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ABSTRACT

Responses from 27 State offices on aging revealed 8 recurring problems of rural and small-town elderly: a need for a uniform legislative definition of rural; the need for a complete rural strategy to reverse discrimination against rural and small-city elderly; a need to streamline Federal regulations; the need for changes in the Older Americans Act; and the need to address specific concerns with regard to transportation, nutrition, health, and housing. Many policies and programs affecting the elderly seem to be designed for urban areas and then applied to rural areas almost as an afterthought. A population density factor and a factor of distance from larger population centers must be included in a rural definition. Because the Federal Government has no rural strategy, the rural elderly do not receive their just share of the support and assistance available. Transportation and the quality of available health care continue to be major problems of rural senior citizens. Federal housing programs do not adequately address needs of the rural elderly. Many States indicated that there is no clearer illustration of rural-urban inequities than across-the-board regulations for the nutrition services program. The Older Americans Act lacks adequate funding levels for rural planning and implementation. (BRR)

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(II)

PREFACE

This report, prepared at my request by Senator Larry Pressler, examines the special problems facing our Nation's rural and small-city elderly citizens.

I recently joined Senator Pressler in forwarding this report to the Administration on Aging. A task force of their personnel will review the report to implement the recommended changes in programs and policies.

My special appreciation goes to Senator Pressler and his legislative assistant, Diane Swenson, for preparing this report. It illustrates only too clearly that we must act swiftly to design a comprehensive national policy to meet the needs of older Americans living in rural areas.

JOHN HEINZ, *Chairman.*

CONTENTS

RURAL AND SMALL-CITY ELDERLY

As a member of the Senate Special Committee on Aging, I have been asked to prepare this report for the Congress on the problems of the rural and small-city elderly. This subject is extremely important to me because of the rural nature of my home State of South Dakota. In the course of the hearings and discussions I have held on this issue, I have become aware that many policies and programs affecting the elderly seem to be designed for urban areas and then applied to rural areas almost as an afterthought. This is a serious problem which begs correction.

In order to prepare this report, which I hope my colleagues will use in addressing legislation affecting the elderly, I contacted each of the 50 State offices on aging. Twenty-seven State offices which are part of our national network on aging responded to my request for comments on the problems faced by the rural aged. My letter solicited an evaluation of the appropriateness of Federal programs and suggestions on how Congress might overcome the roadblocks which exist.

The replies I received from the various directors addressed eight key areas. The reoccurring topics included a need for a uniform legislative definition of rural; the need for a complete rural strategy to reverse discrimination against rural and small-city elderly; an effort to streamline Federal regulations; changes in the Older Americans Act; and specific concerns with regard to transportation, nutrition, health, and housing needs.

Toward a Definition of "Rural"

A comprehensive national policy which addresses the problems faced by the rural elderly must develop a realistic definition of "rural" which relates to the low population density of these large geographic areas. It is clear that action in this area could greatly improve the effect of our legislative initiatives.

Several State offices suggested that the Federal Government place people in the executive departments who are sensitive to rural issues and who are willing to work with Congress in reviewing all legislation and regulatory language which discriminates against the rural areas by creating needless and expensive barriers to the delivery of effective services.

Florida's State director drew attention to the Senate Special Committee on Aging's report to the Senate, Senate Report 95-88, which stated:

> What is rural America? Ask Federal agencies and the answer will vary. For example, according to ACTION, the Administration on Aging, and the Urban Mass Transportation Administration, "rural is any community with 2,500 per-

> sons or less." Ask the Rural Highway Public Transportation Administration, and you will learn that rural is a population of 5,000 or less. The Farmers Home Administration and the Legal Services Corporation define rural as communities with 20,000 or fewer residents. The Department of Housing and Urban Development classifies rural as any area outside of the SMSA (standard metropolitan statistical area). The Social and Rehabilitation Service and several agencies under the U.S. Department of Agriculture define rural as areas with 50,000 residents or less.

Thus, according to our committee statement, a population ranging from 1 to 50,000 could constitute a rural area. It is clear the problem is not a new one, but a Federal initiative is essential if any progress is to be made in addressing the differences between rural and urban. Moreover, the vast differences among the rural areas themselves must be considered. A study of the distinctions between open space and small-city rural, many suggest, will indicate that some rural communities are far more similar to urban areas than they are to other rural areas. We also need a comparison of lifelong rural residents and urbanized persons returning to a rural environment. There may be serious differences in perception of various social, mental, and physical needs.

