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ABSTRACT

This document contains 22 information briefs from the 1981 White House Conference on Aging. Four of the briefs provide data on health, available services, income, and employment from a report comparing the well-being of older people in three rural and urban locations. National estimates are provided about the need for meals for older people, and about the number of older people at the poverty level. The housing situation of older adults is examined in one brief and is followed by a report on congregate housing. Services and care needs of the elderly and the cost of such services are discussed in nine briefs dealing with: (1) preventive care; (2) the comparative costs of home services and institutionalization; (3) the cost impact of possible changes to Medicaid and Medicare; (4) total national expenditure for nursing home care; (5) provision of services; (6) older adults' consumption of health resources; and (7) home care services for older people. Other briefs discuss the nutritional health status of older people, the need for a national information system on the conditions of older people, disability problems of men, and crime and the elderly. (NRB)

WHITE HOUSE CONFERENCE ON AGING, 1981:
Information Briefs, #1 - 22.

Papers presented at the White House Conference on Aging, Washington, DC, November 30 - December 3, 1981.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #1

SUBJECT: Health of older people in rural and urban locations

Attached is health data on older people in three locations--Ohio, Oregon, and Kentucky. This information is extracted from a United States General Accounting Office report to the United States Senate Special Committee on Aging. Page 3 describes the health status of the older people and page 4 describes the number of illnesses greatly interfering with daily living activities.

SOURCE OF DATA: "Comparison of Well-Being of Older People in Three Rural and Urban Locations", United States General Accounting Office report, HRD-80-41, dated February 8, 1980.

QUESTIONS AND ANSWERS ABOUT PEOPLE

65 YEARS OLD AND OLDER

IN THREE LOCATIONS

DESCRIPTION OF DATA BASES

The data for our comparative analyses come from three studies that included information about people 65 years old and older not residing in institutions. The older people in the samples lived in Cleveland, Ohio; Lane County, Oregon; and the Gateway Health District, northeastern Kentucky. Using U.S. Bureau of Census definitions of rural and urban, we classified the data from Cleveland as urban, the data from Lane County as rural and urban, and the data from northeastern Kentucky as rural.

In our comparative analyses we applied appropriate statistical tests to determine if the differences we observed between locations were statistically significant. These statistical tests consider the sample sizes. When we state differences between locations in answering the questions, these differences are statistically significant.

Although the older people in the three locations were interviewed at different times, our statistical procedures made it possible to compare the information. We did not compare people by income, sex, or race because the total number of people in these comparisons was too small to be statistically meaningful.

Cleveland, Ohio

We took a statistical sample from over 80,000 people in Cleveland who were 65 years old and older and were not in institutions, such as nursing homes. In our study, 1,609 older people were interviewed by Case Western University in 1975, and 1,311 were reinterviewed a year later. This analysis uses data on the 1,311 older people interviewed in 1976. We refer to these people in the analyses as urban Cleveland.

Lane County, Oregon

The Lane County study was conducted by the University of Oregon and the Lane County Community Health and Social Services Department. The Oregon study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county. The county, located in west-central Oregon, contains two

adjacent cities, Eugene and Springfield, that had a 1976 combined population of about 132,000 (54 percent of the county). The county also contains four other incorporated areas each with a population over 2,500.

The selection process for the Oregon study involved a statistical sample of 1,197 people from six subareas of the county. The people sampled were interviewed in 1978. Data from the study are to be used for planning and evaluation with a capability to study rural and urban differences.

We segregated data on 868 persons 65 years old and older from the Lane County sample. We divided these data into three groups, which we refer to as rural Lane County, Oregon; urban Lane County, Oregon; and Lane County, Oregon (town). They are described as follows:

--Rural Lane County, Oregon--426 older persons who live in unincorporated areas consisting of farms, timberland, or open space or in incorporated areas with a population less than 2,500 people.

--Urban Lane County, Oregon--318 older persons who live within the corporation limits of Eugene and Springfield, Oregon. Over 60 percent of Lane County's residents who are 65 years old and older live in these two cities.

--Lane County, Oregon (town)--124 older persons who live in three small towns--Florence, Cottage Grove, and Oakridge. These towns have populations of 3,050, 6,900, and 3,930, respectively.

Gateway Health District, Kentucky

The Gateway Health District studied the demographic characteristics and needs of people 60 years old and older living in the district. This district consists of five counties in northeastern Kentucky (Bath, Menifee, Montgomery, Morgan, and Rowan) within the Cumberland Plateau. The district is a severely economically depressed rural area consisting of small communities and homes dispersed over a large area of mountainous terrain in Appalachia. In 1970, this five-county area had a population of 55,678.

A statistical sample of people 60 years old and older living in the five-county area was selected for interviews. This sample included people from rural and urban areas and people in institutions. People not in institutions were interviewed in 1977. Data on 128 people 65 years old and

older, not in institutions and living in an unincorporated or incorporated areas of fewer than 2,500 people, were segregated by us from this sample and used in our comparative analyses. We refer to these 128 people as rural northeastern Kentucky.

QUESTIONS AND ANSWERS

1. Question: What is the well-being (personal conditions) of older people living in the three locations?

Answer: We defined, measured, and compared selected personal conditions--health, security, loneliness, and outlook on life--for older people living in the three locations. The comparisons showed that for all four conditions, older people in rural northeastern Kentucky were in a significantly worse condition than older people elsewhere. Over half the people in rural northeastern Kentucky were in the worst overall condition, compared to 21 percent in Cleveland and 17 percent or less in rural and urban Lane County, as shown in the following table.

Level of conditions (note a)	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Health:					
Best	51	57	51	52	28
Marginal	28	27	29	27	25
Worst	21	16	20	21	47
Security:					
Best	53	64	65	60	24
Marginal	25	22	24	25	28
Worst	22	14	11	15	48
Loneliness:					
Best	60	73	68	66	39
Marginal	28	19	22	25	32
Worst	12	8	10	9	29
Outlook on life:					
Best	25	35	26	29	11
Marginal	51	46	54	49	45
Worst	24	19	20	22	44
Overall:					
Best	31	44	33	37	9
Marginal	48	40	56	46	38
Worst	21	16	11	17	53

a/For a description of conditions and level of conditions, see enclosure II

Older people in urban Lane County were in a significantly better personal condition than older people in Cleveland at all levels. For example, 44 percent of the people in urban Lane County were in the best overall condition, compared to 31 percent in Cleveland.

Also, older people in rural Lane County were in a better personal condition than older people in Cleveland at the security, loneliness, and overall levels. For example, 60 percent of the older people in rural Lane County were in the best security condition, compared to 53 percent in Cleveland.

Illnesses contributed to the worse overall personal condition of people in rural northeastern Kentucky. We focused our analyses on illnesses that interfered a great deal with a person's activities of daily living. Activities of daily living include preparing meals, bathing, walking, eating, and shopping. One of every three older people (34 percent) in rural northeastern Kentucky had three or more illnesses, compared to 1 of 11 older people (9 percent) in rural Lane County and Cleveland, as shown in the following table.

Number of illnesses greatly interfering with daily living activities	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
None	63	65	66	60	37
One	19	23	19	22	19
Two	9	8	10	9	10
Three or more	9	4	5	9	34
Total	100	100	100	100	100

People 75 years old and older tended to have more illnesses that interfered with activities of daily living. For example, a higher percentage of people 75 years old and older had illnesses interfering with activities of daily living, compared to people 65 to 74 years old at all locations, as shown in the following table.

Number of illnesses greatly interfering with daily living activities	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
None:					
65 to 74 years old	68	70	75	67	48
75 years old and older	56	57	53	48	20
One:					
65 to 74 years old	18	20	14	19	17
75 years old and older	21	28	27	27	21
Two or more:					
65 to 74 years old	7	7	8	7	9
75 years old and older	13	10	12	13	12
Three or more:					
65 to 74 years old	7	3	3	7	26
75 years old and older	10	5	8	12	47

In northeastern Kentucky, a greater percentage of people 75 years old and older had three or more illnesses compared to the other locations. As shown, 47 percent of the people 75 years old and older in northeastern Kentucky had three or more illnesses, compared to 12 percent or less at all other locations.

Mental impairments and arthritis most frequently interfered with activities of daily living. As shown in the following table, the percentage of people with mental impairments interfering with activities ranged from 10 percent in urban Lane County to 37 percent in northeastern Kentucky. For arthritis, the range was from 14 percent in urban Lane County to 34 percent in Kentucky.

Illness greatly interfering with activities	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Mental impairment	12	10	10	14	37
Arthritis	18	14	15	20	34
Circulation	10	5	5	7	21
Heart trouble	7	5	5	8	20
High blood pressure	5	4	5	3	16
Stroke	4	2	2	2	5

2. Question: What percentages of older people in the three locations are impaired; that is, people who are unable to do one or more daily tasks even if helped?

Answer: Older people in rural and urban Lane County were less impaired than people in either Cleveland or rural northeastern Kentucky. We defined impairment in terms of a person's ability to perform activities of daily living. If older people could not do one or more of these tasks even if helped, they were considered impaired. As shown in the following table, the percentage of people 65 years old and older who were impaired in rural and urban Lane County is less (7 to 10 percent) than the percentages in Cleveland (15 percent) and in rural northeastern Kentucky (17 percent).

Ability to do daily tasks	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Can do all without help	59	75	68	74	35
Can do all, but only with help in one or more	26	18	26	16	48
Cannot do one or more even with help	15	7	6	10	17
	100	100	100	100	100

Because age affects a person's ability to do daily tasks, we analyzed the samples by comparing two age groups, 65 to 74 years old and 75 years old and older. At all locations, a greater percentage of people 75 years old and older needed assistance in daily tasks than people 65 to 74 years old. For example, 28 percent of the people 65 to 74 years old in Cleveland either needed some help or were totally unable to do one or more active daily living tasks. Of the people 75 years old and older in Cleveland, 56 percent needed help--twice the percentage of the younger group. The table below shows the comparative ability to do daily tasks for the two age groups.

Ability to do daily tasks	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Can do all without help:					
65 to 74 years old	72	83	85	81	48
75 years old and older	44	61	43	60	16
Can do all, but only with help in one or more:					
65 to 74 years old	20	12	14	14	46
75 years old and older	34	29	45	22	51
Cannot do one or more even with help:	28				
65 to 74 years old	8	5	1	5	6
75 years old and older	22	10	12	18	33
	56				

ENCLOSURE I

DEMOGRAPHIC CHARACTERISTICS OF SAMPLES

Characteristics	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Sex:					
Male	38	43	40	50	30
Female	62	57	60	50	70
Age:					
65-74	54	65	59	64	60
75 and older	46	35	41	36	40
Education:					
Less than 12 years	75	53	56	62	87
12 years or more	25	47	44	38	13
Race:					
White	72	99	100	98	98
Black	28	1	0	2	2
Marital status:					
Married	38	59	55	67	61
Widowed	48	32	40	25	37
Single	14	9	5	8	2
Income:					
Less than $3,000	32	13	15	14	52
$3,000 to $6,999	50	44	50	51	40
More than $7,000	18	43	35	35	8
Sample size	1,311	318	124	426	128

ENCLOSURE II

METHODOLOGY

The information contained in this report is based on our study of the personal conditions of older people in Cleveland, Ohio. Five other reports have been issued on this study entitled (1) "The Well-Being of Older People in Cleveland, Ohio" (HRD-77-70, Apr. 19, 1977), (2) "Conditions of Older People: National Information System Needed" (HRD-79-95, Sept. 20, 1979), (3) "Home Health--The Need for a National Policy to Better Provide for the Elderly" (HRD-78-19, Dec. 30, 1977), (4) "Conditions and Needs of People 75 Years Old and Older" (HRD-80-7, Oct. 15, 1979), and (5) "The Potential Need for and Cost of Congregate Housing for Older People" (HRD-80-8, Oct. 15, 1979). Following are the details of the data gathering and analytical methodology from the two-phase study.

WELL-BEING STATUS AND SERVICES DATA BASES

We took a sample from over 80,000 people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, 1,311 of these older people were reinterviewed.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center, in collaboration with HEW's Administration on Aging, former Social and Rehabilitation Service, and Health Resources Administration. The questionnaire contains questions about an older person's well-being status in five areas of functioning--social, economic, mental, physical, and activities of daily living.

