greatly needs.

There are so many health care needs that result from the very special nature of the care that must be given to some of the health conditions that have their greatest incidence among the elderly population. This means bringing to bear on these problems the health care resources of the medical profession, of the nursing profession and of the health related professions. This requires that we look not only at the training of the professionals involved in these programs but that we look at various types of health care arrangements and programs that underpin, and are related to how these professionals work.

It is necessary to link these things together, to keep our lines of communications open, and see how some of the health care needs of older people can be met through the way in which we train our medical students, our nurses and our professionals in the health related professions, and in how we bring them together in health care arrangements such as long-term care facilities and nursing homes. We are interested also in how we can augment the resources of our medical doctors through paramedicals and physician's assistants. We have a very important demonstration underway in the health center of the University of Florida to provide health services to people living in rural areas. This is a significant program because so many older people in need of health care live in rural areas. It is within the context of service delivery programs of this type that we must train our young professionals. It is obvious that programs such as this cannot be started and stopped because the lives of the people who are being cared for are involved, the training of our professionals is involved, the commitment of resources of our educational institutions is involved and the demonstration of valuable approaches, innovative approaches, to difficult problems is involved. In a diversified university, we see so many opportunities to draw on existing intellectual resources and professional training by merely redirecting them into areas that we consider to be priority areas. I think that what I have said indicates the importance of continuity in the funding of programs that can meet the test of professional and peer evaluation.

Cutbacks in educational budgets as a result of the recent economic and other conditions that have confronted educational institutions have created severe administrative problems for those of us who are seeking to meet educational needs in the field of aging. I wish to stress that we in the association appreciate the past actions which the House has taken to extend the time period for programs under the Older Americans Act, such as the action taken in April of last year when the House overwhelmingly voted to extend the Older Americans Act through fiscal year 1979.

In recent years, more and more 2-year, 4-year and graduate educational programs are seeking ways to provide educational and training programs in gerontology as they become aware of the significance of aging and its increasing impact on our society and the lives of millions of people in the years ahead. We feel that there has been a continuing reluctance on the part of the Federal Government to respond with the

essential resources to assure completely trained personnel to meet such needs despite the increasing numbers of older persons and the services which are required to meet their complex social, environmental, psychological, health, and economic needs.

Universities and colleges are attempting to respond to such needs through the development of educational programs at all levels. Faculty and students have been most responsive and are actively seeking careers in the field of aging. Our institutions have had exceptional experience not only in recruiting qualified students, but equally so in seeing them moving into responsible jobs and careers and working with our aging population. As an administrator of a program in a large university, I can assure you that our progress would be greatly accelerated, and this is true generally throughout the country, if there were a larger commitment of financial resources to this effort.

Mr. PEPPER. Thank you very much for the excellent statement. Your background and knowledge have enabled you to make a very valuable contribution to your field, and I know you will continue to make very valuable contributions toward the solution of the problems of the elderly.

By the way, we also have present today Hon. Fred B. Rooney of Pennsylvania, Spark Matsunaga of Hawaii, and Charles E. Grassley of Iowa.

I have just a question or two to ask Dr. Osterbind before I go to another meeting. Doctor, how many people do you have currently in your center?

Mr. OSTERBIND. On our faculty throughout the university we have approximately 78 professional faculty people.

Mr. PEPPER. Would you tell us what your experience has been with respect to the adequacy of the funding of your center? Are you getting Federal funds and if so, how much? Do you think centers of your kind in the country are being adequately funded at the present time?

Mr. OSTERBIND. No, I do not believe that they are being adequately funded for the simple reason that we have many applications for students that we cannot honor because we do not have adequate stipends to support the graduates and undergraduates. We do not have adequate funds to support them in colleges.

I think one of the biggest problems that we confront in trying to operate programs is the lack of adequate leadtime to plan our programs. This is very difficult. Just as in any type of activity, we need to plan ahead and seek out quality staff people and professionals to work in our programs. We need to attract quality students and if we do not have sufficient leadtime, these people are attracted elsewhere.

We are working within our own university, I know it is true in Florida, to develop a stable base with which we can initiate programs.

Mr. PEPPER. If you had adequate funds would you be able to have a larger enrollment of the elderly in your program and second, if you had more elderly trainees, people who have gotten the benefits of your programs, would there be jobs for them when they got out of the program?

Mr. OSTERBIND. I think the answer to those is in the affirmative. I know that we have many applications coming from students, not only in our State but around the country, desiring training and we are not able to encourage but a certain number of them.

In talking with similar administrators of programs around the country, they have the same experience, and many of them with students under stipends and training programs find that cutbacks in budgets create severe problems for students in the process.

Mr. PEPPER. Do you share my feeling that one of the greatest losses of economic productivity that we have in this country is the failure to offer full employment and productive employment for our elderly people?

Mr. OSTERBIND. Yes, sir; I concur with that. In Florida we want to do away with mandatory retirement and we want to open up all types of employment opportunities to draw on the tremendous resources that we have.

Mr. PEPPER. Do you share my view that there ought not to be any arbitrary age period at which a person is forced out of useful employment when that person is qualified to do the job?

Mr. OSTERBIND. Yes, I concur in that view. I have just been arguing that before our State legislature.

Mr. PEPPER. In other words, instead of having the calendar as the criterion of capacity which, I think it is well established, is not a true criterion, people ought to be qualified as long as the individual meets qualifications of ability, not age. Men and women should be permitted to continue in useful employment regardless of age.

Mr. OSTERBIND. Yes, and it would add tremendously to the resources of our State and I think throughout the Nation.

Mr. PEPPER. How many elderly people would you estimate there are in the country today who are capable of useful and productive employment who are not engaged in such employment because there are either rules of retirement or work is just not available to them?

Mr. OSTERBIND. I think that is difficult to answer. We know that there are some people who wish to retire early but I think that the critical matter is that all people who want to work should have this opportunity and I think we see in training with any group of older people that they all want to lead useful and productive lives in some way in their own conception of this as long as they live. I think this is what we need to focus on.

Mr. PEPPER. Do you think that if we gave an opportunity to the elderly people of the country to obtain better training, better qualifications, to revive the learning process, that they would take advantage of it?

Mr. OSTERBIND. Yes; I do.

Mr. PEPPER. We want to thank you again for your kindness. I will ask my distinguished colleague, Mr. Matsunaga of Hawaii if he would take the chair and he and Mr. Walsh may ask further questions. Thank you. I will see you later.

Incidentally, just for the record, I am 75-years old and I would punch anybody in the nose who said I wasn't able to do anything. [Applause].

Mr. MATSUNAGA [presiding]. I am not quite 75, but I wouldn't dare say that Claude Pepper wasn't able to do anything. Mr. Walsh, do you have any questions?

Mr. WALSH. I am delighted to be here this morning. The social work field happens to be my profession, too. I take this special opportunity to welcome you from the field of sociology and social work and

I am delighted to have the opportunity of hearing of the curriculums that are being developed in this field.

I went through the school of social work quite a few years ago and we didn't have the emphasis in gerontology that we have today and I am delighted to see the emphasis on it.

Do you have a retirement policy at the University of Florida?

Mr. OSTERBIND. Yes; we have a compulsory retirement program that affords people the opportunity to work until the age of 70. It is optional after age 65. We are trying to do something that we think is useful in terms of protecting the relationship between a retired professor in the university by making them a continuing part of the university community in a variety of ways. We haven't completely accomplished this, but we want to establish a condition under which they feel that they are a part of us and they come back and participate in our seminars and work with us and our students and counselors in other ways. We haven't fully accomplished this, but we are working on it.

Mr. WALSH. I certainly applaud your efforts in attempting to do away with any type of mandatory retirement. It seems to me that when a person approaches 60, or 65, or 70, that they really have something to offer because of their experience, knowledge, training, and background. To make them mandatorily retire from the job is I think the worst thing in the world that can happen.

I have seen it happen in so many places where people who are forced out of the job market and suffer a tremendous loss. So I would certainly urge all of the people here in the hearing today to concentrate on changing some of the laws and changing some of the procedures that require mandatory retirement.

I think you can do it in the university. We can attempt to change some laws, but we are going to have to have a lot of help. I think if we want to make it optional, fine. But we have to do away with any type of mandatory retirement in this country.

Mr. OSTERBIND. Under special arrangement, I have one staff member who is 77 and another who is 86 making a contribution to our research staff.

Mr. WALSH. I hope they continue to do that, because this is the type of contribution we need.

I was interested in your comments about architecture because I also serve on the Public Buildings and Grounds Subcommittee of the Public Works Committee and I think within the last few years we made quite substantial changes in removing some of the architectural barriers for the handicapped and for the aged. But I wonder what is happening in the schools of architecture around the country. Do you have a School of Architecture?

Mr. OSTERBIND. Yes; we do. I think that there is a great need and the progress that is being made is probably variable. I am not familiar with it throughout the country. In our college, we are developing programs that involve the students in a solid exposure to literature that is relevant to the design and location of housing of all types for older people that has been developed by sociologists and by psychologists and others.

There are seminars and academic programs, and through the specialization of faculty members in that college, we are bringing

these things together. We believe that we are making substantial progress.