Rural areas are characterized by open spaces, but the rural aged often pay a high price for this in isolation, confinement, and more expensive travel.

Those of us advocating changes in the definition of rural and in the provisions of services, in the words of Florida's aging office:

> Must be careful not to create a schism between urban and rural. We do not want to cause confrontation or competition with the urban way of life, but we do want a recognition of the differences which exist and which require innovative study and planning.

Pennsylvania suggested another look be taken at the 1982 publication by the National Council on Aging, entitled "Legislation and Regulations that Discriminate Against Rural Elders." The Pennsylvania Office on Aging is not as ready as some to accept the generalizations about rural/urban differences. This State office feels the needs in some rural areas are far more effectively met than the needs of some urban areas. The answer seems to be that there is much less of a problem where increased flexibility and authority have been granted to the States. Many suggest the programs funded under title III of the Older Americans Act, such as nutrition services, afford some of the best possible areas for State and local adaptation. The reauthorization of the OAA passed by the Senate in May increased the transfer flexibility provided to the States under title III.

However, the basic concerns of definition and approach remain. We need to distinguish between rural and urban in a way which clearly provides for the vast differences among rural areas. A population density factor and a factor of distance from larger population centers must be included. Definitions have long been a problem. Just where an urban area ends and a rural sector begins is often a matter of arbitrary decision. California's Division on Aging suggests that while

the so-called "attitude gap" between rural and urban areas is shrinking, there is no escaping the larger per capita costs involved in supporting rural services.

In summary as Vermont suggests before any inequities can be addressed, a uniform definition must be established. Several studies have documented higher costs of service to rural elders. The Administration on Aging's analysis of title III service expenditures in [redacted] that per recipient costs for fiscal year 1979 were about 9 percent in rural areas. The study concluded with the statement:

> All too often, rural areas have been forced to "take care of their own" while urban areas have the benefit of Government-sponsored and private programs to help the elderly.

A Strategy To Reverse Discrimination

Members of the U.S. Congress must also look at a complete strategy to reverse current discrimination problems. It appears the rural elderly are not receiving their just share of the support and assistance available. They are the victims of a form of discrimination. Because of our concern for the health and well-being of our rural elderly, the Older Americans Act, as amended in 1978, required an emphasis on rural allocations. This was done to ensure services to older individuals residing in rural areas.

In this and subsequent Federal regulations, errors were made. By emphasizing the allocation of special funds rather than by seeking a rural policy, we cannot be sure that the intended extra 5-percent allocation to "rural areas" is sufficient to compensate for rural service delivery problems.

Without a clear policy on rural service delivery, each area agency will decide whether to allocate funds to rural populations. Some services, such as congregate meals, are not well suited for unique rural settings. Service providers may reach farther and farther into extremely rural areas, but in doing so, the cost inefficiencies may rise and the action may be harmful to a rural strategy. At some point, even the most aggressive rural strategy reaches its limits of common sense. To what degree local planning agencies and service providers feel they are justified in reaching out to the isolated elderly, is strictly a local decision. Some will choose to accept lesser efficiencies in order to serve more rural elderly; others will look at this differently. California does not allocate additional moneys to rural areas—either as 105 percent of the 1978 funding level or as a weighted factor in intrastate funding formula. As noted in their letter, at the level below county designation, there is no existing method to help them define "rural areas." With a majority of its counties comprised of both urban and rural populations as defined by the Census Bureau's urban classification, this process is very difficult. Many other States also await a congressional definition of "rural."

After reading the comments from the 27 States replying, it is clear that the Federal Government must establish a rural strategy which includes a strong Federal initiative to reverse the pattern of political rivalries of local, State, and Federal governments. We must also accept the challenge of being the mediator and work hard to establish high urban and rural cooperation. This assignment may seem more

difficult in a time when our Government is moving toward increased State and local authority and improved flexibility in the use of funds.

It is time for Congress to exercise strong leadership and recognize the rural-urban interdependency without compromising current directions of increased State and local authority. The increased flexibility which States and local governments recently were granted was praised by 10 States who answered the survey. The flexibility allowed in the use of Federal grants could make rural elderly programs far more sensible. Special provisions for rural funding set-asides in such critical areas as medical care, public transportation, and housing should be considered. Many States indicated in their responses that they recognize that it is important for those involved in governmental programs to work with the church and social organizations already in the community. As many of these groups appear very ready to help, specialized training by the area agencies would be an invaluable asset. The strategy must be to support and to cooperate with existing institutions.