To identify factors that could affect the well-being of older people, we

--developed specific definitions of services being provided to older people and dimensions for quantifying the services;

--identified the providers of the services--families and friends, health care providers, and over 100 social service agencies;

--obtained information about the services provided to each person in our sample and the source and intensity of these services; and

--developed an average unit cost for each of the 28 services.

In defining and quantifying the services, we used a format developed by the Duke University Center to define 28 different services. These services are defined in appendix V of our prior report. 1/ Services are defined according to four elements: purpose, activity, relevant personnel, and unit of measure. For example, meal preparation was defined as follows:

Purpose:	To regularly prepare meals for an individual.
Activity:	Meal planning, food preparation, and cooking.
Relevant personnel:	Cook, homemaker, family member.
Unit of measure:	Meals.
Examples:	Meals provided under 42 U.S.C. 3045 (supp. V, 1975), the Older Americans Act, and meals-on-wheels programs.

To quantify the service, we used the unit of measure along with the duration, or number of months, during which the service was received.

We also developed an average unit cost for each service based on the experience of 27 Federal, State, local, and private agencies in Cleveland between October 1976 and March 1977. We compared these costs to similar costs in Chicago, Illinois, and Durham, North Carolina. As discussed in our prior report, the family and friends are also important sources of services. In their absence, any services received would have to be from an agency. Therefore, we assigned the same cost to family and friend services that we found for agencies.

1/"The Well-Being of Older People in Cleveland, Ohio," April 19, 1977, HRD-77-70.

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Each piece of data was collected so that it could be related to an individual in our sample. This included the questionnaire data, data on the 28 services provided by social service agencies, and data on the services provided by health care providers. By relating these data to the individual, we were able to do comparative analyses of sampled older people for over 500 different variables.

ANALYTICAL TECHNIQUES

In our prior report, we combined the five areas of functioning--(1) social, (2) economic, (3) mental, (4) physical, and (5) activities of daily living--into a well-being status because we wanted to consider the entire person. We described well-being status as (1) unimpaired, (2) slightly impaired, (3) mildly impaired, (4) moderately impaired, (5) generally impaired, (6) greatly impaired, (7) very greatly impaired, or (8) extremely impaired.

The Duke University Center's questionnaire is unique in that data from the questionnaire can be aggregated into a number of useful measures, each with a specific purpose. As previously discussed, the questionnaire can provide a five-dimensional functional assessment or be combined into a well-being status that we used in our first report. This assessment was not designed, however, for determining the benefits of help for older people. Through our analyses, we were able to develop useful measures of personal conditions of, problems of, and help available to older people. The conditions of older people used in this report--health, security, loneliness, and outlook on life--are described on the following page.

Health condition

An older person's health condition is the ability to do daily tasks. In categorizing a person's ability to do daily tasks, we considered his or her responses to questions on 13 different tasks. For example, regarding meal preparation, each person was asked "Can you prepare your own meals * * * without help, with some help, or are you completely unable to prepare any meals?" We then categorized each person based on the number of the 13 tasks they needed some help with or were completely unable to do. For most of this report we used three categories--(1) can do all 13 tasks without help, (2) need help with one or more but can do all with help, and (3) cannot do any even with help.

CONDITIONS

Level of condition	Health: Illness	Health: Ability to do daily tasks (note a)	Overall	Security	Loneliness	Outlook on life	Overall personal condition
Best	No illness that interferes a great deal with activities	Can do all 13 daily tasks without help	In best category for both illness condition and ability to do daily tasks	Worries hardly ever	Feels lonely almost never	Does not feel useless and finds life exciting	(1) In best category for all 4 conditions or (2) Best for 3 and marginal for the other
Marginal	One illness that interferes a great deal with activities	Can do all 13 daily tasks but only with help in one or more	(1) In best category for illness condition or ability to do daily tasks and marginal in other or (2) in marginal category for both	Worries fairly often	Feels lonely sometimes	(1) Finds life exciting but feels useless or (2) Does not feel useless but finds life dull or routine	(1) In marginal category for 2 or more conditions and best for other(s) or (2) In worst category for only one condition
Worst	Two or more illnesses that interfere a great deal with activities	Can't do at least one task even with help	In worst category for either illness condition or ability to do daily tasks	Worries very often	Feels lonely quite often	Feels useless and finds life routine or dull	In worst category for 2 or more conditions

a/Daily tasks include preparing meals, bathing, walking, shopping, eating, etc. Details on these daily tasks are described on pages 57 to 59 of appendix IV of our April 19, 1977, report, "Well-Being of Older People in Cleveland, Ohio" (HRD-77-70).

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If an older person is not in the best health condition, illnesses were used in defining the person's problems. In categorizing an older person's illness situation, we considered whether an older person had any of 27 different illnesses, including mental illnesses, and how much the illness interfered with his or her activities. For example, each person was asked if he or she had heart trouble. If the person said "yes," he or she was then asked "how much does it interfere with your activities--not at all, a little (some), or a great deal?" We then categorized each person based on the number of illnesses that interfered with his or her activities a great deal. For most of this report we used three categories--(1) those with no illnesses bothering them a great deal, (2) those with one, and (3) those with two or more.

Security condition

A person's security condition can be described by how often a person worries. How often a person worries can be related to the amount of income and caregiving help a person receives. In developing a person's security condition, we used the following question in the questionnaire:

--"How often would you say you worry about things--very often, fairly often, or hardly ever?"

In defining security problems, we used the following three questions. To define a money problem, we asked:

--"How well does the amount of money you have take care of your needs--very well, fairly well, or poorly?"

And these questions were used in defining caregiving problems:

--"Is there someone who would give you any help at all if you were sick or disabled? If 'yes,' * * *"

--"Is there someone who would take care of you as long as needed, or only a short time, or only someone who would help you now and then * * *?"

Loneliness condition

A person's loneliness condition was identified using the following question:

ENCLOSURE II

--"Do you find yourself feeling lonely quite often, sometimes, or almost never?"

The information for identifying loneliness problems was obtained from the following questions:

--"About how many times did you talk to someone--friends, relatives, or others--on the telephone in the past week?"

--"How many times during the past week did you spend some time with someone who does not live with you * * * not at all, once, two to six times, once a day or more?"

Using these questions, the following table shows information combined to establish a loneliness problem variable called social contacts.

	How often a week visits with someone			
How often a week talks on telephone	Once a day or more	Two to six times	Once	Not at all
Once a day or more	High	High	Medium	Medium
Two to six times	High	Medium	Medium	Low
Once	Medium	Medium	Low	Low
Not at all	Medium	Low	Low	Low

Using high, medium, and low activity as a measure of intensity of social contacts, this variable was related to loneliness condition.

Outlook on life condition

The outlook on life condition is obtained by defining life view using information from the questions shown in the following table.

	Feel useless at times	
Life is generally	Yes	No
Exciting	Fair	Good
Pretty routine	Poor	Fair
Dull	Poor	Fair

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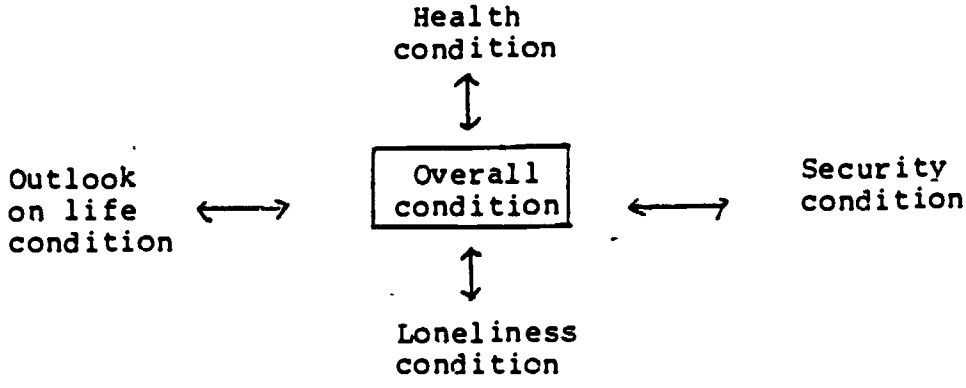
Using this information, we were able to define three levels of outlook on life condition--good, fair, and poor.

Overall condition

Because a person is at all times in some overall condition which results from the integration of each of the four conditions, we constructed a composite condition of a person illustrated as follows.



Our methodology and analytical results show that a useful measure of the conditions of a person can be developed. In some instances, such as the outlook on life condition, the amount of data for constructing this variable is minimal. Nevertheless, methodological concepts and analytical results show the existence of this condition. Further, our measures are logically equivalent to the five-dimensional functional assessment used in our prior report based on the Duke University Center's questionnaire. The health condition is equivalent to the mental, physical, and activities of daily living dimensions; the security condition is related to the economic dimension; and the loneliness condition is related to the social dimension.

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WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #2

SUBJECT: Services to older people in urban and rural locations

Attached is information on services for older people in three locations--Ohio, Oregon, and Kentucky. This information is extracted from a United States General Accounting Office report to the Federal Council on Aging. Page 3 describes transportation services, page 6 housing, and page 7 supplemental security income, food stamps, and Medicaid.

SOURCE OF DATA: "Comparison of Data on Older People in Three Rural and Urban Locations", United States General Accounting Office report, HRD-80-83, dated May 23, 1980.

QUESTIONS AND ANSWERS ABOUT PEOPLE

65 YEARS OLD AND OLDER

IN THREE LOCATIONS

DESCRIPTION OF DATA BASES

The data for our comparative analyses come from three separate studies that included information about people 65 years old and older not residing in institutions. The older people in the samples lived in Cleveland, Ohio; Lane County, Oregon; and the Gateway Health District, northeastern Kentucky. Using Bureau of Census definitions of rural and urban, we classified the data from Cleveland as urban, the data from Lane County as rural and urban, and the data from northeastern Kentucky as rural.

In our comparative analyses we applied statistical tests to determine if the differences we observed among locations were statistically significant. These statistical tests consider the sample sizes. When we state differences between locations in answering the questions, these differences are statistically significant.

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Lane County, Oregon

The Lane County study was made by the University of Oregon and the Lane County Community Health and Social Services Department. The study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county. The county, located in west-central Oregon, contains two adjacent cities, Eugene and Springfield, which had a 1976 combined population of about 132,000 (54 percent of the county's population). The county also contains four other incorporated areas, each with a population over 2,500.

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A statistical sample of people 60 years old and older living in the five-county area was selected for interviews. This sample included people from rural and urban areas, and people in institutions. People not in institutions were interviewed in 1977. Data on 128 people 65 years old and older, not in institutions and living in unincorporated or incorporated areas of fewer than 2,500 people, were segregated by us from this sample and used in our comparative analyses. We refer to these 128 people as rural northeastern Kentucky.

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All three studies used the Older Americans Resources and Service Questionnaire developed by a multidisciplinary team headed by Dr. George Maddox and Dr. Eric Pfeiffer at the Duke University Center for the Study of Aging and Human Development. During a personal interview, the older people in the three studies replied to 101 questions about their well-being in five areas of functioning--social, economic, mental, physical, and activities of daily living. Data from these interviews were used to answer the following questions. The questions are grouped by subject areas--transportation, housing, income, and employment.

Answer: In northeastern Kentucky, 57 percent of the older people received transportation from family and friends. In Lane County, most of the older people provided their own transportation (ranging from 51 to 61 percent). In Cleveland, 52 percent of the older people received transportation from two or more sources, as shown in the following table.

Source of transportation	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
None	1	0	0	1	2
One source:					
Self	13	51	61	54	29
Family and friends	25	20	32	25	57
Public and private agencies	9	4	0	2	3
Two or more sources:					
Family and friends and self	10	7	0	12	3
Agency and family and friends	23	11	6	3	6
Agency and self	8	6	1	3	0
All other possible combinations	11	1	0	0	0
Total	100	100	100	100	100

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2. Question: What percentages of older people in the three locations provided their own transportation?