Mr. WALSH. I think that we can continue to make substantial progress in this field. In my State, which is New York, we have attempted to have some very serious guidelines for the construction of housing. I have been involved in the construction of housing and I think we have made some changes in this field. I would hope that the schools of gerontology would be able to push this type of program. I think it is extremely important. There have been many changes that have been brought about just because people have given some attention to these problems and they have avoided serious injury because they have been able to make these changes.

I do want to get into one other question about funding of part C, the multidisciplinary centers. You indicated that you need $8 million for your center. I believe everybody from every center around the country will probably be talking about the same amount of money for their center. Is this $8 million total?

Mr. OSTERBIND. No; this is $8 million in the appropriations bill.

Mr. WALSH. Is this national; not just for the University of Florida?

Mr. OSTERBIND. No.

Mr. WALSH. I am being very parochial because they have a center at Syracuse University. My daughter is doing graduate work at the center so I want to see them get their fair share.

Just one other question, Mr. Chairman. Yesterday we had some testimony from the Center for Studies of the Mental Health of the Aging at the National Institute of Mental Health and the National Institute of Aging. You are funded under a different program. I assume that if you got into part C, there would be a relationship between the various disciplines then, such as mental health. Is this what we are talking about by multidisciplinary?

Mr. OSTERBIND. Yes. Our effort is to relate to all types of research activities and other types of activities and services within the university. For example, we have a program which is now being carried out by the medical school working with a nursing home in Allen Park which fills one of the residential needs for older people. This involves bringing together in a health-delivery system and a health-care program, people from all types of backgrounds and training in social work, in rehabilitation, and in long-term nursing care.

These programs have to be administered, they have to be analyzed in terms of their cost effectiveness and in terms of their social benefit. We get our programs supported in part maybe by one fund source and part from another, because people are working together for a common objective.

Mr. WALSH. Thank you very much. I have no further questions.

Mr. MATSUNAGA. Thank you, Mr. Walsh. I am certainly glad to see so many present here. I apologize for being late, but as you can see, members belong to so many other committees and the committees all meet just about the same time.

I believe it was brought to our attention earlier that the chairman himself is holding hearings in Alabama. Of course, these hearings were timed with your conference here in Washington.

I have always maintained that the greatness of a nation can be measured accurately by the degree to which it cares for its elderly

citizens. If you trace the history of our civilization, of nations which have come and gone, you will find that every time a civilization neglected its elderly citizens, it fell.

It is important in this bicentennial year of [illegible] Nation's birth that we take this to mind and to heart and care for [illegible]lderly. One of our problems, of course, has been that we have had [illegible]ed personnel to deal with the problems of our elderly. It is for [illegible]ason that we are indeed happy to have you who are the experts in this area to guide us in our legislative program.

Our next witness is Dr. C. Brice Ratchford, president of the University of Missouri, a member of the Governmental Relations Committee of the National University Extension Association and also a member of the executive committee for the Council of Extension of the National Association of State Universities and Land Grant Colleges.

STATEMENT OF C. BRICE RATCHFORD, PRESIDENT, UNIVERSITY OF MISSOURI

Mr. RATCHFORD. Thank you very much, Mr. Chairman, I am an economist, not a social worker. Also, I suppose I am speaking from an administrative point of view because I have now been with the university over 6 years and I am probably addressing that aspect of it. Also, I had a note from Bill Randall who is my Congressman, indicating he could not be here, but I will be in touch with him and get the material to him.

I am not going to speak from my prepared statement. I would like to make a summary of it.

Mr. MATSUNAGA. Without objection, your full statement will be included in the record following your oral testimony.

Mr. RATCHFORD. Thank you. Missouri has more than a usual interest in this problem because 12 percent of our population is over 65. That is three quarters of a million people. Furthermore, in 21 of our 114 counties, over 20 percent of the population is over 65. So it is a problem that is with us and that we must address.

The University of Missouri is the State land grant university in the State, being fortunate in having only one State university which also includes the land grant philosophy. This last year, we had over 53,000 students on campus.

In addition to the four major campuses, as part of our system we have research facilities throughout the State. The extension office which represents not only the University of Missouri but Lincoln University covers 180 land grant institutions in every county. No city is more than 10 miles away from the physical facilities of the University of Missouri.

Furthermore, as an adjunct, we have 250,000 people who received health care treatment in our medical school. We have an exceptionally fine relationship with Lincoln University that was an 1890 land grant institution. We cooperate in teaching programs, research, and extension. As I say, our extension centers around the State have been in the front representing the University of Missouri and Lincoln University.

The university, while often pioneering, basically reflects social values and priorities. Until quite recently, the two overriding priorities of all universities were young people and the advancement of tech-

nology. I believe it is technology which has created some of the major social problems.

We have always had relatively old people, but going back 1,000 years ago, a person 40 years old was a senior citizen. Because of developments in the health care field, now it is over 70. So our emphasis on technology has helped create this problem.

Quite recently within our university, 10 years ago, we started facing up to the problem of senior citizens. It is relatively new in our judgment. We have a cadre of professionals in our faculty who are indeed working with this problem. They work together quite well. I have been surprised at how many there are and the various backgrounds: the engineers and the medical, the professors of medicine, the social scientists. They are all interested, involved and are working on problems of older people.

In my written testimony I gave some specific accomplishments that we have made at the University of Missouri. The Mid-West Council for Social Research in Aging is administrative based at our university. We have established excellent relationships with all of the other public institutions in the State. We do cooperate with each other really quite well. We have a good relationship with the State Office of Aging and the area agencies on aging.

We have set up within the university a means of planning and coordinating all university activities within the aging area. Currently, we have a research thrust related to the senior citizens dealing with housing and retirement patterns of elderly people.

We have training programs. We have programs that lead to degrees on our campuses; and we have continuing education programs. When we started those, we did what we thought our role ought to be. Our role is teaching degree programs, research and continuing education and not delivery of services. Now I would say the quid pro quo there is that noneducational agencies ought to let the educational agencies do this. I would not encourage the University of Missouri to get into the actual delivery of the service. So I think the functions ought to be assigned where they really belong.

We have learned a lot. I think we are doing many things right. We are stimulating wide interest within the university and outside the university.

What about the future? At this point, I will read an addendum to my testimony. We are ready to move ahead, but I think one thing that we need to really move ahead is a stable continuing source of funding.

In titles IV-A, IV-B, and IV-C you have the vehicle for doing this. Let me mention three things, three parallels—and you know about all of them. I do not feel the Federal Government should fund all of the efforts in the field of aging. I think funding should be shared.

Let me just talk about three places where this has happened. The land grant university was created in 1862 by an Act of Congress, the Morrill Act. There has been continuing funding, but in addition to the Federal funds which are now a very small percent, we have State funding, student fees, gifts and various other sources of funds. Now the Federal funding is considerably less than 50 percent.

But the Federal funding provides the continuity. If you go back and read the history on experimental research, the states in the earlier years would have done away with the Agricultural Experiment Stations had that Federal funding not been there and required matching.

The other point I would make is that if there can be stable Federal funding, I would suggest a matching provision of some sort. The important point I am making is continuity. What we have done up to now has been useful, but I would consider it experimental and if this nation establishes a policy to have a continuing program, then I think there should be a continuing source of funding. I realize that this will involve some new formulas where we talk about new development and other Federal programs.

I would also say that those parts of the act which are properly university functions should be so indicated. I would simply say in conclusion that our university is ready to go.

[The prepared statement follows:]

PREPARED STATEMENT OF C. BRICE RATCHFORD

I am pleased to have this opportunity to participate in these hearings. It is also gratifying to know that this nation's older Americans and those of us who serve the elderly, now have a Select Committee in the House of Representatives to which we can address our comments and concerns. I commend the House for its wisdom and foresight in recognizing the need to direct attention to the some 21 million of our citizens who are 65 years and older.

I also understand that this Committee has just completed its first year of tenure and your track record indicates that you have actively pursued your mission of obtaining facts concerning the status of the older American. It is this type of dedicated congressional leadership and support which those of us at the state and local level need if we are going to make a difference in the lives of this nation's elderly.

Faculty members of the University of Missouri have become acutely aware of the numbers of Missouri citizens who are 65 years and older, where they live, and the problems which are attendant to the process of growing old in today's society.

As the Committee knows, the state of Missouri ranks sixth among the states in the percentage of citizens who are 65 years of age and older. Twelve percent of our state's population, or approximately three-quarters of a million people, comprise our older Missourian population. In many of our rural areas the percentage of older persons is even more dramatic. For example, in 21 of our 114 counties over 20% of the population is 65 years of age and older. As farms have consolidated -- as the young have moved to the cities -- the older folks have remained on the farms and in the small towns. Older people are also heavily concentrated in the older sections of our cities. In recent years retired people have been moving in large numbers into the Missouri Ozarks. They are migrating from the city of Chicago as well as the states of Iowa and Nebraska. In Missouri we have many senior citizens and they represent a wide range of socio-economic characteristics.

Our investigations of the problems facing the older Missourian confirm the findings of this committee - the transportation crisis; limited medical care; small fixed incomes which are being squeezed by inflation; and isolation and loneliness problems. We have also found that there is a shortage of trained personnel available to staff state and locally initiated service programs for the elderly.