As Milt Erickson, the director of one of South Dakota's largest senior citizen centers put it, the core of assistance is one's family and friends, rings of assistance beyond that include fellow members of church and community organizations, members of the community in general, and finally, governmental agencies. It is by educating these core individuals that we will be best able to assist other parts of the network in supporting the senior citizen. The Government programs should and must be there then. However, we should not let our Government programs run the risk of destroying the excellent assistance provided by family, friends, and neighbors.

Unfortunately, many feel that very specialized training is needed to work with the rural aged. This is not true. All that is needed is a spirit of caring. The most important thing to remember is that the Federal programs must be made compatible with—and not work against—the lifestyle of the rural senior citizen.

Health Care: The Top Priority

Efforts to improve the quality of health care available to the rural elderly are considered a top priority in all of the States responding to my inquiry. Georgia's State office suggested that more mobile health service units, minimedical clinics, visiting nurses, and emergency transportation services would be helpful in increasing access to health care. Nurse practitioners and physicians' assistants were cited as a great means of delivering timely care to rural patients by Pennsylvania, Oklahoma, and Utah State directors. It is reported that 900 counties in the United States, most of which are rural, currently experience a doctor shortage. This results in a narrower range of medical services. Over 56 percent of the 49 million citizens who live in medically underserved areas live in rural America. Here again, if we are to make changes, we must begin by drafting legislation with a Federal definition of the health care needs of the rural elderly.

The current economy and the press for cost-containment in health care must not be allowed to jeopardize the small, 20- to 30-bed hospitals found in rural States like South Dakota.

We must take steps now to assure the best possible access to quality care. As Iowa's State director pointed out, rural areas have only 12 percent of the Nation's doctors, 14 percent of its pharmacies, and 18 percent of its nurses, yet they contain 30 percent of its total population. We must act now to increase availability of preventive services such as health screening clinics, preventive innoculations, nutrition counseling and wellnesss education. Other alternatives—such as adult day care, hospice and respite care, homemaker services, and meal deliveries which help our elderly remain in their homes—must be made available in our small cities and rural communities.

Much of this work has begun. My home State of South Dakota has many fine examples of this program. In Aberdeen, SD, there are 1,400 members in the senior center and over 100 meals are shared each day. This continuum of health care, which is available in some of our small cities, has much improved the independent living situation. Often, in the rural areas of South Dakota, the home health care burden falls upon the families. Adult day care services, which are now available in the city of Sioux Falls, SD, will hopefully become available in many small-city senior centers.

The State of Maine has begun reimbursing families, neighbors, and friends for providing home health care and working with nursing homes to provide particular programs such as specialized diets. Maine also has taken the lead in working with unemployed nurses who are encouraged to take on rural cases.

Maryland's State director on aging believes a long-term care program which addresses the health and social needs of all elderly persons should be of primary concern to all service agencies and Government officials. Several States mentioned their support of tax incentives for home health care. Legislative initiatives in this area are moving forward.

Many responses also mentioned a need for increased emphasis on gerontology at our medical schools. At an Aging Committee field hearing in Sioux Falls, SD, witnesses speaking on Alzheimer's disease—a senile dementia which increasingly strikes the elderly—mentioned the need for more medical courses in gerontology and particularly on this and other forms of dementia. These speakers said they feel many are crying out for training. They want to be prepared to deal with the difficult challenges of assisting the frail elderly who suffer from Alzheimer's disease. The challenge is often overwhelming to nurses, doctors, and all health practitioners. They deserve better preparation and updates on research and treatment.

The State of Nebraska has begun a service management system in each of its rural area agencies. This system provides thorough assessments of frail older people and links them to appropriate services. The system is based on an extension model and uses a nurse in each county, working out of her home, teamed with a social worker from the department of public welfare. A combination of public and private funds is used to support this new project.

Oklahoma suggested that paraprofessionals, nontechnical medical care providers, and adult day care alternatives become increasingly available. Many people face the rigors of growing older in an area with limited financial and human resources. The Federal Government's leadership in providing care alternatives is needed now.

Vermont pointed out that mental health resources are in shorter supply in rural areas:

> Rural people received only 31 percent as many facility staff hours and only 6 percent as many psychiatric hours per 100,000 population as the central city poor people did.

Often, this mental health care can be a key factor in living out happy, productive lives. All of the suggestions in the health care area should have our immediate attention in considering upcoming legislation.