Answer: Most people in Lane County, Oregon (ranging from 62 to 69 percent), provided all or some of their own transportation. In Cleveland and northeastern Kentucky, however, 58 and 68 percent, respectively, provided none of their own transportation, as shown in the table on the following page.

Transportation provided by self	Urban: Cleveland	Urban: Lane County, Oregon	Lane County, Oregon (town)	Rural: Lane County, Oregon	Rural: Northeastern Kentucky
	(percent)				
All	13	51	61	54	29
		65	62	69	
Some	29	14	1	15	3
None	58	35	38	31	68
Total	100	100	100	100	100

3. Question: Did older people feel they needed more transportation than was available?

Answer: Older people in Cleveland (17 percent) and northeastern Kentucky (20 percent) were more likely to express a need for more transportation than those in Lane County (8 percent or less), as shown in the following table.

Expressed need for more transportation	Urban: Cleveland	Urban: Lane County, Oregon	Lane County, Oregon (town)	Rural: Lane County, Oregon	Rural: Northeastern Kentucky
	(percent)				
Yes	17	8	2	4	20
No	83	92	98	96	80
Total	100	100	100	100	100

4. Question: Did older people living in rural locations make fewer weekly trips (visiting friends, going shopping, going to the doctor, etc.) than people living in urban locations?

Answer: Older people living in rural locations made significantly fewer weekly trips than urban people. Greater percentages of older people living in rural Lane County and northeastern Kentucky--78 percent and 85 percent, respectively--made three or fewer trips weekly, compared to 63 percent in Cleveland and 52 percent in urban Lane County, as shown in the following table.

Number of trips (weekly)	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
None	23	13	18	24	31
One to three trips	40	39	59	54	54
	63	52	77	78	85
Four or more trips	37	48	23	22	15
Total	100	100	100	100	100

Housing

1. Question: What percentage of the older people owned homes?

Answer: Fewer older people owned homes in Cleveland than in Lane County or northeastern Kentucky. As shown in the following table, 51 percent owned homes in Cleveland, compared to 79 percent or more in the other locations.

Home ownership	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Owned home	51	88	79	88	84
Did not own home	49	12	21	12	16
Total	100	100	100	100	100

In Cleveland, 61 percent of the unmarried older people rented housing or lived in public housing, the highest for all locations. Of these, 51 percent rented housing and 10 percent lived in public housing. In all locations married people had higher home ownership than unmarried people. For example, in Cleveland 70 percent of the married people owned homes, compared to 39 percent of those not married, as shown in the following table. 1/

Location	Marital status	Owned home	Did not own home: Rental housing	Did not own home: Public housing	Total
		(percent)			
Cleveland	Married	70	26	4	100
	Not married	39	51	10 (61)	100
Urban Lane County, Oregon	Married	94	6	0	100
	Not married	79	21	0	100
Rural Lane County, Oregon	Married	92	7	1	100
	Not married	77	23	0	100
Northeastern Kentucky	Married	85	15	0	100
	Not married	82	18	0	100

1/The sample size in Lane County (town) was not large enough for this analysis.

2. Question: What percentages of older people received Supplemental Security Income, food stamps, and/or Medicaid?

Answer: Older people in northeastern Kentucky were more likely to receive Supplemental Security Income, food stamps, and/or Medicaid and often from more than one source compared to the other locations. As shown in the table on the following page, 28 percent of the older people in northeastern Kentucky received such aid (17 percent from two or three sources), compared to a range of 3 percent in Lane County (town) to 13 percent in Cleveland.

Aids received	Urban: Cleveland	Urban: Lane County, Oregon	Lane County, Oregon (town)	Rural: Lane County, Oregon	Rural: Northeastern Kentucky
	(percent)				
None	87	89	97	91	72
One	10	10	2	7	11
Two	2 } 13	1 } 11	1 } 3	2 } 9	11 } 28
Three	1	0	0	0	6
Total	100	100	100	100	100

Analysis of the homeowners receiving Supplemental Security Income, food stamps, and/or Medicaid shows that 23 percent of the homeowners in northeastern Kentucky received aid, compared to a range of 1 percent in Lane County (town) to 9 percent in urban Lane County, as shown in the following table.

Homeowners received aid	Urban: Cleveland	Urban: Lane County, Oregon	Lane County, Oregon (town)	Rural: Lane County, Oregon	Rural: Northeastern Kentucky
	(percent)				
Yes	6	9	1	7	23
No	94	91	99	93	77
Total	100	100	100	100	100
Number in sample owning homes	656	276	95	367	104
Percent of total sample	51	88	79	88	84

ENCLOSURE I

DEMOGRAPHIC CHARACTERISTICS OF SAMPLES

Characteristics	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Sex:					
Male	38	43	40	50	30
Female	62	57	60	50	70
Age:					
65-74	54	65	59	64	60
75 and older	46	35	41	36	40
Education:					
Less than 12 years	75	53	56	62	87
12 years or more	25	47	44	38	13
Race:					
White	72	99	100	98	98
Black	28	1	0	2	2
Marital status:					
Married	38	59	55	67	61
Widowed	48	32	40	25	37
Single	14	9	5	8	2
Income:					
Less than $3,000	32	13	15	14	52
$3,000 to $6,999	50	44	50	51	40
More than $7,000	18	43	35	35	8
Number in sample	1,311	318	124	426	128

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #3

SUBJECT: Older people and their need for meals

Attached is our national estimates of the need for meals for older people. This information is extracted from the United States General Accounting Office briefing on the nutritional health of older people provided to the staff of the House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition.

SOURCE OF DATA: "Information on the Nutritional Health of the Elderly", United States General Accounting Office Briefing, House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition.

NUTRITION

DESCRIPTION OF DATA BASES

The data for our analyses come from three studies that included information about people 65 years old and older not residing in institutions. The older people in the sample lived in Cleveland, Ohio; Lane County, Oregon; and the Gateway Health District, northeastern Kentucky.

Cleveland, Ohio

We took a statistical sample from over 80,000 people in Cleveland who were 65 years old and older and were not in institutions, such as nursing homes. In our study, 1,609 older people were interviewed by Case Western University in 1975, and 1,311 were reinterviewed a year later. This analysis uses data on the 1,311 older people interviewed in 1976.

Lane County, Oregon

The Lane County study was conducted by the University of Oregon and the Lane County Community Health and Social Services Department. The Oregon study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county. The county, located in west-central Oregon, contains two adjacent cities, Eugene and Springfield, that had a 1976 combined population of about 132,000 (54 percent of the county). The county also contains four other incorporated areas each with a population over 2,500.

The selection process for the Oregon study involved a statistical sample of 1,197 people from six subareas of the county. The people

sampled were interviewed in 1978. Data from the study are to be used for planning and evaluation with a capability to study rural and urban differences.

We segregated data on 868 persons 65 years old and older from the Lane County sample. We divided these data into three groups, described as rural Lane County, Oregon; urban Lane County, Oregon; and Lane County, Oregon (town). They are described as follows:

--Rural Lane County, Oregon--426 older persons who live in unincorporated areas consisting of farms, timberland, or open space or in incorporated areas with a population less than 2,500 people.

--Urban Lane County, Oregon--318 older persons who live within the corporation limits of Eugene and Springfield, Oregon. Over 60 percent of Lane County's residents who are 65 years old and older live in these two cities.

--Lane County, Oregon (town)--124 older persons who live in three small towns--Florence, Cottage Grove, and Oakridge. These towns have populations of 3,050, 6,900, and 3,930, respectively.

Gateway Health District, Kentucky

The Gateway Health District studied the demographic characteristics and needs of people 60 years old and older living in the district. This district consists of five rural counties in northeastern Kentucky (Bath, Menifee, Montgomery, Morgan, and Rowan) within the Cumberland Plateau. The district is a severely economically depressed rural area consisting of small communities

and homes dispersed over a large area of mountainous terrain in Appalachia. In 1970, this five-county area had a population of 55,678.

A statistical sample of people 60 years old and older living in the five-county area was selected for interviews. This sample included people from rural and urban areas and people in institutions. People not in institutions were interviewed in 1977. Data on 128 people 65 years old and older, not in institutions and living in an unincorporated or incorporated areas of fewer than 2,500 people, were segregated by us from this sample and used in our analyses.

METHODOLOGY

Using these urban and rural data bases, we grouped older people in the following five categories defining the degree of need for meals served at sites such as schools and senior centers.

--Older people who may need meals because they have low income

This category contains older people

1.) who were able to go places, shop, and prepare own meals without help and

2.) whose total income was less than $7,000 if married or $5,000 if single and met their needs fairly well, or

3.) whose total income met their needs poorly regardless of amount.

--Older people unlikely to use meals because physically and financially able to satisfy own needs

This category contains older people who were able to go places, shop, and prepare their own meals without help and who have total annual

income other than that described in the previous category.

--Older people who are receiving help from other sources but who could transfer their source of meals

This category contains older people who were unable to get places, shop, or prepare their own meals without help. These people receive meals from agencies or family and friends could give up that source of help, and use the meals at schools instead.

--Older people who are unable to use meals

This category contains older people who were not able to get out of bed, walk, get places, or eat. If older people could not do one of those tasks even if helped, they were placed in this category.

--Older people who probably need meals

This category contains older people who were unable to get places, shop, or prepare their own meals and were not receiving help in performing these activities.

These five categories were divided into subgroups by race, geographical location (urban and rural), sex, and age. We applied appropriate statistical tests to determine if the differences we observed between subgroups were statistically significant.

The statistical tests showed that significant differences existed in the likelihood that an older person would be included in one of the five categories depending on whether the person lived in a urban or rural area, was male or female, and was 65 to 74 years old, 75 to 84, or 85 years old and older. Our estimates of the percent of older people in each of the five categories considered these statistical differences.

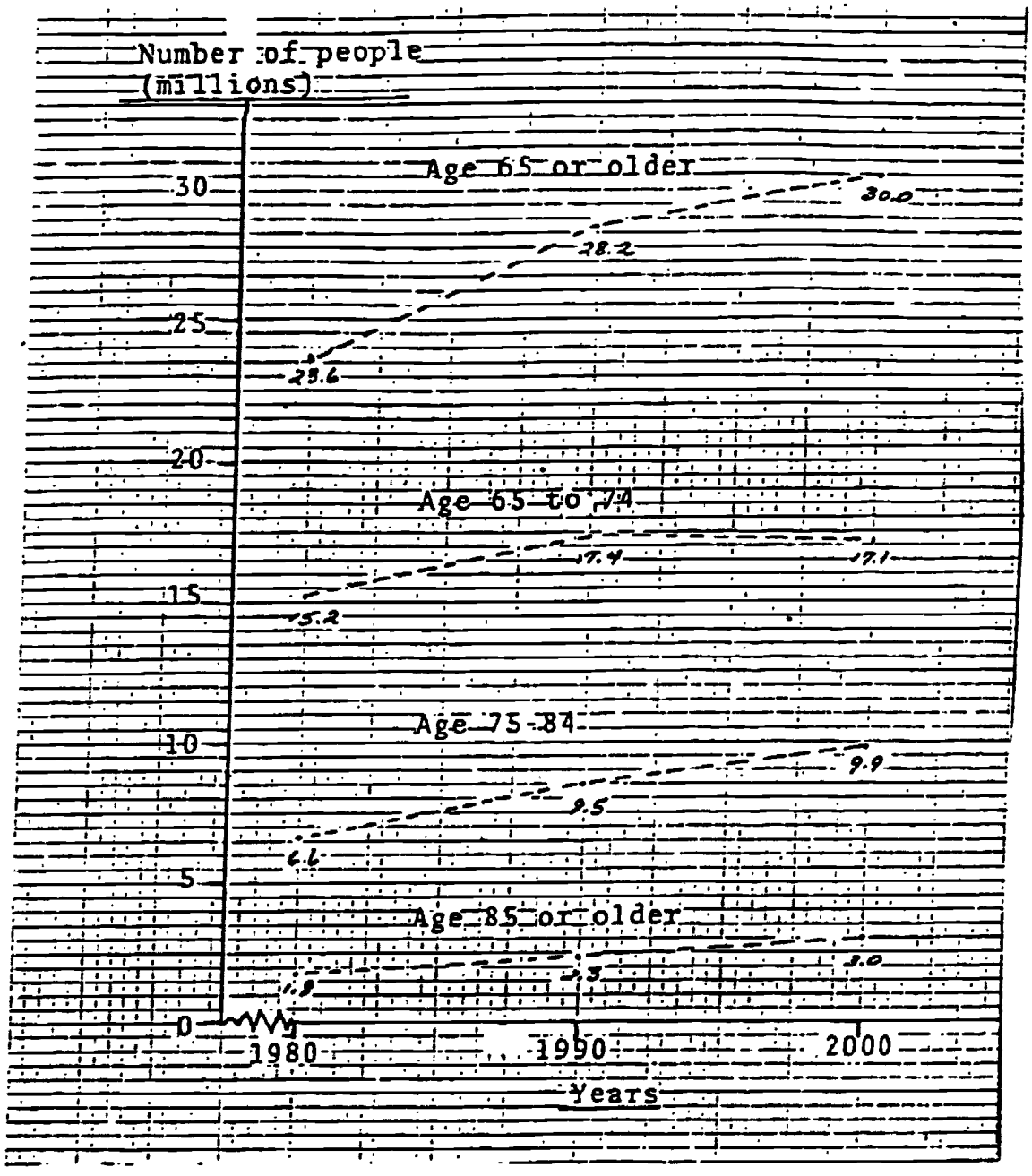
These estimates based on our three data bases were projected nationally to obtain national estimates of the number of older people in the five categories. In computing the national estimates,

we used U.S. Bureau of Census data on people 65 years old and older in the population institutionalized and not institutionalized. In comparing totals between graphs and tables in this report, small differences occur that are due to rounding.