Our inquiries have also revealed that our university services, in the main, reflect society's values and priorities which have placed emphasis upon technological innovation and the youth in a young adult culture. Our research, textbooks, teaching strategies, and continuing education services have understandably focused upon these priorities. The direct payoff to senior citizens has been marginal at best. We live in a society which places primary emphasis on children, youth, and young adults. While retaining educational and developmental opportunities for young people, we need to expand the educational-developmental opportunities for persons in later adulthood and in old age.

Let me explain that the University of Missouri was founded in 1839 as the first state university west of the Mississippi River. After Congress, with great wisdom and foresight, passed the Morrill Act of 1862, the University became a land-grant university with extensive responsibilities in the fields of agriculture, home economics, and youth. The Hatch Act of 1887 set in motion our extensive agricultural experiment station research efforts. Today the University of Missouri system includes four campuses, which are located at Columbia, Kansas City, Rolla, and St. Louis and a statewide extension delivery system which reaches into every county of the state. The current full-time equivalent student enrollment totals 43,100.

In 1890 the Congress passed the second Morrill Act which granted land-grant status to Lincoln University, and this institution has concentrated its efforts on serving black Missourians. Lincoln University is located in Jefferson City and currently has an enrollment of approximately 2,500 full-time equivalent students.

In 1973 Lincoln University and the University of Missouri unified their extension and continuing education efforts and all of our off-campus extension centers now serve as the centralized outreach arm for Lincoln University and the four campuses of the University of Missouri. The Smith-Lever Act provides us with the mandate and appropriations to continue this valuable extension mission in the areas of agriculture, home economics, community resource development, and youth development.

Within the last two years the administration of the University has become concerned about aging. As we have conducted inventories of programs in aging on our campuses and have found that there is a contingent of faculty members who are doing research and teaching in gerontology, the fact that the University of Missouri has faculty members involved in aging-related pursuits can be attributed, in part, to programs which Congress has supported at other universities for a number of years. For example, on the Columbia campus Professor Donald Cowgill's initial interest in aging derived from a summer institute in gerontology which was conducted by the University of Michigan with federal support some years ago. Professor Warren Peterson on the Kansas City campus received his graduate training in one of the early federally supported gerontological programs at the University of Chicago. Joining the faculty at Kansas City next year is a young woman who has been trained with NIH support in the gerontological center at Duke University.

Following active participation in the 1961 White House Conference on Aging, some of our faculty members joined with others in the midwest to form the Midwest Council for Social Research on Aging. The Council, now administratively based at our University, conducts a pre-doctoral and post-doctoral training program which has been supported by NIH for a number of years. This has been a highly successful program which, at relatively low cost, has trained a wide range of gerontologists in midwestern universities, including several who are active in research and teaching on our campuses. The point I am making is that federal investments in gerontological training are effective and are yielding results. We sense that there is, as indeed there should be, an expanding network of effort in aging in colleges and universities across the country. The University of Missouri is committed to carrying out its proper responsibilities. In doing this, it is committed to inter-campus cooperation within the system and to full cooperation with gerontological programs in other colleges and universities.

Our extension service, notably since the passage of the Older Americans Act of 1965, has worked with officials of the Missouri Office of Aging and the Region VII Office of the Administration on Aging in organizing and supporting locally initiated action projects. When the Area Agency on Aging (AAA) network was authorized, our off-campus staff worked closely with the Missouri Office of Aging in establishing area agencies. We have also formed special aging-related interdisciplinary extension off-campus staff support committees in each of our 20 extension program planning units. Extension specialists in home economics,

community development, and continuing education comprise the membership of these committees. Their chairperson serves as the contact point with the local AAA, and their mission is to provide educational support and serve as the local connecting point with the University of Missouri and Lincoln University.

In March, 1975 I authorized the creation of the Older Missourian Programs (OMP) which is a statewide organizational structure for stimulating and coordinating all of our aging-related research, on-campus instruction, and extension services. It is an effort to put it all together. It is coordinated through the office of the University of Missouri Vice-President for Extension. I am attaching to this testimony an abstract description of the OMP.

In addition to these organizational matters, our faculty have received a number of grants from the Missouri Office of Aging, the Federal Office of the Administration on Aging, the National Institute of Mental Health, the National Institute of Aging, and the Social Security Administration. Supplemented by University funds, these grants have allowed us to accelerate our work in the field. We are, of course, highly indebted to those state and federal agencies who have been generous in the investment of their funds and who have helped us with our work.

On the research front we have major investigations focusing upon the (1) housing and retirement problems and settlement patterns of the elderly, (2) social, psychological and cultural problems of the aged in rural settings, (3) physiological processes of aging as manifest in the growth patterns of swine, and (4) nutritional problems of the older Missourian.

Our campus-based instruction mission has been enhanced through a small Title IV-A training grant to the Columbia campus which has led to the creation of a campus-wide Center for Aging Studies. Twenty-three graduate students from thirteen different academic departments are being trained to serve the elderly. Faculty development and new course development are also a part of the Center's agenda.

In the extension area, we are conducting statewide training programs for (1) board members and advisory committee members on the AAAs and the Governor's Advisory Council on Aging, and (2) service provider agency personnel who desire to work together in developing integrated human service delivery systems for the elderly at the local level. We are also experimenting with the use of an extension specialist in gerontology whose work patterns closely parallel those of specialists in the college of agriculture/extension model which has successfully served agriculture for the past 50 years. This specialist has the responsibility

for transmitting new knowledge from our academic departments to extension off-campus staff, who in turn share it with the elderly and professionals who serve the elderly. We rely heavily upon the train-the-trainer model.

I am pleased with our progress to date. I feel that we have created an inter-campus organizational model which is consistent with our land-grant mission. It also has the potential for longevity and permanence. We have relied heavily upon our experiences in other fields. We are fashioning a model which will stimulate and coordinate aging-related research, instruction, and continuing education on our four campuses, Lincoln University, and the statewide extension service.

We have carefully limited our role to education and we have not ventured into the business of providing direct services. This has also facilitated the establishment of good working relationships and a high level of cooperation and coordination with the Missouri Office of Aging and the other public and private aging-related service providers throughout the state.

We have done things right up to this point. However, my major concern now rests with the problems of consistent funding in order to maintain our momentum. The very helpful categorical grant support from the state and national offices of the Administration on Aging, National Institute of Mental Health, National Institute of Aging, and the Social Security Administration have gotten us started and have helped us mount some useful programs. Unfortunately, categorical grants do not offer the degree of stability and security which is necessary for comprehensive long-range programming. Although we have a land-grant university aging-related delivery model, we do not have the stable source of federally appropriated formula funds which have undergirded the success model in agriculture. We need a Morrill Act, Hatch Act, or a Smith-Lever Act to reinforce our OMP. These Acts provided the land-grant universities with the financing and long-range commitments to put a solid statewide educational delivery system in place. They allowed the universities time to engage in disciplined, well-planned and time-consuming research. They acknowledge that investment in research is a long-range phenomenon and they realize that the results of research often offer both primary results and secondary biproducts which ripple through the economy with the passage of time. They also provide the land-grant universities with the resources to recruit and train competent staff who could analyze, interpret, apply, and transmit the results of research to the local community. It allowed for the development of an integrated knowledge factory which made America the breadbasket of the world.

Adequate and consistent appropriations on the part of Congress for the

National Institute on Aging and for Titles IV-A, IV-B, and IV-C of the Older Americans Act of 1965, as amended, can provide colleges and universities in this country with the resources required to make a major impact in the field of aging -- comparable to the impact on agriculture. Unfortunately, the National Institute on Aging and Titles IV-A and IV-B continue to receive only modest funding and Title IV-C has never received an appropriation.

The possibility of generating additional state and local financing is completely unrealistic at the present time. Our state and local revenue base is simply not adequate. Any small incremental increases which become available are immediately consumed by inflation. We are being forced to cut back on programs and faculty positions and our quality is being steadily diminished. The local and state revenue pie is simply not large enough to accommodate any new program thrusts in aging or any other field.

Congress has the wisdom and authority to set national policy and provide the appropriations which will help us to continue making contributions toward the improvement of the quality of life of the older American. The elderly are a national resource. Their problems are not confined to local or state boundaries. They are national and international in scope. We need continued federal direction and support if we are to succeed.

I believe that there is a parallel that can be drawn between the contribution to agriculture made by the universities, with federal support, and the potential contributions that universities can make in enabling people -- and future generations of people -- to live fuller and more productive lives after 40. For the majority of people to live into old age is a new thing in history. We live in a society which placed primary emphasis on children, youth, and young adults. While retaining educational and developmental opportunities for young people, we need to expand the educational-developmental opportunities for persons in later adulthood and in old age.

If the college and university system in this country can focus their research and educational resources on the potentials of the older population, I am confident that there will be measurable progress, decade by decade. The mission of universities in aging is that of extending the period of life of full and active participation and contribution. Universities can and should help in adjusting or transforming the society to include and utilize the older population.

ABSTRACT

UNIVERSITY OF MISSOURI OLDER MISSOURIAN PROGRAMS (OMP)

Older Missourian Programs (OMP) is an inter-institutional cooperative program where University of Missouri (UM) faculty at the Kansas City, Columbia, Rolla, and St. Louis campuses, Lincoln University faculty and UM off-campus extension specialists work together on a wide range of research, resident instruction, and continuing education services for the elderly and professionals who serve the elderly. These institutions collectively enroll more than 55,000 students and employ over 5,000 teaching, research, and extension faculty. The four UM campuses and Lincoln University are land-grant institutions and form a statewide extension network.