Streamlined Programs and Increased Local Involvement Are Musts

It appears that the streamlining of Federal regulations, program procedures, and paperwork would be, and is, an excellent catalyst for innovative and improved services for our rural elderly. To establish program credibility and to gain program acceptance, we must allow the rural elderly to participate in the planning, development, and administration of programs.

Many of the requirements for Federal grant applications are overwhelming to individuals who lack the know-how to participate to win. Rural senior citizens often do not receive their fair share of Federal grants. Lack of bureaucratic know-how is one of the administrative obstacles. Unfortunately, even if the grant application does not intimidate and a grant is obtainable, many rural areas cannot meet the matching fund requirements. States responding to my survey suggested that lower matching fund requirements should be allowed when it appears that the population cannot possibly meet the matching amount and that without this change, services will not be available.

The problem with funds being administered on a per capita basis, Iowa notes, is the fact that while it is intuitively fair to allot funds on the basis of "one head equals one dollar," it is not fair to do so when there are certain minimum fixed expenses involved. These fixed expenses must be faced by any organization, but in rural areas, these organizations are forced to either shift funds from services or attempt to perform inadequately.

A more equitable method might include the distribution of an equal base amount for fixed costs plus a per capita distribution. Utah agreed that population cannot be the lone criterion. Maryland suggested that a formula like this is especially important for volunteer programs such as ACTION's Senior Companion, RSVP, and Foster Grandparents. The tremendously successful subsidized employment programs like Green Thumb also should be administered this way. It is counterproductive if the caps on mileage reimbursement for provision of volunteer services are so limiting that services once delivered are terminated. This results in hard feelings and makes it difficult for Government programs to regain credibility. Priorities, objectives, and funding formulas should reflect the differences between rural and urban America if they are to be responsive to the needs of older Americans.

Many suggested that more local options be allowed in the development of policy, rules, and regulations. Oklahoma suggests a reduction in reporting requirements to the bare essentials of documentation needed to monitor programs should be sufficient. Technical assistance should also be made available on how to retain and develop the community's resources.

In Vermont's response, positive efforts made in the rural components or set-asides in Federal laws were classified into five categories:

(1) Those programs that require a certain percentage of the program funds to be used in rural areas. Earmarking of funds—HUD urban development action grants, community development block grants, housing funds, and HEW emergency medical systems and health maintenance organization.

(2) Those programs that permit variation in matching requirement. Newer ideas take into consideration the limited capacity of smaller communities to raise as much as larger ones. The following require that rural areas put up a small portion of the total cost of the program: HEW hospital construction, community mental health centers, developmentally disabled, and HUD interim assistance to blighted areas.

(3) Those programs that have directed research and development activities to take place in rural areas or to focus on rural problems: HEW Research-Elderly-Rural and Isolated, DOL CETA Rural Area Demonstration, EPA Sewage Treatment, and CSA Pilot Projects Rural Poverty.

(4) Those programs where rural characteristics or conditions qualify for special consideration.

(5) Those programs that specify the money be distributed equitably between urban and rural areas or that give special consideration to rural areas.

The Federal Government has taken steps to correct inequities. The use of earmarked funds, variations in matching fund requirements, and special consideration for rural characteristics and equitable distribution are steps in the right direction. The problems remain in programs which require excessive paperwork or whose regulations result in formal services which the rural elderly do not support. Local funding for rural programs is often further stymied by the decline of the small family farm and the outmigration of the young. The historical underfunding of rural welfare departments means fewer services are in place and less money is currently available. A plan to undo past discrimination is needed.

A Commonsense Approach to Policies/Programs

Wyoming expressed a concern that the Federal Government fails to use common sense in developing policies and programs. Fortunately, many of these mistakes have no impact on the elderly directly, but they assuredly have an impact on the administrative cost and workload. One example included a Federal mandate to designate community focal points. This assignment did not require specialized training or the development of key evaluation criteria—at least not in rural Wyoming.

Wyoming notes that it doesn't make sense to force States to spend money on services that are already available through other resources. Many States expressed their appreciation for the increased flexibility granted in the OAA.

Wyoming's comments summarized the regulation changes needed. They included:

—A call for the relaxation of standards of compliance under the Davis-Bacon Act and section 504 of the Rehabilitation Act. It was suggested that these standards result in needless increases in costs of senior center construction and renovation projects in rural areas.