NON-INSTITUTIONALIZED POPULATION

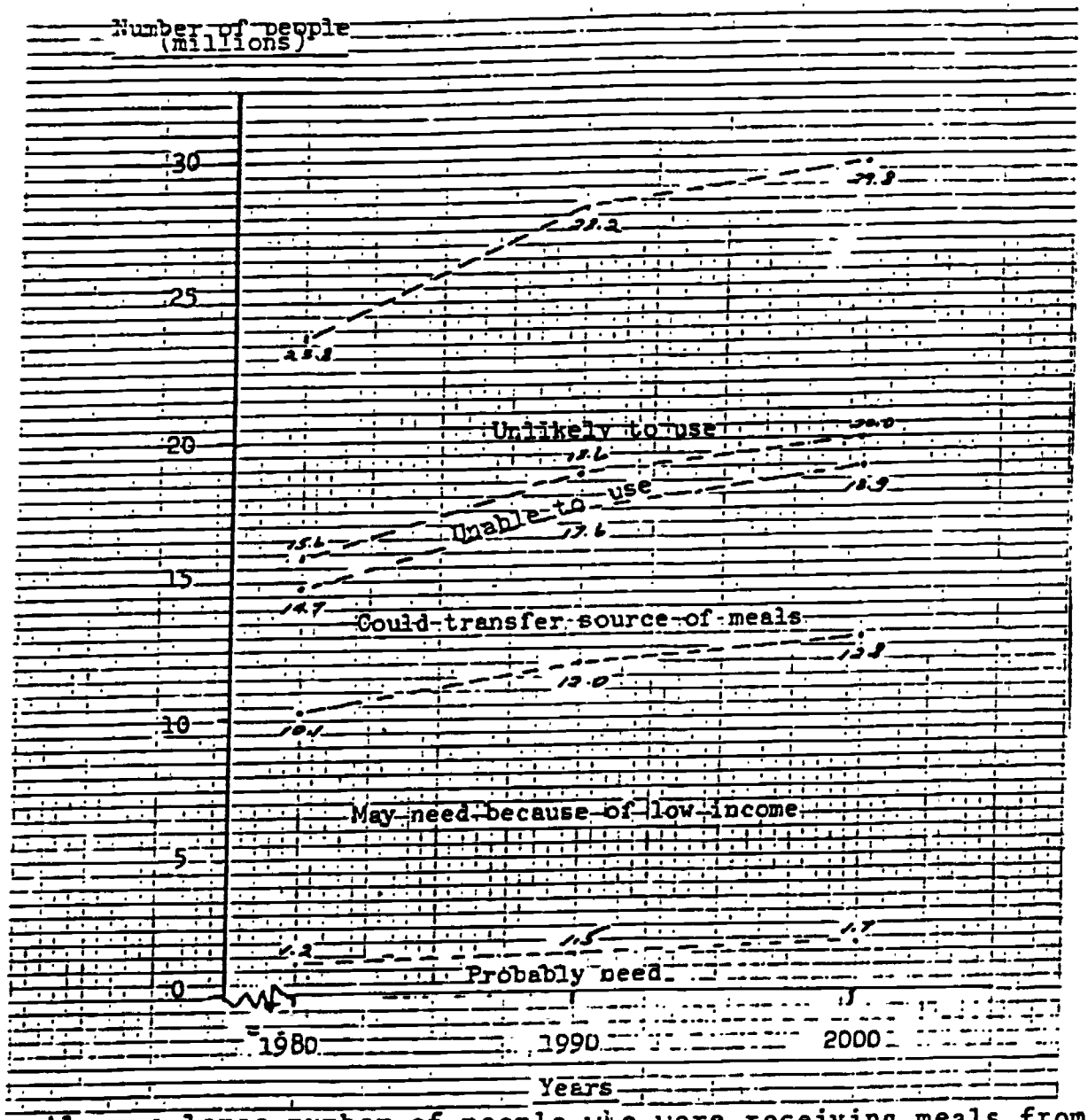
The older population (both institutionalized and non-institutionalized people) of this country is increasing both in numbers and in percentage of the total population. In 1940, shortly after passage of the Social Security Act, the United States contained 9 million people (7 percent of the population) over 65 years old. By 1977, the number had more than doubled to 23 million (11 percent of the population). By the year 2000, the older population will increase by another 9 million--to a total of 32 million people (12 percent of the total population).

Most older people are not in institutions such as nursing homes. Our estimates of the non-institutionalized population indicate that 23.6 million people would be 65 years old and older in 1980 compared to 30 million in the year 2000, as shown on the following graph.


Number of people
(millions)
Age 65 or older
30
25
20
15
10
5
0
30.0
28.2
23.6
Age 65 to 74
17.4
17.1
15.2
Age 75-84
9.9
9.5
6.6
Age 85 or older
8.0
5.3
1.9
1980
1990
2000
Years

Also, 43 percent (9.9 plus 3.0 million) of the 30 million people would be 75 years old and older in the year 2000.

Many older people not in institutions could use meals in schools. In 1980, 10.1 million people may need or probably need meals compared to 12.8 in the year 2000, as shown in the following graph.



Also, a large number of people who were receiving meals from agencies or family and friends could obtain their meals from

schools. In 1980, 4.6 million people (14.7 million minus 10.1 million) could transfer their source of meals compared to 6.1 million in the year 2000.

The estimated cost of meals in schools in 1980 for 10.1 million older people would be $5.3 billion annually. If the 4.6 million people who received meals from other sources were to obtain their meals from schools an additional $2.4 billion would be required or a total cost of $7.7 billion, as shown in the following table.

Category	1980 population (millions)	Estimated annual cost (note a)
People who probably need meals	1.2	$ 627
People who may need meals	8.9	4,646
Sub-total	10.1	$5,273
People who could transfer source of meals	4.6	2,401
	14.7	$7,674

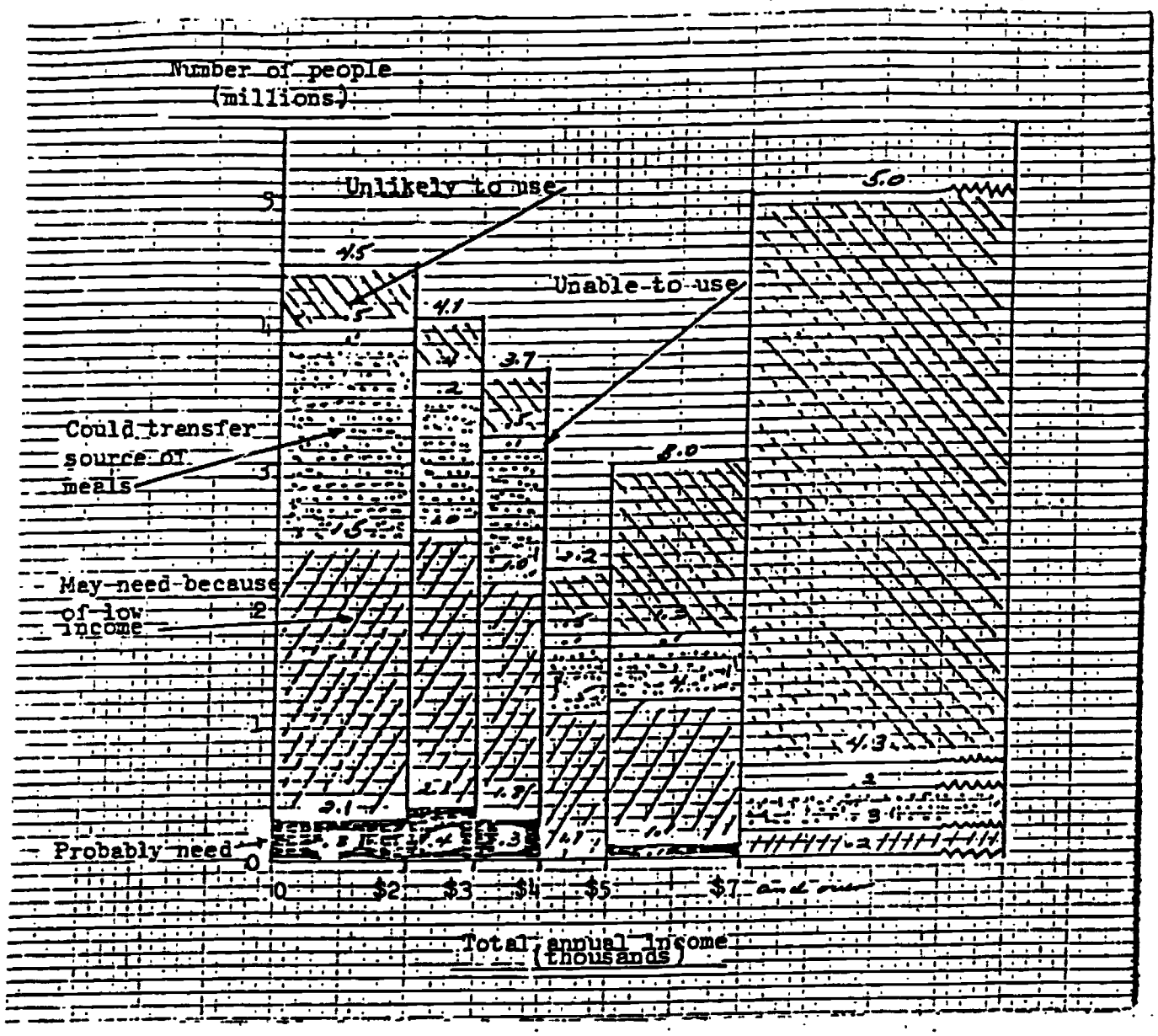
a/ Assuming that meals were provided once a day at $2.00 a meal, five days a week for 52 weeks a year or $522 annually.

Of the $2.4 billion, we estimate $1.8 billion in meals are provided by family and friends, and .6 billion by public and private agencies.

A majority of the cost of meals would be incurred for people with annual income under $3,000. Fifty-two percent of the $7.7 billion would be incurred for 10.1 million older people in 1980 with annual incomes under $3,000, as shown in the following table.