OMP is a new statewide organization designed to integrate quality research and educational services in the field of aging. Its role is to make the University of Missouri and Lincoln University's efforts in the aging field more systematic, vigorous and visible.

The purpose of OMP is to encourage the (1) provision of professional and technical services in the field of aging, (2) initiation of research inquiries and stimulation of aging-related research activities among faculty and graduate students, (3) stimulation of aging-related curriculum change and program development, and (4) motivation of more students currently enrolled in a wide variety of academic disciplines, toward employment in aging-related, professional, and service fields.

OMP is governed by an Executive Board of Directors representing the two universities and extension field staff. The Board is responsible for formulating policy and identifying and recommending the assignment of campus and off-campus resources to action projects. These projects may be initiated by campus or off-campus units or by the OMP. All projects are carried out by campus or off-campus faculty with the OMP serving only in a coordinating role. A coordinator has been assigned to serve as staff to the Board and to facilitate programming among the operational units.

Mr. MATSUNAGA. Thank you, Dr. Ratchford. I am sure that if your Congressman, Mr. Randall were here, he would have some questions for you. After he reads your statement, he may forward some questions by letter to you.

You suggest matching funds. One of the problems with matching funds has been that many of the State and local governments fail to put up their share, because they are unable to come up with the funds. At least that is the reason they give us in the Congress.

What if we put it on a need basis, if they show to the satisfaction of the Federal Government that they are unable to put up the matching funds then such matching funds would not be required? Or would you strictly insist on matching funds by the local government?

Mr. RATCHFORD. If you are talking about grants from 1 to 3 years, there would be no matching as far as I am concerned. If it is to be an ongoing program, on a statewide basis, we don't have any problem at all in matching.

Mr. MATSUNAGA. On a statewide basis?

Mr. RATCHFORD. There may be problems in isolated counties—if you go to some counties, they might not be matching. It would be a lot easier for many to say "you find it," but I would rather have a cooperative program, which I don't think it really will be until we put some dollars into it.

Mr. MATSUNAGA. So are you saying that in this program to train personnel for the care of the elderly, you would insist on matching funds?

Mr. RATCHFORD. That is my recommendation, and I don't restrict how we match them.

Mr. MATSUNAGA. Do you happen to know how many students are involved in the training program in your State?

Mr. RATCHFORD. The testimony mentioned 75 in degree programs.

Mr. MATSUNAGA. What is the age range of those students?

Mr. RATCHFORD. These are generally graduate students, equivalent to the masters in social work, which I suppose runs from 22 to 25 and some older.

Mr. MATSUNAGA. It is good to know that the younger ones are taking an interest in this area.

Mr. RATCHFORD. They are looking for careers now, and that is very important. There are other activities also, the research activities which are generally done by a different group—for example, nutritional services and home economics, in contrast to most of the training that is being done in social work and development.

Mr. MATSUNAGA. Thank you very much, Dr. Ratchford.

Mr. RATCHFORD. Thank you very much.

Mr. MATSUNAGA. Our next witness is Dr. James J. Kelly, who is assistant professor of social work at the University of Hawaii. He is a past teaching assistant at Andrus Gerontology Center at the University of Southern California, where he was assistant to the director of the summer institute.

As you can well see, he is from Hawaii, with an aloha shirt with puka shell lei and with sun-surf tan. As a representative from the sunny State of Hawaii, I am indeed happy to be able to present Dr. James J. Kelly. You may proceed.

STATEMENT OF JAMES J. KELLY, Ph. D., ASSISTANT PROFESSOR OF SOCIAL WORK, UNIVERSITY OF HAWAII

Mr. KELLY. Thank you, Mr. Chairman. I would like to inform you about some of the stimulating programs we have developed at the University of Hawaii, in large part with the assistance of a training grant from the Administration on Aging. The educational activities I am about to describe are but one set of examples which demonstrate how Federal assistance for gerontological training has been put into effect.

As to the need for assistance, in 1973, the Honorable John B. Martin, former Commissioner of the Administration on Aging made the following remarks before the U.S. Senate's Special Committee on Aging:

> Many young people today do not think about the elderly and the aging as an area in which they would have any particular interest in investing time and planning it as a career.
>
> I think it is perhaps natural, because they have no contact in our culture with older people, so that it seems to me entirely in order to offer some inducement to them through having a program which is visible, has some visibility in these institutions, and which encourages them to take a look at gerontology, and gerontological activities as a possible career.

I agree with this statement and I must emphasize that it is only realistic to expect students to follow the path of incentives. In our country's schools of social work, psychology, and public health we have grants from the National Institute of Mental Health and have long had other grants, scholarships, and loans for the mental health field.

These funds have often been earmarked for students working with children or families. Even had moneys been available for those who wished to study specifically in the field of aging, courses of study and gerontology social resource persons were rare if they were available at all.

Across the country, we in the field of gerontological instruction are funding capable, energetic, and devoted students who, once exposed to the area, become committed to the relatively young field of the study of aging.

Though it is hard to calculate percentages, my experience has overwhelmingly demonstrated to me that a majority of these students have been turned on and recruited to gerontology by the visibility of the federally supported training programs and the stimulus of the traineeships available.

Without one such traineeship which I received a few years ago, I might not have been attracted to the field of gerontology. Sad, but true, is the fact that without a career training grant I would not be teaching at the University of Hawaii and, therefore, could not have created several new courses, a geriopsychiatric field unit as well as setting up the University of Hawaii Gerontological Summer Institute.

Our program of gerontological career training is a joint endeavor of the Schools of Public Health and Social Work. I want to briefly outline what our objectives have been through this past year and then

explain how these goals are being enacted in actuality. Our programs are:

One: To prepare, at the master's level, individuals with specialized knowledge in gerontology and competence to assume planning and administrative level positions in programs and agencies serving the elderly.

Two: To provide courses and field experience in gerontology for students from other fields of study who will have impact on the lives of the elderly.

Three: To provide assistance to faculty members from other areas who desire gerontological input into their curricula, research projects, or service activities.

Inherent in these objectives are anticipated results including (a) a stronger working relationship between the two schools and community agencies and (b) far more visibility for gerontology along with increased interest by students and faculty. Starting with a strong base of curricula, research, and community service in gerontology by the two schools, we intend to develop university support for a comprehensive gerontology program.

Working toward fulfilling the national need for skillfully trained gerontological planners, program administrators, and practitioners has been our program's first priority. A 1972–73 survey by the University of Hawaii School of Public Health looked at future man and womanpower needs of 127 Hawaii State agencies serving the elderly. This survey did not consider the need for reeducation of present employees nor did it take into account the 1973 Federal legislation which has promoted expansion of planning and service delivery for the elderly. Thus, the research was probably conservative in estimating a need statewide for 111 new workers with master's degrees and gerontological training by 1978.

We have 30 students concentrating in gerontology at present. Ten receive no aid from the gerontology training grant. The 20 students who are receiving financial assistance from the career training grant in gerontology receive varying amounts of money covering their tuition and partial living expenses on an individual need basis as established through the university's office of financial aid. Of these 20 students receiving traineeships, 2 are undergraduates in the human development sequence. Of the 18 graduate students receiving gerontology training grants, the breakdown in disciplines is as follows: Two are in law, one is in medicine, eight are in social work, and seven are in public health.

The variety of background disciplines shown here signals the growing awareness that complex, sophisticated training is required for both administrative and direct service workers in handling the interrelationships of program planning and evaluation, the complexities of new and changing laws, and the compendium of health, counseling, and general knowledge necessary for human services.

On the graduate level, the jointly coordinated training program of the schools of social work and public health make available courses of study and experience leading to either a master of social work or a master of public health degree. A few examples of the range of courses offered at present are: social welfare concepts and issues in gerontology, health and aging, care of long-term patients, human

development, studies of middle age and old age, readings and research, social policy and aging, therapeutic strategies with the older adult and death as a community health issue.

Field practical experiences are given in a wide rang of administrative and direct service positions. Students may work with the elderly in the State mental health clinics at a retired senior volunteer unit which was established at the university in 1974 and at the Hawaii State Senior Center with which the university is affiliated. Also available are placements with the Commission on Aging, Area Agency on Aging, State Health Department, and First Hawaiian Trust Co.

Hawaii offers a unique learning situation because its population of elderly is comprised of: 32 percent Japanese, 29 percent Caucasians, 18 percent Filipinos, 9 percent Chinese, 8 percent Hawaiians and part-Hawaiians, plus other smaller minorities. Therefore, we are developing a training program which prepares students to work in a multicultural, multiethnic milieu. Colloquia, panel discussions, and presentations have been given on topics ranging from special techniques for working with Samoans, Filipinos, and Hawaiians, to perspectives on international social work in Nepal and Thailand.

Some gerontology program students are taking part in State legislative hearings and decisionmaking activities. There has been participation by them in special action groups and at State and local conferences on aging. This summer, at least six of the gerontology students will take part in multidisciplinary student-faculty teams working with the elderly on the islands of Molokai and Kauai. These field training projects involve the schools of medicine, nursing, public health, and social work.