—An effort to resolve conflicts between title III of the OAA, section 18 of the Urban Mass Transportation Act, and titles XVIII and XIX of the Social Security Act in order to assure the coordination of services and encourage cost-effective use of limited funds.

—Support for the adoption of one universal definition of low income, which will eliminate the duplicative certification of clients.

—Support for the relaxation of section 504 of the Rehabilitation Act so rural nutrition sites may be "reasonably barrier-free" when full compliance would result in the termination of nutrition services in rural communities with limited facilities.

—The elimination of restrictive language concerning the collection and utilization of project income to allow maximum local discretion in using limited funds to address documented local needs.

—The support of a relaxation of Federal technical requirements and planning constraints which prohibit rural agencies with skeletal administrative staffs from competing for model and demonstration project funds.

—The establishment of a single certification point for applicants seeking Federal funds.

Transportation: The Key To Service Delivery

Transportation continues to be one of the major problems for rural senior citizens to overcome. Some leaders have suggested the need for Federal and State legislation requiring coordination of all transit services, including, for example, our Nation's school buses. They suggested that this effort would be assisted by the colocation of all human services in the community in order to complement coordinated transit services.

When the National Center on Rural Aging estimates that 7 to 9 million rural elderly lack adequate transportation, the time for Congress to act is now. It is clear that rural and small-city elderly are severely limited in their ability to reach needed services.

One hundred percent of the urban area agencies on aging provide transportation when only 39 percent of the rural associations do so. Several State agencies pointed out that ridership is too low for them to continue their programs. More funds must be targeted to correct this situation. The problem is not just one of getting to town but in having mobility while there. This was one of my reasons for opposing bus deregulation. Bus access is severely limited now. As Iowa's letter noted, it is estimated that about one-half of the rural elderly are without a car, and, as a result, often without access to transportation. This indicates limited access to grocery shopping, which leads to poor diets

and poor health. As my recent senior citizen intern, Dakota Hildebrandt, pointed out, "Many senior citizens have trouble meeting doctor appointments."

Both Ohio and Maryland suggested inadequate transportation systems result in an underutilization of senior centers and a lack of participation in congregate meal programs. Increased funding for the purchase of vans is essential. South Carolina suggested that transportation costs be built in when establishing any Federal program for the elderly. The program is useless if no one has access to it. In the words of Tennessee's State director:

> The problem with service delivery to the rural elderly is essentially a problem of accessibility, not program design.

Nineteen of the twenty-seven States responding named transportation as a problem.

Nebraska is one of the States taking steps to correct these inequities—a fleet of over 100 specially equipped handibuses crosses the State. There is also an active Nebraska Rural Transit Providers Association. Congress must consider transportation alternatives. I have found transportation to be a consistent problem since I arrived in Congress in 1975 and started holding my senior citizen seminars.

Housing: The Greatest Financial Burden

Adequate housing is a necessity that must not be taken for granted. Housing represents the No. 1 financial expenditure for the elderly. There was some discussion of home equity conversion in the State responses. The concern appears to be that rural States will have trouble developing home equity conversion statutes because of lower housing values, the fear that rural individuals have of liens, and the small pool of investors available.

Some suggest it would be preferable to establish a transfer of assets provision for Federal housing programs similar to the one for medicaid. It would then be possible to give States more flexibility in determining eligibility for subsidized housing. Presently, the national standards are so high that only the very poor elderly can qualify, and this is very upsetting to people of rural communities where income levels are very different.

For the elderly, maintenance of adequate housing may be the greatest financial burden they encounter. Even if they have housing, they find themselves paying more than 30 percent of their income for shelter costs. Maintenance and potential safety hazards are the heavy burdens. Over 50 percent of elderly householders live in structures built in 1930 or earlier. Much disrepair and the increased failure to meet the needs of the elderly is due to the large size, the lack of insulation, and the multiple levels of these older homes.

FmHA's section 502 was designed to assist people in rural areas in building new homes and rehabilitating existing houses. But the regulations say the borrower must be without personal financial resources, unable to obtain a loan through private resources, and be living in unsafe and unsanitary conditions. Participants also must demonstrate the ability to pay insurance premiums, taxes and maintenance costs.

The guaranteed loan program is restricted to families with moderate incomes, rather than low incomes. Home repair loans of section 504

are to assist the poor, but they are 60 percent under-utilized. Many State leaders say this program should be expanded. The small number of housing alternatives proves that Federal programs have not kept pace with the need.