Annual income ranges	1980 Population who				Percent	
	Probably need	May need because of low income	Could transfer source of meals	Total	Total	Cumulati
	(millions)					
$0 -$1,999	$157	$1,148	$ 731	$2,036	26.5	-
$2,000 -$2,999	261	1,148	522	1,931	25.1	51.6
$3,000 -$3,999	157	992	522	1,671	21.8	73.4
$4,000 -$4,999	0	627	261	888	11.6	85.0
$5,000 -$6,999	52	627	208	887	11.6	96.6
$7,000 or more	0	104	157	261	3.4	100.0
Total	$627	$4,646	$2,401	$7,674	100.0	

To estimate the number of people nationally by total annual income and their need for school meals, we used 1977 census data, the Cleveland sample, and the five need categories described previously. Of the 4.5 million older people with annual income under $2,000, 2.4 million people (53 percent) may need or probably need meals. Conversely, of the 5.0 million people with annual income over $7,000, 4.3 million people (86 percent) were unlikely to use because they were physically and financially able to satisfy their needs, as shown in the following graph.


Number of people
(millions)
Unlikely to use
Unable-to-use
Could transfer
source of
meals
May need because
of low
income
Probably need
4.5
4.1
3.7
8.0
5.0
4.3
2.1
0
$2
$3
$4
$5
$7
Total annual income
(thousands)

To estimate the number of people nationally receiving meals, we used 1976 census data and the three samples. Of the 21.7 million people not in institutions in 1976, 2.7 million people (12 percent) received meals from family and friends, and .8 million people (4 percent) from agencies.

CHANGES IN NEED FOR MEALS AFTER A YEAR

Data on older people sampled in Cleveland were available for two consecutive years (1975 and 1976) and therefore, changes in need for meals could be identified. As shown in the following table,

--25.1 percent of the older people unlikely to use meals in 1975 may have needed meals in 1976 because of low income. These people had a decrease in annual income over the year.

--10.3 percent of the older people who could have transferred source of meals in 1975 may have needed meals because of low income in 1976. These people had a temporary need for meals in 1975 and had a decrease in income over the year.

--Of the older people who probably needed meals in 1975, 52.4 percent died in 1976 and 23.2 percent obtained meals in 1976.

--26.8 percent of the older people who were unable to use meals in 1975 were deceased in 1976.

1975 category	Unlikely to use	Could transfer source of meals	May need	Probably need	Unable to use	Institution-alized	Deceased	Total
Unlikely to use								
Number	244	23	95	3	2	1	10	378
Percent	64.6	6.1	25.1	.8	.5	.3	2.6	100.0
Could transfer source of meals								
Number	7	211	29	15	15	4	0	281
Percent	2.5	75.1	10.3	5.3	5.3	1.5	0.0	100.0
May need								
Number	97	55	388	8	5	7	16	576
Percent	16.8	9.5	67.4	1.4	.9	1.2	2.8	100.0
Probably need								
Number	5	19	10	5	0	0	43	82
Percent	6.1	23.2	12.2	6.1	0.0	0.0	52.4	100.0
Unable to use								
Number	1	12	1	2	13	1	11	41
Percent	2.4	29.4	2.4		31.7	2.4	26.8	100.0
Total	354	320	523	33	35	13	80	1358

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #4

SUBJECT: Preventive care for older people

Attached is information on preventive care for older people. This information was extracted from the House of Representatives Subcommittee on Human Services report on "Future Directions for Aging Policy: A Human Service Model". Page 88 has information on preventive care strategy and page 89 has projections over a 10 year period. Page 131-135 is a reprint of the United States General Accounting Office report supporting the projections.

SOURCE OF DATA: "Future Directions for Aging Policy: A Human Service Model", Subcommittee on Human Services of the Select Committee on Aging, U.S. House of Representatives, Committee Publication Number 96-226, May 1980.

CHAPTER XI

The Cost of Complete Overhaul

Our nation faces a two-horned dilemma in care for its seniors. One horn is demographic—sheer numbers. Each year 500,000 people attain senior status, of whom 100,000 have serious disabilities.

Today there may well be 4–4.5 million seniors in need of special assistance.[1]

By the year 2000, 45 percent of the senior population will be elders (75+), or about 5 million persons (today there are 9 million); less conservative estimates put this future figure between 15–19 million.

Of this older population, between 6–8 million will be over 80 years old; 3.8 million 85+.

By the year 2000, there may be more than 10 million people who will be functionally dependent.

The other horn of the dilemma is fiscal: budgets at all governmental levels will be tighter in the years ahead. The mood of the country is opposed to more government spending, and economic conditions have inflated the cost of all government services. The Era of Limits has descended on America's policy planners.

To solve this Human Service Dilemma, a complete overhaul is needed. Figure 15 depicts the specific options legislators must now face and the solutions our foresight studies lead us to recommend. Taken together, these preferred initiatives constitute a research-based, future oriented Human Service Policy Model (see Fig. 15, p. 84). This model is also cost effective, as we propose to demonstrate.

The Alternative Route: Today's Policies Projected

Consider what will happen if nothing is done to overhaul human service to seniors. The current bill for senior care amounts to about $112 billion—5 percent of the Gross National Product and 24 percent of the fiscal year 1978 Federal Budget.[2] Real spending under these programs in 1978 was four times what it was in 1960, when only 2.5 percent of the GNP went for programs for seniors. And from only 13 percent of the federal budget in 1960 the percentage has nearly doubled, largely due to the enactment of such programs as Medicare and Medicaid, real benefit increases in Social Security, and other program expansions.

While these expenditures are staggering, they can only increase in the future if nothing is done today. Under the major programs mentioned, real spending will more than triple to $350 billion by the year 2010. Between 2010 and 2025 when the "baby boom" becomes the "senior boom," real spending will escalate from more than $350 billion to around $635 billion. According to such a projection, it will constitute more than 10 percent of the GNP, more than 40 percent of total federal outlays.

There may be some question about what is included in these overall calculations (for example, should the $20 billion in Social Security disability, sur-

[1] Ethel Shanas estimates that one-fourth of all seniors living in the community require home services. Other estimates range from 27 to 40 percent (GAO). To these must be added the 5 percent who are institutionalized at any one time.

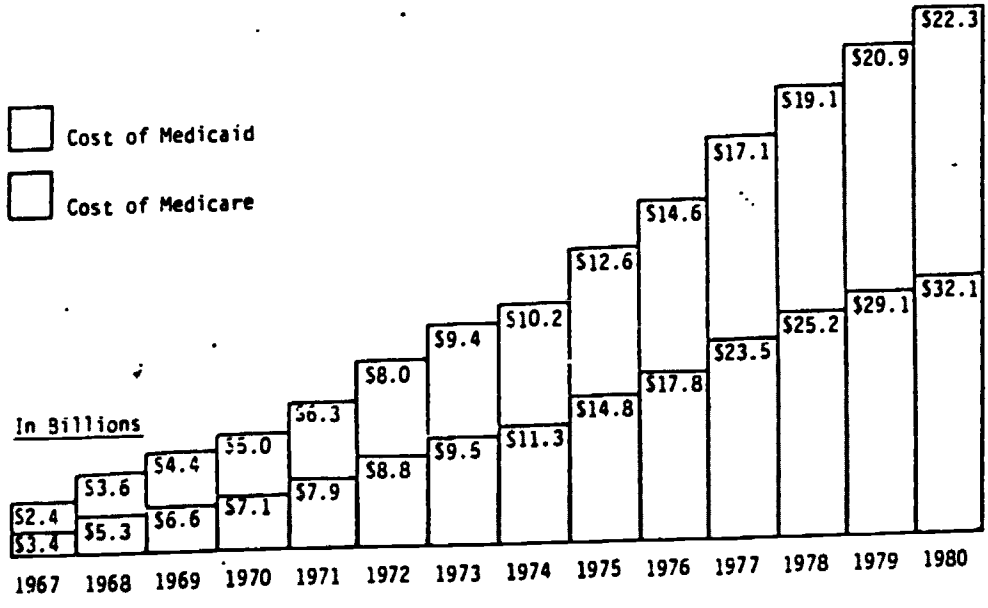
[2] According to then-HEW Secretary Califano, $94 billion was paid in 1978 for Old Age Survivor's and Disability Insurance, Medicare, Medicaid, SSI, and Black Lung Benefits—all programs for which HEW has responsibility. Another $14 billion was paid to this group under the civil service, railroad, and military retirement programs. Still another $4 billion went to seniors under programs providing housing, food stamps, and social and employment services.

vivor. and dependent payments to persons under 62 be counted and should not military retirement be excluded since the average age of retirement is 42.) The conclusion is inescapable: America's senior population costs more now than ever before and will continue to escalate dramatically for many years to come.

A particularly vexing part of the problem is the cost of health care in America. In 1977, total health care expenditures were approximately $163 billion, representing $737 for every man. woman, and child in the population. It is senior Americans, more than any other group, who need and use this care. For example, fiscal year 1977 public expenditures for health care for seniors, including Medicare and Medicaid. amounted to $27.6 billion, a full 67 percent of national health expenditures. Medicare paid only 38 percent of the total senior health care bill. Seniors themselves paid an average $562 "out of pocket" in 1976 for personal health care. In addition to these public and private costs it is estimated that over 50 percent of American seniors have at least one insurance policy to fill gaps in coverage (in some cases witnesses have claimed to have ten, twenty, and even sixty policies!): total premiums are between $500 million and $1 billion annually.

All indications for the future see health care costs growing steadily higher. The Administration's fiscal 1979 budget estimates that spending for Medicaid will jump 15 percent to $20.9 billion (see Fig. 16). Medicaid payments to seniors only will increase 10 percent to $12.1 billion. Longer range projections by Secretary Califano show that the cost of Medicare for seniors will increase in real terms "more than 10 times—twice as fast a pace as the increases in Social Security"—between now and 2025!

FIGURE 16



Note: Official estimates for 1979 and 1980. Years ending June 30, except September 30 after 1976.
Source: U.S. Department of Health, Education, and Welfare, U.S. Office of Management and Budget.

These dramatic cost projections will be spent largely for one kind of health care—a medically oriented. treatment based. and institutionally biased approach. There is relatively little available for other kinds of care. Total national spending for institutional care in fiscal year 1977 was $12.6 billion; 56 percent was paid for by the federal government (Medicaid, $6.4 billion and Medicare

$[illegible] million). Only $575 million of Medicaid and Medicare funds was for ambulatory care or home health services—what we have called, in our model, community care.

If we continue at the present rate, 1985 spending for institutional services will be from $59 to $65 billion, and skilled nursing home expenditures will quadruple by 1985 to $45.6 billion. Ambulatory and home health services expenditures, on the other hand, will remain only a small portion of total long-term medical services outlays—rising to $4–10 billion by fiscal year 1985. That is if there are no legislative changes in current health care policies.

A DECISION AT THE CROSSROADS

It seems therefore that we are at a crossroads. Should we continue care that is acute, medically oriented, treatment based, and institutionally biased—the Medical Model, which we cannot afford in the future—or should we move to a longer-term, preventive, service oriented, home care approach—A Human Service Model, which we can afford? Should we continue in this dead heat to bankruptcy—or should we break step, and attempt a change in policy direction?

In the light of all the data our research has mustered, our committee has opted for policy change—to an affordable Human Service Policy Model (see Fig. 15, p. 84). Accordingly, we foresee a human service system that limits itself to the most vulnerable segment of our adult population (those who are elders), provides a full floor of services to this target group, makes available to them a comprehensive continuum of care that is preventive and community based (but which also includes appropriate institutional care), that is decentralized wherever possible and utilizes all the natural, in-place systems of private care as more humane and less costly.

RESEARCH BACKGROUND FROM GAO STUDIES

Vigorous support for this decision came from the General Accounting Office in the form of two published reports and a third in progress [a] and unpublished materials provided at the subcommittee's request (see Appendix 6). All this data is based on longitudinal studies conducted in Cleveland, Ohio, which were projected nationally at our request.

The GAO's first study ("The Well-Being of Older People in Cleveland, Ohio") looked into the status of Cleveland's seniors. Measurements in five areas of human concern (social and economic status, mental and physical health, and ability to do daily tasks) uncovered that:

23 percent of the senior population was impaired in at least 4 areas.
56 percent was impaired in 1 to 3 areas.
21 percent was not impaired.

The study also revealed that most seniors had someone available to take care of them as long as they needed—42 percent mentioned children, 27 percent a spouse, 10 percent a brother or sister, 9 percent another relative, and 8 percent a friend.