Furthermore, our gerontology students are involved in investigating a varied spectrum of issues; the students generally show dedication to providing humanitarian services. It is my belief that students' accomplishments will show that their training grants were a small price to pay toward greater respect for all Americans, because they are making us more aware of the need for governmental intervention in terms of alternating the fate of the aged. If we can see all of our citizens treated with dignity throughout their lives, the positive effect on our national self-esteem would be incalculable.

Simultaneously, it is a reasonable hope that the Nation's gerontology students may provide a savings of Federal financial resources far outweighing the investment of administration on aging grants. Some of my students are interested in changing the service base of the medicaid-medicare system since they realize that the system is not currently operating on a level that will insure optimum care for the elderly.

Also, students interested in preventive nutrition programs might help save many elderly from needing costly intensive or custodial care. Similarly, elderly with reversible brain syndromes and improved rehabilitative techniques with stroke victims could alleviate tremendous amounts of suffering and save a fortune spent by the public and the Government on custodial care. Improved management of nursing homes is another vital area being studied by some of our students.

I wish to finish my presentation by briefly outlining our forthcoming gerontological summer institute. The activities have been coordinated with the Hawaii Governor's Bicentennial Conference on

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Aging by having our institute precede and follow the conference. This institute will be the first to include both professionals and graduate students in the field, as well as senior citizens. Elderly individuals will receive both training, and opportunities to contribute to the conference in important roles. Faculty participating as students should stimulate development of gerontological programs in other courses and departments.

Another first for the summer institute is that it is the first cross-national, multidisciplinary approach given in a gerontological institute. We will have the first courses ever taught in International Gerontological Research. Nine different departments from the university will be offering courses covering such areas as phychological perspectives on aging, social policies of the world toward aging, law and aging, ethnicity and aging, considerations in nursing care, curriculum development, and health management and nutrition.

The unique resource of Hawaii will be utilized in several ways. The cooperative scheduling with the Governor's conference will allow us to share several expert speakers in the field in addition to the institute's faculty. Several exhibits and workshops will be given by the Governor's conference while the University of Hawaii Summer Institute will provide seminars, informal discussion sessions, and field trips to special cultural events.

A particularly interesting event will be an exchange of ideas and philosophies of aging with Fiji, New Zealand, New Guinea, and other Pacific Basin countries via satellite while the institute is in session.

We are excited about the University of Hawaii's gerontology program, with what we have already implemented and with the potential for a full-range, campus-wide gerontology program. Continued financial support from the Administration on Aging is vital at this point in the development of our gerontology program and probably for most universities in our Nation. At the University of Hawaii, of the three faculty members directly involved in coordinating the gerontology training program, two, including myself, are present at the university solely by virtue of the Administration on Aging grant.

We are currently in a period where the greatest expansion of the population will be among the middle and older areas. Today 11 percent of our population is over 65 years old, and it is feasible that by the year 2000 the elderly will comprise an even greater segment of the population.

Fortunately, we have begun an era where social consciousness of the rights of the elderly and the value of each human being are becoming increasingly important values.

Any investment which we fail to make in gerontological training at this time will cost us far more in inefficiency, ineptitude, and lack of personnel than we think we are saving. And morally, the cost of hesitation is too high to pay.

The allocation of Federal funds for gerontology programs is a matter of using a tiny percentage of our resources toward the highest social purpose humankind knows: the maintenance of human dignity by giving priority to the alleviation of unnecessary physical and mental suffering and by securing the basic necessities of life for all.

Mr. MATSUNAGA. Thank you very much, Dr. Kelly. I wish to congratulate you on your statement. I have read it in full and I certainly

am proud that the University of Hawaii, under the leadership of people such as yourself, is taking a real forward step in the area of care for the aged and looking to the future so that we have trained personnel in this area.

You say that there are just 30 students now concentrating on gerontology at the University of Hawaii?

Mr. KELLY. Yes.

Mr. MATSUNAGA. Do you anticipate any increase in the enrollment in this area in the future?

Mr. KELLY. I think what we have is a start, and there is definitely going to be an increase. If you look at the statistics, they say that the study found that we need 111 new positions by 1978. From the statistics I calculate, we are going to have graduated 75 students by that time and in looking at that number of 75, a number of the students who we have graduated have gone on to higher education elsewhere, or have not been able to get jobs because of just where the state of the economy is at this time.

I think it is important to note that there is a need for reeducating people who already are holding current jobs. I think most of the people who work with the elderly today have not had this training. It usually takes about 6 months or a year to get our students placed, but we have been getting them in good gerontological jobs.

Mr. MATSUNAGA. Are you satisfied with the number of students whom you are able to enroll and train with your present faculty and the facilities?

Mr. KELLY. I am satisfied with the number of students. I think the main problem is there are three of us at the University of Hawaii who do the gerontological instruction. We are just overwhelmed. We are mainly doing maintenance types of activity. I teach four courses 2 days a week in the Waikiki Mental Health Clinic. I do an awful lot of inservice training for a number of agencies in Hawaii, and I sit on seven boards and a couple of the Governor's Commissions on Aging. Time is something I just don't have. My schedule right now is booked to August. I have an offer to have my dissertation published and I had to turn it down because I had to do maintenance type activities.

Also I was offered a hard money slot at the University of Hawaii, in a policy position. If I did that, I would not have any responsibility for geronotological instruction at all. Jobwise for me it means security. I could be tenured and I would advance. Right now I don't know if I am going to be terminated on June 30 and I probably won't know until May 29.

I have a commitment to gerontology. I was trained by the Federal Government to be a gerontologist, but I don't know how much longer my survival will be there.

Mr. MATSUNAGA. As I understand it, the problem of the University of Hawaii is not a department nor a center and it is a collection of related courses held together by a few dedicated people such as yourself.

Would a more solid institutional framework help you to achieve your training and research goals more efficiently?

Mr. KELLY. Yes. I think that what I was trying to conceptualize, is that the three of us are just run ragged with the demands that are placed on us by the community, by State personnel and by students. We

don't have the time. Hawaii, as I told you, by our statistics has probably the largest ethnic mix in the United States. There is very little research that has been done in this area at all. I don't have the time to be doing any of it. Neither do either of my other two faculty members.

If we had a program, we could start trying to get research grants and projects going. We could be much more effective also in looking at international issues in gerontology. Right now gerontology is low priority in a number of these different schools and it is mainly because they have all other types of areas which are more important to them, with "hard money" people sitting on these slots.

Mr. MATSUNAGA. Would you recommend that we provide that grants shall be made only to those institutions which establish a department or center for gerontology?

Mr. KELLY. I think that is a good point, but I don't know if I would want to see that be the only way that the money went. That is one way of getting support and I think there may be other ways that remain to be looked at.

Mr. MATSUNAGA. I have no other questions. It is almost 12 o'clock and we have four more witnesses.

I would like to acknowledge the presence of another member of the committee, Mr. Grassley of Iowa. Do you have any questions?

Mr. GRASSLEY. Not at this time.

Mr. MATSUNAGA. Our next witness is a professor of medical sociology at Duke University. He is a senior fellow at the Center for the Study of Aging and Human Development and past research sociologist with the Social Security Administration, Dr. Erdman Palmore.

STATEMENT OF ERDMAN PALMORE, PROFESSOR OF MEDICAL SOCIOLOGY, DUKE UNIVERSITY

Mr. PALMORE. I would like to first read a quote from the 1971 White House Conference on Aging which I think is a succinct summary of the situation and the need for research now.

> Aging is one circumstance which affects every individual, and growing old will be the fate of all those privileged to live as long as seven or more decades. In view of this universality of the aging process and the certainty of its eventual outcome, it is surprising that a major research effort to ferret out its nature and its personal and societal consequences has not been made a national priority.
>
> Instead, Federal support for research on aging has been relatively minimal in comparison to that provided for conditions to which only a limited segment of the population will succumb. Most of the funds have been allotted to medical and health-related studies, while support for the social-behavioral and biological components of aging has been very minimal indeed. (1971 White House Conference on Aging, "Toward a National Policy on Aging," Final Report, Vol. II, p. 93.)

This 1971 statement sums up the neglect and need for research on aging. This situation has not basically changed during the years since then. There has been some increase in research through title IV of the Older Americans Amendments of 1975 and the creation of the National Institute on Aging. But compared to the billions in total Federal expenditures for the aged, he relatively few millions spent for research remain clearly inadequate to meet the challenges and opportunities to acquire the knowledge we need to deal with the problems of older Americans.

NEED FOR LARGER AMOUNTS OF RESEARCH

It is difficult to even estimate how much is being spent on gerontological research because of varying definitions of what constitutes research and how much of it is gerontological. The best estimate of total Federal expenditures in fiscal 1976 for research on aging appears to be around $55 million (not including the Veterans' Administration's medical and prosthetics research) as follows:

Proposed fiscal 1976 budgets for research on aging [1]

	Millions
Social Security Administration research and development	$30.5
National Institute on Aging	16.2
Older Americans Act, title IV	7.0
National Institute on Mental Health, Center on Aging	1.3
Total	55.0

[1] Source: Special Senate Committee on Aging, "The Proposed Fiscal 1976 Budget: What It Means to Older Americans," February 1975. Social Security Administration Research and Development Effort, fiscal 1976 estimate.

In contrast, the Federal Government is currently spending over $100 billion a year on retirement benefits and medicare alone. Thus, the Federal Government is spending less than one-twentieth of one percent of its total aging expenditures on research for the aged. Industry and other large organizations typically allot from 2 to 10 percent of their operating budgets to research and development. In comparison the one-twentieth of one percent for aging research pales into insignificance.