Inequities In Nutrition Services

Many indicated there is no clearer illustration of rural urban inequities than across-the-board regulations for the nutrition services program. Rural nutrition site directors have complained for years about the fact that an allowance is not being made for higher costs of food and its delivery. The congregate meal site facilities are limited in rural areas. If available, compliance with accessibility and safety regulations may require costly remodeling. Such action requires a Federal loan or grant. This, in turn, requires local community matching funds from smaller rural communities which have less capacity to generate enough local dollars.

The Older Americans Act establishes a nutrition program of congregate meals and home-delivered meals for the homebound. It should be noted that this program has proved very successful. Florida suggests, however, that we need an inbetween category of "at home or minicongregate meals." This would be done by two or three elderly citizens of small cities or rural areas meeting at a home to share a delivered meal.

A Critique of the Older Americans Act

Most of the States responding to my survey mentioned problems with the Older Americans Act. Alabama suggests this act is the primary source of funds to assist the rural elderly and yet the emphasis on adequate funding levels for rural planning and services agencies is lacking. Many believe rural agencies should be funded at least 50 percent higher than urban planning agencies with the same population because of the high costs of delivery.

Administrative costs of rural planning agencies are also higher. The severe limitations imposed upon administration by the 1978 amendments to the Older Americans Act forced reductions in the area agencies' staffs. Many feel that this has impacted much more adversely upon rural elderly than the urban. Several States indicated that they would like to see the OAA amended to provide expanded counseling for the rural elderly.

Maine also has problems with the Older Americans Act formula—while State and area agencies are required to serve clients in the greatest social or economic need, the formula through which funds are disbursed to States is done on a population basis. It was suggested that the formula needs to be rewritten to recognize the percentage of clients in greatest need in a State and to recognize the differing costs of a rural State. The argument made is that it is unfair for States like Florida, which have many more wealthy retirees, to get significantly more resources under the act simply because of the numbers when the percentage of clients in greatest need in a State and the differing costs of delivering services are not considered.

Maine's recommendation included a formula based on levels of functional impairment of older Americans and a factor which dealt with population density.

Other States suggested that, while the requirement for multipurpose senior centers has been lessened in the Older Americans Act regulations, the original initiative to require multipurpose senior centers did not take into consideration small rural towns. The costs of such centers would be prohibitive. Quantity requirements also were criticized.

ACTION has required two grandparents in each site of the Foster Grandparents Program in a rural area. This requirement, according to some responses, does not make sense when many of the sites are individual homes.

One hundred and five percent of the 1978 funding level is to be allocated to rural planning and service areas--thus the nonrural planning and service areas were reduced. The major flaw from the rural perspective is the major emphasis on coordination and cooperative arrangements with other private agencies. But in rural planning areas like Alabama, there are few industries and social service agencies, and no public transportation, so there is little opportunity for private initiative. How are they to coordinate?

Many reports made the case for 50-percent higher funding by stating that the cost of maintaining the most basic services is at least that high. The primary source of funds for all these services is the Older Americans Act, yet there is a lack of emphasis on adequate funding levels for rural planning.

Conclusion

In conclusion, I feel it is most important to note that the attitude of the rural elderly is one of "we look after our own." We may find an unwillingness on the part of many to participate in Federal programs. These independent, hardworking people do not want to turn to anyone for help. However, these independent citizens are taxpayers who deserve their fair share of Federal programs paid for with their tax dollars. Since coming to Congress in 1975 from the rural State of South Dakota, I have fought to improve my urban colleague's knowledge of rural issues. From cutting needless redtape to fighting bus deregulation, I have fought for the rural citizen's needs.

I am grateful to the many State agencies who responded to my request for comments on the problems facing rural and small-city elderly. The letters I have received have been most helpful. I have attached these letters to the report forwarded to Senator Heinz, chairman of the Senate Aging Committee, with my thanks for his assistance in this effort.

I believe this short summary will give my colleagues some good ideas on the preparation of a uniform definition of rural, and the use of complete legislative strategy for the rural elderly. I also believe the State agencies have highlighted some very good reasons for streamlining Federal regulations, for changing provisions of the Older Americans Act, and for making specific changes in transportation, nutrition, health, and housing programs.

Over 13 percent of South Dakota's population is made up of people 65 years of age or older. With the dangerous outmigration of the young, a greater tax burden will be placed on the elderly of many of these rural communities. We, in Congress, must take our responsibilities seriously and act now to improve the lives of this country's rural elderly.

O