The total cost of senior care in Cleveland was $74.3 million, paid for as follows: $66.7 million came from the federal government ($57.3 for Medicare, Medicaid, and SSI and $9.4 million for the services of various agencies), while $7.6 million came from other sources: county ($.7 million), state ($1.3 million), city ($1.6 million), and the private sector ($4.0 million). This database—(1) status, (2) availability of help, and (3) cost of care—was used and amplified in all later studies.

In the second study ("Home Health—The Need for a National Policy to Better Provide for the Elderly"), the GAO dealt specifically with the need for national policy in home health care. It revealed such telling points as:

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[a] "The Well-Being of Older People in Cleveland, Ohio," GAO, April 1977. "Home Health—The Need for a National Policy to Better Provide for the Elderly," GAO 1977.
"Conditions of Older People: National Information System Needed," a study, now in progress by General Accounting Office.

1. About 60 percent of the elderly who are extremely impaired live outside of institutions. However, these people receive a wide array of in-home services such as personal care, meal preparation, nursing care, homemaker service, and continuous supervision. Other services are transportation, housing, and social and recreational. Because all these services help to maintain a person in his home, they are referred to as "home services."

2. At all levels of impairment, the value of services provided by families and friends greatly exceeded the cost of such services when provided by public agencies at public expense.

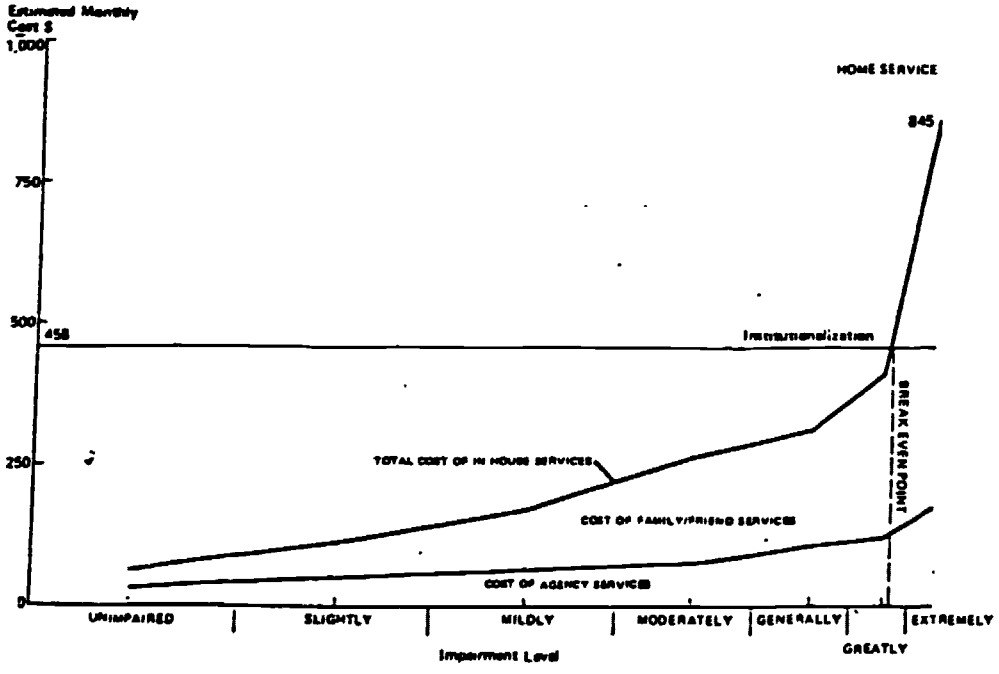
3. As people become more impaired, the costs or values of home services increase and the proportion of care provided by families and friends also increases.

4. At the "greatly impaired" level where the breakeven point in cost is reached, families and friends are providing over 70 percent of the value of services received by older people. Families and friends are providing about $287 per month in services for every $120 being spent by agencies.

5. Until older people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting these people in institutions (see Fig. 17).

FIGURE 17

COMPARISON OF EXTIMATED MONTHLY COST
OF HOME SERVICES AND INSTITUTIONALIZATION AT EACH IMPAIRMENT LEVEL PER INDIVIDUAL



SOURCE.—"Home Health—The Need for a National Policy to Better Provide for the Elderly," General Accounting Office report of Dec. 30, 1977.

This research makes it clear that a community based preventive care strategy is desirable and cost efficient for all except those who are greatly or extremely impaired and require some level of institutional care.

In order to assess how effective and cost efficient our current system of senior care is, the GAO undertook a third study, "Conditions of Older People: National Information System Needed". At our request, further calculations were made on the target group (age 75+) for our model. The results of these two studies bear out the fiscal feasibility of our policy model.

It is now clearly established that elders (75+) should be the target group as they are significantly worse off than senior adults (65–74).[4] Their health is worse (as measured by physical and mental health and ability to do daily tasks), they are more lonely, and their outlook on life is poorer. Overall, the personal condition of 74 percent of our elder population can be deemed "marginal or worse": only 26 percent are in an overall personal condition that can be termed "best".

If the Cleveland data is representative of the nation as a whole, the cost of America's help[5] to today's 7.8 million noninstitutionalized elders is approximately $58 billion. (This figure includes costs of $23.5 billion for direct financial assistance—Social Security, SSI, Veterans' pensions, etc.), which are not included in calculations for our Human Service Policy Model. About 68 percent of all the help (the entire $55 billion) is provided through federal, state, local, and private agencies; most of the help is federally funded.

The single greatest portion of the help (44 percent) is for compensatory services. It is this kind of care that keeps people in their own homes and helps to avoid the escalating cost of inappropriate institutional care. The study indicates that family and friends of elders provide 77 percent of this compensatory help by performing daily tasks for them. This means that the pivotal type of care—aid in tasks of daily living—is already being provided by family and friends, without much help from public or private agencies.

Unfortunately, the Cleveland data also show that not all elders are receiving the care they need. Overall, 73 percent of our elder population is currently in need of some kind of help; 12 percent are receiving all the help they need, but a whopping 61 percent are not. In spite of the rhetoric about objectives, programs, and expenses, the reality is that we are not responding to three out of every five elders in America. The current system of care is not reaching the majority of elders in need.

PROJECTIONS FROM THE GAO DATA BASE

Our recommendation is that the full floor of care must be provided to all elders, and projections from the GAO studies show it could be paid for. Here's how it works. For currently available services[6] to a minority of elders in need, it now costs $4,408 per year per elder, including medical treatment ($1,039), compensatory care ($3,232), social-recreational help ($130), caregiving ($6), and developmental services ($1). Projected nationally, these costs are approximately $34.4 billion/year.

Projecting further from the GAO's Cleveland studies, we have found that the average annual cost of expanding the full floor of services to all elders (75+) would be $741/elder ($132 for medical care, $537 for compensatory services, $64 for social/recreational, $2 for care giving, and $6 for developmental). Nationally, it would cost an additional $5.8 billion the first year.

BETTER CARE AT LOWER COST

However, savings would occur over the long haul because of the overall preventive nature of this approach. The inevitable effect of expanding care to all elders with such preventive measures as self-help health, outreach, better detection of needs, and earlier, more inclusive treatment[7] will ultimately be to lower all medical and compensatory costs.

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[4] Our Subcommittee's definition of senior adult, 60–74 years, adds five years on to the young end of the GAO's definition (65–75), thereby strengthening even further the statistical difference.

[5] Elders receive six different kinds of help: (1) treatment for illnesses, (2) help to compensate for an older person's inability to do daily tasks (e.g., meal preparation, homemaker, etc.) (3) financial help for money problems, (4) social-recreational help for older people with little or no social contact, (5) care giving help when the older person feels there is no one to provide care if he becomes sick or disabled, and (6) developmental help (e.g. educational and employment services) for those people with few interests leading to a negative outlook on life.

[6] For the purposes of our service strategy, direct financial help to seniors is not included: this must be taken up as part of a preventive economic strategy (see Appendix 5).

[7] And indeed the total range of supportive services (transportation, nutrition, homemaker, and home health) can be considered as contributing to this overall improvement in the condition of elders.

The first-year cost would be $40.2 billion ($34.4 billion present cost plus $5.8 billion for expanded care). Probably the only possible savings would be the continued absorption of 77 percent of compensatory service cost by natural care givers (family, friends, etc.). Projected over ten years, however, the changes brought about by expanded care to all elders and the preventive approach result in a combined annual saving of $5.6 billion, as compared with projections reflecting no such changes. This saving virtually covers costs over and above present services to only a portion of the nation's elders. In other words, initial investment to expand help now is paid for by a savings due to reduced need for help in the future.

And the savings shown above do not reflect the effects of either inflation or the increase in the number of elders in the future, both of which could lead to even higher savings. First, inflation is expected to lead to higher medical costs later on, and second, the increasing numbers of elders who had entered the preventive care continuum at an earlier age before they become functionally impaired would be reflected in larger dollar savings.

In a word, the GAO fiscal studies show that:

1. A full floor of care can be provided to all elders,
2. All of whom will receive the appropriate care they need,
3. From the most natural care givers available, and
4. Over a period of ten years, this would not cost the government any more than it is now spending for care to less than half of today's elders.

With this Human Service Policy Model, the nation could do a better job for all elders than is now being done for only a few—a result that can be achieved at no extra cost. This is the impact of prevention; for the first time, hard data show that such a human service approach would work.

APPENDIX 6

STUDIES OF ELDERS FROM THE GENERAL ACCOUNTING OFFICE

People 75 years old and older; comparison of the personal conditions of older people

In 1975, we measured the personal conditions—health, security, loneliness, outlook on life—of two groups of older people in Cleveland. The first group was composed of people 65 to 74 years old and the second of people 75 years old and over. A comparison of the personal conditions of these two groups showed that overall people 75 years old and over were generally in a worse condition than those age 65–74. Comparisons of the two age groups can be made for all personal conditions by examining the information in the following two tables. The first table shows the personal conditions of people 65 to 74 years old.

[In percent]

Conditions [1]	Level of conditions			
	Best	Marginal	Worst	Total
Health	61	25	14	100
Security	[2] 51	[2] 25	[2] 24	100
Loneliness	64	25	11	100
Outlook on life	28	49	23	100
Overall	35	47	18	100

[1] For a description of conditions and level of conditions, see the methodology.
[2] No statistically significant difference between the age groups at this level of personal condition.

The personal conditions of people 75 years old and over are shown in the following table.

[In percent]

Conditions [1]	Level of conditions			
	Best	Marginal	Worst	Total
Health	42	32	26	100
Security	[2] 52	[2] 24	[2] 24	100
Loneliness	55	31	14	100
Outlook on life	20	51	29	100
Overall	26	49	25	100

[1] For a description of conditions and level of conditions, see the methodology.
[2] No statistically significant difference between the age groups at this level of personal condition.

ESTIMATE OF THE PERCENTAGE OF PEOPLE WHO ARE FUNCTIONALLY IMPAIRED BY AGE GROUP
PEOPLE 65 TO 74 YR OLD

	Percent of people in sample	Projection of number of people nationwide [1] (millions)
Ability to do daily tasks: [2]		
Able to do all tasks without help	71	9.4
Can do all daily task but only with help in 1 or more	21	2.8
Can not do at least 1 task even with help	8	1.0
Total	100	13.2

[1] Projection based on an estimated 13,152,000 people 65 to 74 yr old.
[2] Daily tasks include preparing meals, bathing, walking, shopping, eating, etc. Details on those daily tasks are described in our prior report on pp. 57–70 of app. IV.

A comparison of the two age groups shows that people 75 years and older are significantly more functionally impaired than those 65 to 74 years old.

PEOPLE 75 YR OLD AND OLDER

	Percent of people in sample	Projection of number of people nationwide[1] (millions)
Ability to do daily tasks:[2]		
Able to do all tasks without help	46	3.6
Can do all daily tasks but only with help in 1 or more	36	2.8
Cannot do at least 1 task even with help	18	1.4
Total	100	7.8

[1] Projection based on an estimated 7,808,000 people 75 yr. old and over.
[2] Daily tasks include preparing meals, bathing, walking, shopping, eating, etc. Details on those daily tasks are described in our prior report on pp. 57-60 of app. IV.