Therefore, the basic need in research on aging is simply the need for a much larger amount of research. This requires the recruitment and motivation of more professionals for such research and the provision of more space and facilities. Both of these two factors are dependent mainly on the provision of more adequate funds.

The 1971 White House Conference on Aging recommended a major increase in Federal funds for research:

> Appropriation of general revenues for programs in the interests of older persons should contain additional funds amounting in the average to no less than 3.5 percent of such expenditures, these funds to be allocated for research, demonstration, and evaluation.

If this recommendation was followed in the Administration on Aging, for example, the present $7 million for research would be more than doubled to over $17 million.

TYPES OF RESEARCH NEEDED

As the name implies, basic research underlies long range progress on the more applied and evaluative types of research. Basic research in aging has been so sparse that we are just beginning to understand the basic biological processes of aging, and even less is understood about the interactions between biological aging and psychological and social factors. We are fairly sure that the important outcomes of aging, such as adaptation, life satisfaction, and longevity, are strongly influenced by physiological, psychological, and social factors, but we are uncertain about the relative importance of these factors in varying

situations, and know little about the complex mechanisms through which these factors interact.

More longitudinal and interdisciplinary studies are particularly needed because aging is by definition a process that occurs over time and because the aging process cannot be adequately understood by any one academic discipline alone.

Because of their long tradition of concern with basic research, institutions of higher learning are the most frequent settings for research into the fundamental processes of aging.

The distinction between basic and applied research is often an artificial one because much basic research results in findings with practical implications, and applied research often results in new understanding of basic aging processes. However, with the proliferation of new programs for the aged, there is a critical need for more objective and systematic evaluation of the effectiveness of these programs. Too often demonstration projects have simply demonstrated that a given staff can be assembled and a program put into effect for a short time, but there has rarely been objective and systematic evaluation of the actual impact, its long-term effects, if any, and its cost-effectiveness compared to other programs. Usually these demonstration projects do not have adequate funds or personnel for such evaluation. As a result, the evidence for its cost-benefit is not convincing enough to get long-term funding and the project dies. The evaluations which have occurred often are attempted after the program has been put into effect. The most effective evaluations are built into the project design from the beginning.

Because of their traditional scientific objectivity, institutions of higher education constitute a primary resource for more effective evaluation research.

Despite meager funds for research, gerontologists have managed to amass an impressive array of findings. Unfortunately, many of these findings are based on small samples in limited localities. The field urgently needs more replication and testing of these findings in other areas and on larger samples in order to establish their representativeness and generalizability, as well as to discover any variations in their applications to different populations under different conditions. Replication is particularly needed in social and behavioral research because social conditions and characteristics can vary widely from one population group to another.

Scientific communities in institutions of higher education have long recognized the critical importance of replication and have usually attempted to replicate important findings whenever sufficient resources were available.

SUMMARY

Research on aging is a relatively neglected and underdeveloped area which, if adequately funded, could solve the mysteries of growing old, increase our control of the aging process, and guide social policies to provide the opportunities for a meaningful and rewarding life throughout old age. The Association for Gerontology in Higher Education recommends more adequate funding for such research. Thank you.

Mr. MATSUNAGA. Thank you very much, Dr. Palmore. Unless you have any questions, Mr. Grassley, I will go on to the next witness. If there are any questions, the witnesses are free to remain, and we will have questioning as time permits after the remaining witnesses have testified.

Our next witness is the associate chairman of the Gerontology Center at Penn State University and he is the president-elect of the Association for Gerontology in Higher Education, Dr. Tom Hickey. Dr. Hickey, it is nice to have you here.

STATEMENT OF DR. TOM HICKEY, ASSOCIATE CHAIRMAN, GERONTOLOGY CENTER, PENNSYLVANIA STATE UNIVERSITY

Dr. HICKEY. We are here this morning to bring to the attention of the Congress through your committee the continuing importance of the role of colleges and universities in preparing individuals throughout the country for research and service careers in the field of aging.

Let me say at the outset that the Association for Gerontology in Higher Education greatly appreciates the opportunity you have given us to appear before you today. Furthermore, I would like to underscore the fact that we are appreciative of the efforts of this committee to convene this special hearing while our association is meeting here in Washington. Our association is a voluntary organization of colleges and university programs and centers in gerontology. We represent approximately fifty educational programs and centers nationwide in the field of aging. These centers specialize in research and training activities related to the needs of the elderly. They are multi-disciplinary in their educational focus, including medical and health related areas as well as social service research and training. The basic purpose of this association is to improve educational programs by providing a network of communication and effective collaboration to promote, encourage, and develop gerontological education in this country.

Ultimately, this effort improves both the quality of services and the capability of people conducting research and service programs which deal with the needs of older citizens throughout the Nation. As will be evident from subsequent testimony, it is perhaps somewhat paradoxical that this association has emerged during the 1970's in direct response to the Federal Government's request for professional guidance and assistance in developing a strong educational network in gerontology for this country.

It has only been in recent years that Federal funds have been appropriated for training programs in gerontology. Beginning in 1936, these programs were supported under what was then title V of the Older Americans Act of 1965. At that time there was one authorization of appropriations for title IV—research and development—and title V—training—and the levels in those early years were rather insubstantial. However, after the 1971 White House Conference on Aging, increased public interest in the problems of the elderly and a commitment by the Congress as well as the administration, to expand aging programs, led to an increase in funds for title V. Regional offices of the Department of Health, Education, and Welfare—recog-

nizing the need for additional manpower to administer expanding programs for the elderly—began to encourage colleges and universities to develop, with the assistance of Federal dollars, specialized programs in gerontology to train individuals to carry out research, and to operate programs for and provide services to our older population. As a result, a number of universities, including my own, made commitments, typically based upon 5-year contracts with HEW, to establish centers for the study of gerontology.

As the National Council on the Aging recommended to the 1971 White House Conference on Aging:

> The need for personnel especially trained for serving the older person and for teaching and research is of a magnitude to require increased Federal and State governmental support, as well as support from other sources. Such support is required for all levels of training—from the paraprofessional working at a neighborhood level to those working at the doctoral level; for inservice training programs as well as those of a more academic nature.

Unfortunately, within a year or two after adopting a policy of encouraging expansion of such training programs, the administration, contrary to the recommendations which followed the White House Conference on Aging, suddenly reversed itself and decided to phase out Federal assistance for such programs. We believe this decision was not only unwise and not in the public interest, but was also contrary to the Government's own contractual obligations. At a time when public faith and trust in "big government" is probably at a low point, we simply cannot afford any more examples of an administration saying one thing and doing another.

As I just stated, the initial response of the administration following the White House Conference on Aging was to expand the Federal programs of assistance to States for the development of comprehensive programs for the elderly, and to increase funds for training individuals to plan, develop, and administer these programs. However, this policy was short lived. It was only after considerable pressure was brought to bear on HEW, that the administration decided to continue support in 1973, but at 50 percent of the 1972 level. Since 1973, this pattern has continued on the part of the administration, resulting in much annual chaos both for gerontology programs in higher education, as well as for the States in their efforts to plan for inservice training and career development programs for present professionals.

As has been stated during congressional hearings in the past, the need for trained professionals and paraprofessionals for the field of aging, as well as the need for training for research have increased dramatically in the last 10 years. At the beginning of this decade, the administration itself projected a need for trained personnel for the field of aging to double if not triple during the 1970's. Thus, the continuing lack of support for training is lamentable indeed.

We are just beginning to develop a body of knowledge and experience in aging. In this brief 10-year period, there is only the beginning of a critical mass of researchers, educators, and applied professionals for this field. This critical mass has emerged largely as a result of outstanding training, education, and research programs of the major universities of this Nation. This development would not have been possible without Federal support. Now it becomes much wasted history as this capability is beginning to be established and to emerge

in a wide variety of educational institutions around the country—including junior and community colleges where a significant portion of older adults return for career retraining.

In this era of educational retrenchment there is no clear constituency at this point for gerontology related programs to continue successfully on their own within many institutions of higher education. We believe that the gradual dissipation and withdrawal of support for degree-granting programs would result in much wasted history as well as providing many negative and disastrous consequences for the future of gerontological education, and ultimately upon services and the lives of older people themselves. Not only would career and degree granting programs be threatened, but short-term training would be severely impaired in quality and effectiveness. It has been amply demonstrated that the best inservice training has emerged where there is history of a continuing commitment, and other available educational resources in gerontology. As we stated before:

> We need to strengthen the capacity of universities and colleges throughout this country to provide trained manpower for human services and to help to prepare men and women for future leadership in this field. We accept the obligation to help to upgrade the skills of those now administering and providing services to the elderly by offering short-term, noncredit training.

We believe that you are beginning to see the results of our educational programs within the past 10 years. Some of the staff members for these congressional committees have been graduates of our programs. There are some very successful and capable directors of State units on aging in this country—including some of the States represented by this congressional committee—who are graduates of our programs. Moreover, on the front lines, our students are filling important needs in the local areawide agencies on aging as well as by providing direct services in the area of homemaker assistance, health care, and nutritional programs in many communities within this country.

Once again, we thank you for inviting us here today. The purpose of the following testimonies is to specifically elucidate some of the research and education needs we see in this field. Thank you.

Mr. MATSUNAGA. Thank you for taking time out of your busy day to be with us today and congratulations upon your election to the presidency of the Association for Gerontology in Higher Education.

Our next witness is director of the Center on Aging at the University of Maryland, Mrs. Jody Olsen. We would be happy to hear from you, Mrs. Olsen.

STATEMENT OF JODY OLSEN, DIRECTOR, CENTER ON AGING, UNIVERSITY OF MARYLAND

Mrs. OLSEN. The Association for Gerontology in Higher Education is interested in a wide variety of gerontological aspects of higher education including education for older adults and how to structure graduate and undergraduate gerontological curricula, and problems of administering and funding training in gerontology in higher education. It is on the issue of funding training programs that I would like to focus.

Unfortunately, testimony concerning training needs in the field of gerontology changes little from year to year, because, despite the

efforts of gerontologists and educators nationwide, there is little change in the problem. It remains simply that of a lack of adequate and stable funding for training programs in aging.

It was pointed out at the 1971 White House Conference that, in order to meet the demands of present and future aging populations, there needed to be a major increase in training in the 1970's. Some basic statistics on the growing aging population bear this out. The number of elderly in the United States has risen from 3.1 million or 4.1 percent of the population to 20.2 million or 9.9 percent of the population. By the year 2020, it is expected to increase to 40.3 million or 13.1 percent of the population. Coupled with this, the life expectancy has increased by 23.6 years from 47.3 years in 1900 to 70.0 years in 1970.

What does this mean in terms of trained personpower? There is and will continue to be an increase in planning, developing, and providing programs and services for the elderly, all of which need well trained and sensitive staff both at the professional and paraprofessional level. Let me state a few examples.

The title VII Nutrition program—Older Americans Act—has generated positions for an estimated 85,000 people, almost all of whom come into direct contact with elderly and/or need some specialized knowledge about the elderly in order to function successfully. The program and thus the staff needs will certainly grow in the next few years. The title III program—Older Americans Act—with its variety of planning and direct service positions at all levels of employment offers almost the same number of aging related positions. The nursing home industry now employs approximately 583,000 people, of whom 60 percent plan for or have direct contact with the older people they serve. It is projected that by 1980 the figure will rise to 873,000 workers, of whom 576,000 will have direct patient contact, a rapidly increasing labor force needing specialized training in gerontology. There are many other areas for which personnel figures could be extrapolated such as recreation, community health and mental health, geriatric day care, and income maintenance. The only known study of personnel needs in the field, done in 1968 before many of the programs we have today were developed, estimated that there would be over 1 million people in the field of aging by 1975.

These figures become important when we recognize that working with and planning programs for older people does require specialized skills. Without specialized education, the prejudices, personal feelings, and stereotyped misconceptions interfere with job performance. We acknowledge this with children's and young adults' programs, but are reluctant to afford the same acknowledgment for older people.

It is evident that there is a growing number of needed services and programs exclusively for the elderly all of which require adequately prepared personnel. In addition, some general service programs are experiencing a change in population focus from young to old. This is particularly true in many health care professions. Service providers, trained in general service practice, find themselves increasingly confronted with the speciality of aging and yet lack the training necessary to properly handle this age group. Referring to health care, Dr. Butler points out that "there is little to indicate that older people are receiving quality in-patient care from health practitioners, whether doctors,

nurses, or aides. Few are well trained in the broad principles and special knowledge of chronic disease and geriatric health care." Many of these people want to come back to school to develop new skills in gerontology so as to better perform in their service specialities. As one masters student said, "If I had only known earlier what I know now about aging! I want to go back and apologize to all those people I have hurt."

In addition to those who prepare to work in aging programs and those who work in general service programs with a high proportion of elderly, there are those people who, as part of career training programs not necessarily in aging, want to take courses in the field of gerontology. They are anxious to upgrade their own personal knowledge in the area. It is said that two generations ago, a couple could plan on dealing with the ramifications of one of their parents growing into old age. Now, that same couple needs to consider the ramifications of three or four parents reaching old age. Some young people recognize this change and want academic experience to better enable them to cope with the increased number of older people with whom they come into contact. These students taking aging courses might never be counted as working in the field of aging, but hopefully their increased sensitivity to aging programs help them function better in a variety of settings. In addition, they can help set a climate conducive to the proper support of older people in society. Many times, when looking at whether or not training funds have been properly expended, those investigating only look at the number of trainees who take jobs in the field of aging. Although difficult, if not impossible to measure, it should be noted that the training has also influenced and positively changed those who take jobs in which only part of their work is with older people, and those who have little professional involvement but extensive personal contact with older people. Measurement of successful training of those who only work indirectly with older people can be seen through long term attitudinal change; this is important when looking at the dehumanized treatment so many of our elderly are now receiving. Money spent in training that leads to this change should not be considered money wasted.

As we are all aware, considering that there was almost no money for training before 1965, the last 11 years has brought considerable expansion in training programs. The major impetus for this expansion has been section A, title IV of the Older Americans Act of 1965. Money made available under title IVA has not only enabled students to get the necessary training, but has allowed development of visible gerontology programs that campuses have been able to see and in some cases embrace. In the past 10 years, the traineeship program providing opportunities for both short courses and degree programs has involved 50 career training programs across the country. The money for these programs supports students and expands faculty and staff in gerontologically related areas. Considering the complete lack of training available before 1966, the results have been excellent. By 1975 about 2,750 have been involved in degree programs. In addition, by having the programs available on campuses many students not receiving stipends have been able to enroll in the programs. The administration estimates that today approximately 4,000 students are enrolled in

courses directly or indirectly funded by money made available under title IVA.

Unfortunately, funding under title IVA has run into two problems: a reluctance by the administration to recommend funding for the section and the fiscal difficulties in higher education. I would like to discuss the latter problem first.

As is well known, colleges and universities are in a tenuous fiscal condition. Costs have far outstripped the ability to generate revenue, even in those colleges where enrollment has been relatively stable. Many State colleges and universities have become the victims of State legislatures, despite a recent enrollment upsurge, because of a shrinking tax base and the rising costs of running a government.

Tight budgets do not allow schools necessary revenue for development of new academic programs, particularly for those first 2 to 5 years, when enrollment is being generated—when the program has not yet proven itself. Sometimes programs in gerontology fall victim to extinction before even beginning because they are new and relatively untried. Campus administrators cannot afford to take the risk. Because of severe internal budget constraints, an institution of higher education (1) looks for a 3 to 5 year record of program achievement before committing hard money to the program and (2) looks for assurance that other sources of money will be available at least during the development time and possibly afterward so that the program will not collapse.

The Federal administration, for the 4th year in a row, has recommended no funding for title IVA, and it has been only through the strong efforts of Congress that a minimal amount of money has been allocated each year. A discontinuance of funding under this section can only spell disaster for gerontology in higher education. Even continuing the funding at the present level with its characteristic "on again off again," "don't count on it" allocations provides for planning chaos almost equal to no program at all. As was discussed, despite strong efforts by dedicated people to develop gerontology programs in schools, it can only come about through the promise of Federal money, money that (1) can be assured early in the spring before the academic year begins so that appropriate recruitment can take place and (2) can be counted on for a defined period of time to allow the institution to make the necessary money adjustments, a long and difficult process. Year by year and "maybe not this year" funding only encourages an institution to drop a developing gerontology program.

The administration has said that a growth in programs for the elderly is essential and has demonstrated it by increasing moneys for such programs. If the administration cannot make a similar commitment to train the people who work in these programs, it is dooming its own programs to failure.

In closing, we would like to make four recommendations concerning training moneys for higher education:

1. Money available under title IVA should be expanded 20 percent a year over the next 5 years. The money made available this year should be $15 million.

2. The discretion of the Administration in deciding the proportion between short-term and long-term training should be limited.

We would hope that a fixed percentage of title IVA funds be allowed to be allocated to short-term training, with the majority going to long-term training.

3. Title IV, section C of the Older Americans Act which authorizes the establishment of Multi-Disciplinary Gerontology Centers should be retained. Although the Administration has consistently refused to recommend funding of these, there is little doubt that if they were funded, the development of the field of training would be encouraged immeasurable.

4. Professional gerontologists, gerontology educators, and appropriate administration personnel should begin the work of outlining standards by which to measure programs in gerontology and setting minimum criteria for programs at the various levels of higher education.

Mr. MATSUNAGA. Thank you very much, Mrs. Olsen. For the benefit of the members of the AGHE, I will state that had it not been for the aggressive effort on the part of Mrs. Olsen, these hearings probably could not have been held in coordination with your conference here in Washington. I think Mrs. Olsen deserves a lot of credit. I am certainly happy to know that she is on our side.

Our final witness is the Director of the Faye-McBeath Institute of Aging and Adult Life of the University of Wisconsin, Dr. Martin Loeb.

STATEMENT OF MARTIN LOEB, DIRECTOR, FAYE-McBEATH INSTITUTE OF AGING AND ADULT LIFE, UNIVERSITY OF WISCONSIN

Mr. MATSUNAGA. Do you have a written statement?

Mr. LOEB. I will have. I do not have one now, because my task is to summarize what went on here.

Mr. MATSUNAGA. Without objection, you are given permission to revise and extend your statement.[1]

Mr. LOEB. Thank you very much.