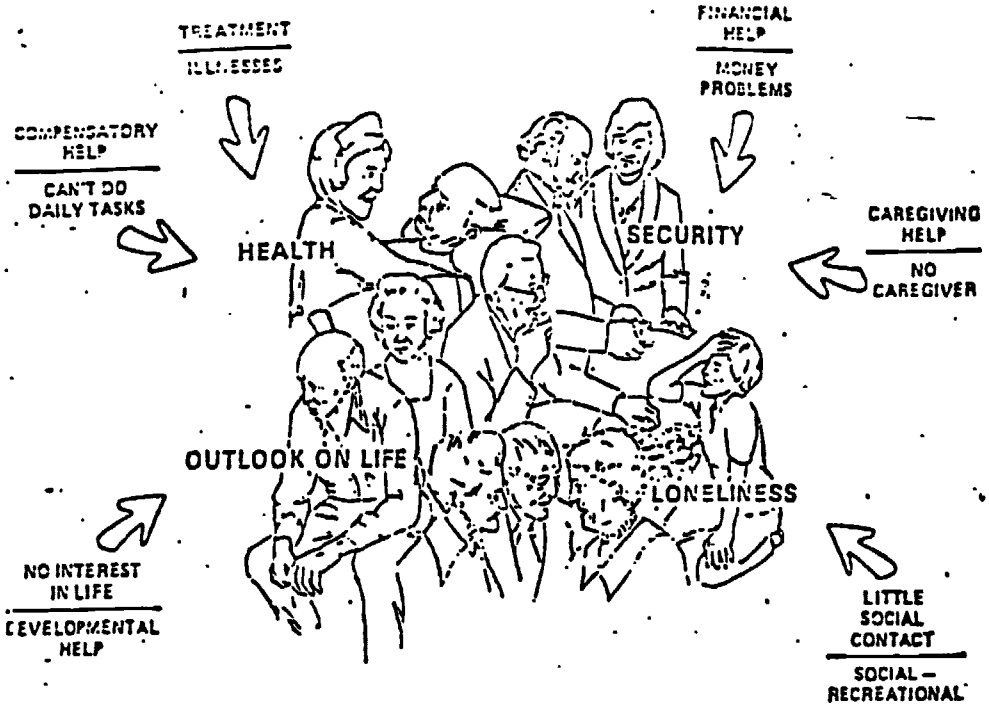
A comparison of the two groups shows that people 75 years old and older are significantly more functionally impaired than those 65 to 74 years old.

Services received by people 75 years old and over

We could not obtain national estimates of the cost of help provided to older people from all sources. Therefore, we projected the results found in Cleveland to the 7.8 million non-institutionalized older people 75 years old and older in 1975 in the Nation. These projections, which may or may not be representative of the Nation as a whole, show that about $58 billion in help is provided annually to the 7.8 million people in this country who are 75 years old and older and live outside institutions. About 63 percent of the help older people receive is provided through Federal, State, local, and private agencies. Most of this help is federally funded.

Many problems afflict older people and more than one kind of help may be appropriate for each problem. Further, it is not unusual for persons to have numerous problems which must be addressed simultaneously. To illustrate, the diagram on the following page depicts the whole person—conditions, related problems, and kinds of help currently being provided. It shows that older people could receive six kinds of help:

1. *Treatment* for illnesses,
2. *Compensatory* help to compensate for an older person's inability to do daily tasks (e.g., meal preparation, homemaker, etc.),
3. *Financial help* for money problems,
4. *Social-recreational help* for older people with little or no social contact,
5. *Caregiving help* when the older person feels there is no one to provide care if he becomes sick or disabled, and
6. *Developmental help* (e.g., educational and employment services) for those people with little interests which leads to a negative outlook on life as illustrated in the following figure.



In Cleveland the annual cost of providing these kinds of help to people 75 years old and over averaged $7,413 a person. Various agencies provided $4,682 worth of help, and family and friends provided the remaining $2,731, as shown in the following table:

AVERAGE COST OF HELP FOR EACH PERSON IN CLEVELAND 75 YR OLD AND OVER

Kind of help	From family and friends	From agencies	Total		Our projected national estimate [1] (billions)
			Amount	Percent	
Medical treatment	0	$1,039	$1,039	14.02	$8.1
Compensatory (77 pe cent)	$2,492	740	3,232	43.60	25.2
Financial	237	2,768	3,005	40.54	23.5
Social-recreational [2]	0	130	130	1.75	1.0
Caregiving	2	4	6	.08	.05
Developmental [2]	0	1	1	.01	.01
	2,731	4,682	7,413	100.00	57.9
Percent	37	63	100		

[1] Projected national estimate based on the total cost of services from all sources and an estimated 7,808,000 people age 75 and over in 1975 who are not institutionalized.
[2] As defined in our review, these helps can only be proved by agencies.

As shown, the greatest portion (44 percent) of help is compensatory for inability to perform daily tasks without help. The next greatest is financial help (41 percent) and then medical (14 percent). Social-recreational help accounts for only 2 percent and caregiving and developmental help each account for less than 1 percent.

Comparing sources of help, the families and friends of older people provide 77 percent ($2,492 of $3,232) of the compensatory help by performing daily tasks for them, and only about 8 percent of the financial help ($237 of $3,005). The other kinds are provided mostly by public and private agencies funded under Federal programs. From the agency standpoint, 59 percent of their cost was in financial help ($2,768 of $4,682) and 22 percent in treatment of illnesses ($1,039 of $4,682).

Unmet needs of people 75 years old and over

We determined the helps needed by people 75 years old and over and compared their needs to the helps they were receiving. This comparison showed the extent of unmet needs by kinds of help. The kinds of help that were reaching the least proportion of those in need were financial. social-recreational and developmental. Overall. 73 percent of these people needed some kind of help—12 percent received all the help needed and 61 percent needed additional help. The following table shows the unmet needs of people 75 years old and over for each kind of help.

Kind of help	Definition of need	Percent of sample age 75 plus			
		Not in need	In need	Receiving all the help needed	Not receiving all the help needed
Medical treatment	Have illness that interferes a great deal with activities.	61	39	16	23
Compensatory	Cannot do daily task without help	46	54	35	19
Financial	Inadequacy in amount of money	84	16	1	15
Social-recreational	Infrequent social contacts	81	19	1	18
Caregiving	No one available to help if become sick or disabled or help available only now and then.	86	14	5	9
Developmental	Negative outlook on life	71	29	1	28
Overall	1 or more of the above	27	73	12	61

First year costs to expand help to people 75 years old and older

Expansion of all six kinds of help to people 75 years old and older would mean a 24 percent increase in total cost. More than half ($8 billion) of the additional cost to expand help would be for financial help. Nearly one-third ($4.2 billion) would be needed for compensatory help and about $1 billion would go for additional medical help. The following table shows the average costs per person along with our estimates of cost to expand each kind of help to those in need. (These estimates do not reflect added costs due to the predicted increase in the older population in the future or to inflation.)

Kind of help	Additional cost to expand help			
	Average cost per person without expanding help	Average per person	National total estimate (millions)	Percent of total additional cost
Medical treatment	$1,039	$132	$1,031	7.5
Compensatory	3,232	537	4,193	30.3
Financial	3,005	1,029	8,034	58.1
Social-recreational	130	64	500	3.6
Caregiving	6	2	16	.1
Developmental	1	6	47	.4
Total	7,413	1,770	13,821	100.0

If the family and friends of older people do not absorb any of the $13.8 billion increase, public costs would have to increase by more than one-third (38 percent) to expand help to all those in need. However, if the family and friends could be encouraged to provide more compensatory help (in the same proportion as they did in 1975), public costs would have to be increased by much less. Nationally, we estimate that $3.2 billion less public money would be required to expand help if family and friends would provide this additional compensatory help.

First year costs to expand help to people 65 years old and older

Expansion of all six kinds of help would mean a 24 percent increase in total cost. More than half ($19.5 billion) of the additional cost to expand help would be for financial help. Nearly one-third ($10.5 billion) would be needed for compensatory help and about $2.3 billion would go for additional medical help.

The following table shows the average cost per person along with our estimates of cost to expand each kind of help to those in need. These estimates do not reflect added costs due to the predicted increase in the older population in the future or to inflation.

Kind of help	Average cost per person without expanding help	Additional cost to expand help: Average per person	Additional cost to expand help: National total estimate (millions)	Additional cost to expand help: Percent of total additional cost
Medical treatment	$960	$109	$2,229	6.8
Compensatory	2,399	498	10,458	31.1
Financial	3,116	930	19,530	58.1
Social-recreational	134	56	1,176	3.5
Caregiving	5	2	42	.1
Developmental	1	6	126	.4
Total	6,617	1,601	33,621	100.0

If the family and friends of older people do not absorb any of the $34 billion increase, public costs would have to increase by more than one-third (35 percent) to expand help to all those in need. However, if the family and friends could be encouraged to provide more compensatory help (in the same proportion as they did in 1975), public costs would have to be increased by much less. Nationally, we estimate that $8 billion less public money would be required to expand help if family and friends would provide this additional compensatory help.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #5

SUBJECT: Source of income of older people in urban and rural locations

Attached is information on source of income of older people in three locations--Ohio, Oregon, and Kentucky. This information is extracted from a United States General Accounting Office report to the Federal Council on Aging.

SOURCE OF DATA: "Comparison of Data on Older People in Three Rural and Urban Locations", United States General Accounting Office report, HRD-80-83, dated May 23, 1980.

QUESTIONS AND ANSWERS ABOUT PEOPLE

65 YEARS OLD AND OLDER

IN THREE LOCATIONS

DESCRIPTION OF DATA BASES

The data for our comparative analyses come from three separate studies that included information about people 65 years old and older not residing in institutions. The older people in the samples lived in Cleveland, Ohio; Lane County, Oregon; and the Gateway Health District, northeastern Kentucky. Using Bureau of Census definitions of rural and urban, we classified the data from Cleveland as urban, the data from Lane County as rural and urban, and the data from northeastern Kentucky as rural.

In our comparative analyses we applied statistical tests to determine if the differences we observed among locations were statistically significant. These statistical tests consider the sample sizes. When we state differences between locations in answering the questions, these differences are statistically significant.

Although the older people in the three locations were interviewed at different times, our statistical procedures made it possible to compare the information. We did not compare people by income, sex, or race because the total number of people in these comparisions was too small to be statistically meaningful.

Cleveland, Ohio

We took a statistical sample of people from over 80,000 people in Cleveland who were 65 years old and older and were not in institutions, such as nursing homes. In our study, 1,609 older people were interviewed by Case Western University in 1975 and 1,311 were reinterviewed a year later. Our analysis used data on the 1,311 older people interviewed in 1976. We refer to these people in the analyses as urban Cleveland.

Lane County, Oregon

The Lane County study was made by the University of Oregon and the Lane County Community Health and Social Services Department. The study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county. The county, located in west-central Oregon, contains two adjacent cities, Eugene and Springfield, which had a 1976 combined population of about 132,000 (54 percent of the county's population). The county also contains four other incorporated areas, each with a population over 2,500.

The selection process for the Oregon study involved a statistical sample of 1,197 people from six subareas of the county. The people sampled were interviewed in 1978. Data from the study are to be used for planning and evaluation with a capability to study rural and urban differences.

We segregated data on 868 persons 65 years old and older from the Lane County sample. We divided the data into three groups, which we refer to as rural Lane County, Oregon; urban Lane County, Oregon; and Lane County, Oregon (town). They are described as follows:

--Rural Lane County, Oregon--426 older persons who live in unincorporated areas consisting of farms, timberland, or open space or in incorporated areas with populations of fewer than 2,500 people.

--Urban Lane County, Oregon--318 older persons who live within the corporation limits of Eugene and Springfield, Oregon. Over 60 percent of Lane County's residents who are 65 years old and older live in these two cities.

--Lane County, Oregon (town)--124 older persons who live in three small towns--Florence, Cottage Grove, and Oakridge. These towns have populations of 3,050, 6,900, and 3,930, respectively.