Mr. MATSUNAGA. You may proceed.

Mr. LOEB. What we have talked about here this afternoon is the specific kinds of programs that have been supported, but not adequately, in the field of aging. One major point that I want to make has to do with the appropriation for titles IV–A, B and C.

We have seen a great increase in the number of aged persons in the country. We have seen an equally great increase in the number of people who are concerned and who want to make a career of working with the aged. One of the major reasons for this is that over the last several years we have been doing research that produces know-how to help old people.

When I entered this field a long time ago, we really didn't know very much. We had a good heart. We were willing to try, but we didn't know much and now we can teach things we learn because there is research.

There is research of two kinds. We have done the basic research, the great things that have been done in social and behavioral sciences,

[1] No additional material has been received.

the clinical areas and biological areas about how to help people. The professional people in doing research are doing their jobs better. You can see in the Federal Government those who are concerned with basic research, the scientists who are dealing with it in a more professional manner—it is a kind of filtered-down basic research.

As to the training programs, we obtain what we know and pass it on to the students who are going to make a career of working with the aged.

So what we see is the need for some support from the various places in the Federal Government that can help. We rely on the Federal Government for all sorts of things, but don't underestimate the fact that there is a lot of other funding being used to train people and to do research in the field of aging.

What I see the Federal Government doing is providing some continuity and seed money and getting people to see that this is a great problem area and one that has great needs. I don't think that we ought to be dependent on the Federal Government. I am not sure that I would go all the way with president Ratchford about matching funds, but I would personally go a long way in that direction.

The problem of aging is everybody's problem and it is not just a Federal Government problem. But what the Federal Government can do is to provide continuity and seed money, which it has done. I wish to pay attention to the fact that we have had a very successful program in the Administration on Aging. Unfortunately, since they have had cutbacks, we can barely keep up.

We have managed to convince Congress that these multidisciplinary centers are important, but we have never been able to convince anybody to appropriate any money. Actually, we can establish multidisciplinary centers in universities. I have 100 scientists from 50 different departments working on problems of aging at my university. We did this with a very modest amount of money and it can be done.

I think the models of how we can do that are what the bureaucracy has to deal with. It is in the multidisciplinary area that we know that we can do something, not only in research, but in training so that the people and the profession can now work with one another to help the aging population.

I am afraid I will have to stop now. Thank you very much.

Mr. MATSUNAGA. Thank you very much, Dr. Loeb. I certainly appreciate your remaining this long to present us with your summary statement.

Just one observation here: As you probably know, in 1975 under title IV-A of the Older Americans Act, the training program, we had $8 million appropriated. The Administration now is proposing a zero amount. This committee, as you know, will appear before the Subcommittee on Appropriations chaired by Congressman Flood and will request $10 million.

For title IV-B, research, while in 1975 there was an appropriation of $7 million, the Administration is recommending only $5.8 million and the Select Committee on Aging is recommending $8 million.

For title IV-C, multidisciplinary gerontological centers, the Administration is recommending zero amount. We are recommending $1 million for the next fiscal year. So as you have all noted, there is definitely a tendency toward paying more attention to the problems

of the elderly. The creation of this select committee in just this 94th Congress is an indication of that.

I wish to assure those members of the AGHE who are present here today that it has been my personal observation, in my 14 years here, that more and more Members of Congress are becoming cognizant of and sympathetic to the problems of the elderly. I think we can look to a much better future. Thank you again for your presence here today. The committee stands adjourned.

[Whereupon, at 12:15 p.m., Thursday, March 4, 1976, the committee was adjourned.]

APPENDIX

Material Submitted for the Record by Dr. Greulich

FEDERAL AGENCIES AND MAJOR COMPONENTS

SUPPORTING RESEARCH ON AGING WITH FISCAL YEAR 1975 FUNDS

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (DHEW)

- Assistant Secretary for Health (ASH) - Public Health Service (PHS)
    - National Institutes of Health (NIH)
        - National Cancer Institute (NCI)
        - National Eye Institute (NEI)
        - National Heart and Lung Institute (NHLI)
        - National Institute on Aging (NIA)
            - Adult Development and Aging Branch (ADAB)
            - Gerontology Research Center (GRC)
        - National Institute of Allergy and Infectious Diseases (NIAID)
        - National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD)
        - National Institute of Child Health and Human Development (NICHD)
        - National Institute of Dental Research (NIDR)
        - National Institute of General Medical Sciences (NIGMS)
        - National Institute of Neurological and Communicative Disorders and Stroke (NINCDS)
    - Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)
        - National Institute of Mental Health (NIMH)
            - Division of Extramural Research Programs
            - Division of Mental Health Service Programs
            - Division of Special Mental Health Programs Center on Aging
            - Division of Manpower and Training
    - Food and Drug Administration (FDA)
        - Office of Science
            - Extramural Research Staff
    - Health Resources Administration (HRA)
        - National Center for Health Statistics (NCHS)
        - National Center for Health Services Research (NCHSR)
    - Health Services Administration (HSA)
        - Bureau of Medical Services (BMS)
- Assistant Secretary for Education (ASE)
    - Fund for the Improvement of Post-Secondary Education
    - National Institute for Education (NIE)

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (cont.)

Assistant Secretary for Human Development (ASHD)
- Administration on Aging (AoA)
  - Office of Research, Demonstration and Manpower Resources
  - Office of Program, Planning and Evaluation

Assistant Secretary for Planning and Evalation (ASPE)
- Office of Health (H)
- Office of Program Systems (PS)
- Office of Social Services and Human Development (SS-HD)

Social Rehabilitation Service (SRS)
- Office of Planning, Research and Evaluation

Social Security Administration (SSA)
- Office of Research and Statistics (ORS)
  - Division of Economic Long Range Studies
  - Division of Retirement and Survivor Studies
  - Division of Health Insurance Studies
  - Division of Disability Studies
  - Division of Supplemental Security Studies
  - Division of Old Age Survivors and Disability Insurance Statistics

DEPARTMENT OF LABOR (DOL)

Assistant Secretary for Policy, Evaluation and Research

DEPARTMENT OF TRANSPORTATION (DOT)

Assistant Secretary for Policy, Plans and International Affairs
Assistant Secretary for Systems Development and Technology
Federal Aviation Administration
Urban Mass Transit Administration

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)

Office of Policy Development and Research

NATIONAL SCIENCE FOUNDATION (NSF)

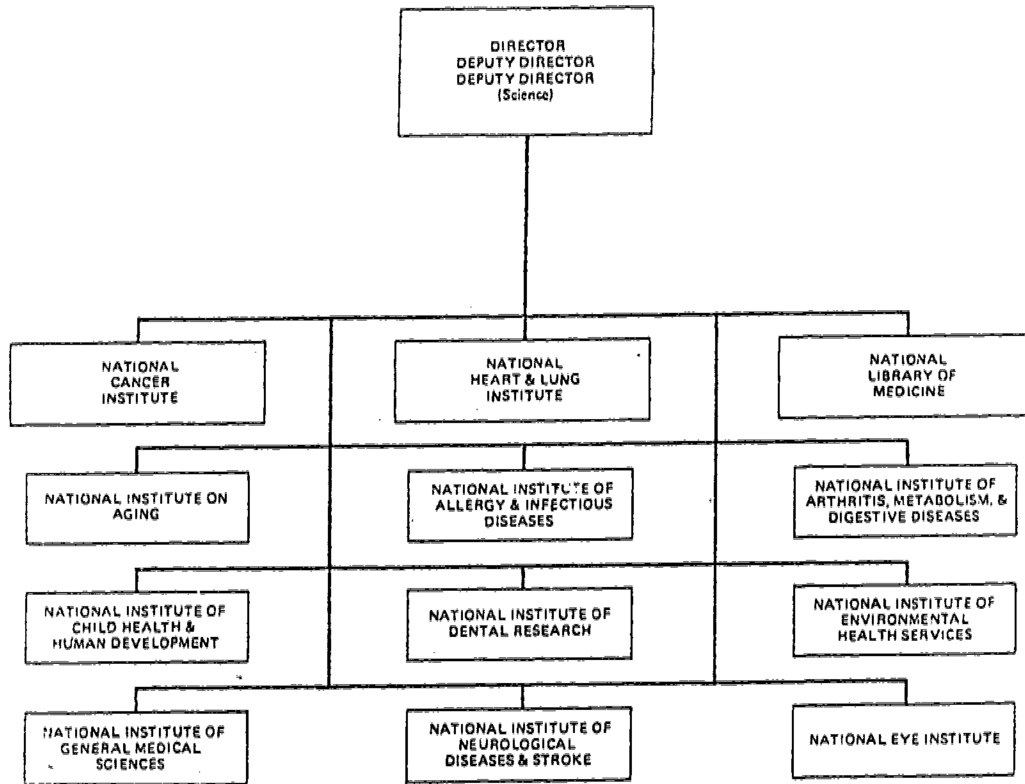
VETERANS ADMINISTRATION (VA)

Assistant Chief Medical Director for Extended Care
Geriatric Research, Education and Clinical Centers (GRECC's)

ENERGY RESEARCH AND DEVELOPMENT ADMINISTRATION (ERDA)

Division of Biomedical and Environmental Research

NATIONAL INSTITUTES OF HEALTH



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ORGANIZATION CHART