Gateway Health District, Kentucky

The Gateway Health District studied the demographic characteristics and needs of people 60 years old and older living in the district. This district consists of five counties in northeastern Kentucky (Bath, Menifee, Montgomery, Morgan, and Rowan) within the Cumberland Plateau. The district is a severely economically depressed rural area consisting of small communities and homes dispersed over a large area of mountainous terrain in Appalachia. In 1970, this area had a population of 55,678.

A statistical sample of people 60 years old and older living in the five-county area was selected for interviews. This sample included people from rural and urban areas, and people in institutions. People not in institutions were interviewed in 1977. Data on 128 people 65 years old and older, not in institutions and living in unincorporated or incorporated areas of fewer than 2,500 people, were segregated by us from this sample and used in our comparative analyses. We refer to these 128 people as rural northeastern Kentucky.

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All three studies used the Older Americans Resources and Service Questionnaire developed by a multidisciplinary team headed by Dr. George Maddox and Dr. Eric Pfeiffer at the Duke University Center for the Study of Aging and Human Development. During a personal interview, the older people in the three studies replied to 101 questions about their well-being in five areas of functioning--social, economic, mental, physical, and activities of daily living. Data from these interviews were used to answer the following questions. The questions are grouped by subject areas--transportation, housing, income, and employment.

Income

1. Question: Did family income vary among the three locations?

Answer: Family incomes were lower in northeastern Kentucky than in the other locations. Over 52 percent of the older people in northeastern Kentucky had incomes of less than $3,000, compared to 32 percent in Cleveland and 15 percent or less in Lane County.

Because married people often have higher incomes than single people and because the percentage of married people varies at each location, we analyzed income by location and marital status. As shown in the following table (even when marital status is considered), older people in northeastern Kentucky have lower incomes than those in other locations. For example, 80 percent of the married people in northeastern Kentucky have an income of less than $5,000. In urban Lane County only 11 percent of the married people had an income under $5,000.

Income range	Marital status	Urban: Cleveland	Urban: Lane County, Oregon	Lane County, Oregon (town)	Rural: Lane County, Oregon	Rural: Northeastern Kentucky
		(percent)				
Less than $3,000	Married	6	1	3	3	39
	Not married	48	29	32	37	73
		35	11	15	29	80
$3,000 to $3,999	Married	10	3	7	12	23
	Not married	23	26	25	24	10
$4,000 to $4,999	Married	19	7	5	14	18
	Not married	11	14	11	9	0
$5,000 or over	Married	65	89	85	71	20
	Not married	18	31	32	30	17

2. Question: Were there differences in sources of income among the three locations?

Answer: Similarities: Most older people at the three locations had income from social security--ranging from 88 percent in northeastern Kentucky to 96 percent in urban Lane County. Differences: Fewer people in northeastern Kentucky (14 percent) had retirement pensions than elsewhere (ranging from 33 percent in rural Lane County to 43 percent in urban Lane County). Also, more older people in northeastern Kentucky had income from Supplemental Security Income payments (18 percent) compared to the other locations--3 percent in rural Lane County, 5 percent in Cleveland, and 1 percent in urban Lane County. This information is shown in the following table.

Income sources	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Wage, salary, business income	8	18	10	12	13
Rental, interest, investments	23	45	36	27	19
Retirement pension	34	43	36	33	14
Veterans' benefits	5	7	11	5	9
Social Security	92	96	94	93	88
Supplemental Security Income	5	1	1	3	18

3. Question: Did the number of self-supporting households differ among the three locations?

Answer: We defined a household to be self-supporting if the family did not receive financial help in the form of rent, food, or regular money assistance from family or private organizations. Cleveland had significantly more households receiving some form of financial aid than did Lane County. For example, 27 percent received aid in Cleveland, compared to a range of 10 to 14 percent in Lane County, as shown in the following table.

Was household self-supporting?	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Yes	73	87	90	86	81
No	27	13	10	14	19
Total	100	100	100	100	100

Employment

1. Question: What was the employment status of the older people in the three locations?

Answer: Only a small percentage of the older people were employed full time in any of the locations--1 percent in northeastern Kentucky to 3 percent in urban Lane County. About 5 to 11 percent were employed part time, as shown in the following table.

Employment status	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Full time	2	3	1	1	1
Part time	6	11	9	5	5
Not employed	92	86	90	94	94
Total	100	100	100	100	100

2. Question: Were older people seeking employment?

Answer: Most older people were not seeking employment. Three percent or less of the older people in all of the locations were seeking employment, as shown in the following table.

Not employed but seeking work	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Yes	3	2	1	0	1
No	97	98	99	100	99
Total	100	100	100	100	100

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #6

SUBJECT: Older people and the poverty level

Attached is our national estimates of the number of older people at the poverty level. This information is extracted from the United States General Accounting Office briefing on the nutritional health of older people provided to the staff of the House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition.

SOURCE OF DATA: " Information on the Nutritional Health of the Elderly", United States General Accounting Office Briefing, House of Representatives Subcommittee on Domestic Marketing. Consumer Relations, and Nutrition.

WHO ARE THE ELDERLY?

The elderly are persons aged 65 and over. They are a growing segment of the population which has proportionately more poor than the population in general. As a group they account for about 30 percent of the cost of all the health services and supplies received directly by individuals.

The lower age limit of 65 is partially arbitrary and partially a recognition of factors which have combined to make the attainment of age 65 a milestone--a time of Social Security benefits, Medicare coverage, income tax advantages and reductions in transit fares and admission prices. Not everything, however, is keyed to age 65. The Older American Act of 1965, as amended, authorizes nutrition and social services for persons aged 60 and older and sets 55 as the minimum age for participation in the community service employment program established by the Act. As mentioned in the body of our letter, "older" Americans will be used when we refer to persons aged 60 and over.

THE ELDERLY ARE A GROWING POPULATION WHICH INCLUDES MANY POOR

The proportion of elderly persons in the total population is likely to continue to rise, but more slowly than in the past. The rise may not be steady because of fluctuations in the fertil-

...ever, two of the three series of projections published by the Census Bureau show a general rise in the proportion and all of the projected range for that proportion is above the level of 1976. The Bureau of the Census projected percents for persons aged 65 and over, including the projected range, show that the elderly are a growing segment of the population.

Year	The Elderly as a Percent of Total Population
1976	10.7
1980	11.2 (11.1 - 11.3)
1990	12.2 (11.7 - 12.6)
2000	12.2 (11.3 - 12.9)

According to the Bureau of the Census, between 1976 and the end of the century the population aged 65 and over will increase by nearly 40 percent, from 23 million in 1976 to 32 million in 2000. In this period all age segments of the older population are expected to grow rapidly, particularly the extreme aged.

Total Population in the Older Ages a/

	60 years and over	65 years and over	70 years and over	75 years and over	85 years and over
1970	28,753	20,087	13,065	7,600	1,432
1976	32,244	22,934	14,654	8,741	1,966
1980	34,724	24,927	16,227	9,434	2,294
1990	40,184	29,824	19,803	12,021	2,881
2000	41,973	31,822	22,630	14,384	3,756

a/ Numbers in thousands. Estimates and projections as of July 1. Figures refer to the total population of the 50 states and District of Columbia.

About 1 out of every 7 persons 65 years and over in 1977, or 3.2 million persons, lived in families or as unrelated individuals with incomes low enough to place them below the Bureau of the Census definition of the poverty level.

Although the total number of poor people in the United States has not changed much since 1970, the number of elderly poor (those 65 years and over) dropped by about 1.5 million, or from one-fourth of the age group in 1970 to about one-seventh in 1977.

Poverty Status of Persons of All Ages a/ and Persons 65 Years and Older

	All persons below poverty level		Persons 65 years and over below poverty level	
	Number	Percent	Number	Percent
1970	25,420	12.6	4,709	24.5
1972	24,460	11.9	3,733	18.6
1974	24,260	11.6	3,308	15.7
1976	24,975	11.8	3,313	15.0
1977	24,720	11.6	3,177	14.1

a/ Numbers in thousands. Persons as of March of the following year. Numbers exclude unrelated individuals under 14 years old, inmates of institutions, and members of the Armed Forces

As shown below, about 10.5 million people age 65 and over, about 47 percent of the total, had incomes of less than $3,500.

Total Money Income in 1977
of Persons 65 Years and Over a/

	Male	Female	Total	Cumulative Total	Cumulative Percent
Total	9,170	13,298	22,468	--	
With income	9,145	12,322	21,467	--	
Without income	25	976	1,001	1,001	4.5
$1 to $999	87	417	504	1,505	6.7
$1,000 to $1,499	173	1,062	1,235	2,740	12.2
$1,500 to $1,999	244	1,489	1,733	4,473	19.9
$2,000 to $2,499	591	1,686	2,277	6,750	30.1
$2,500 to $2,999	510	1,286	1,796	8,546	38.0
$3,000 to $3,499	706	1,252	1,958	10,504	46.6
$3,500 to $3,999	696	1,033	1,729	12,233	54.5
$4,000 to $4,999	1,066	1,139	2,205	14,438	64.3
$5,000 to $5,999	950	772	1,722	16,160	71.9
$6,000 to $6,999	793	515	1,308	17,468	77.8
$7,000 to $7,999	597	394	991	18,459	82.2
$8,000 to $8,999	431	275	706	19,165	85.3
$9,000 to $9,999	339	194	533	19,698	87.7
$10,000 to $11,999	518	245	763	20,461	91.1
$12,000 to $14,999	429	269	698	21,159	94.2
$15,000 to $19,999	450	165	615	21,774	96.9
$20,000 to $24,999	199	63	262	22,036	98.1
$25,000 and over	366	64	430	22,466	100.0

a/ Numbers in thousands. Persons as of March 1978.

According to the Administration on Aging (AOA) although the number of elderly poor declined in recent years, this decline was partially offset by an increase in the number of elderly persons with incomes above the poverty level but below the "near-poor" level (125 percent of the poverty level).

Projections for persons aged 65 years and over below the poverty level were not readily available. However, a 1978 AOA statistical report on prospects for the future elderly-population states that women and minorities--subgroups which tend to have worked less

in the past and have worked in lower paying occupations, and therefore tend to have fewer financial assets to rely on after retirement--will insure the continued existance of a substantial number of elderly persons with incomes near or below the poverty level.

To get some idea of what the low income elderly population might be in 1990 we made some estimates based on assumptions about the number of elderly poor in relation to total population. These estimates in no way take into account changes in the inflation rate or the level at which poverty is defined--two factors which could dramatically influence the size of the low-income population.

If the ratio of elderly poor in relation to the total elderly stabilizes at 14 percent, we can expect there will be about 4,175,000 persons 65 years and over below the poverty level in 1990. If the ratio of elderly poor continues to decrease and stabilizes at the ratio for the poor of all ages (11.6 percent in 1977), we can expect there will be about 3,460,000 persons 65 years and over below the poverty level in 1990.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #7

SUBJECT: Cost of home services versus cost of institutionalization

Attached is information on cost of home services compared to cost of institutionalization. Page 8 shows source of home services and page 10 graphically presents the cost comparisons. This information is extracted from a United States General Accounting Office report to the Congress.

SOURCE OF DATA: "Home Health--The Need for a National Policy to Better Provide for the Elderly", United States General Accounting Office report, HRD-78-19, dated December 30, 1977.

COSTS OF HOME SERVICES COMPARED TO INSTITUTIONALIZATION

About 60 percent of the elderly who are extremely impaired live outside of institutions. However, these people receive a wide array of in-home services such as personal care, meal preparation, nursing care, homemaker service, and continuous supervision. Other services are transportation, housing, and social and recreational. Because all these services help to maintain a person in his home, they are called, for simplicity, "home services." These home services are combined with each other to help sustain health, activity, and independence. The combination of services and frequency of each service varies depending on the level of impairment of the individual.

At all levels of impairment, the value of services provided by families and friends greatly exceeded that cost of services provided by public agencies at public expense. The total cost of these home services becomes greater than the cost of institutionalization for older people who are greatly or extremely impaired. About 17 percent of those 65 or over fall into these categories.

We examined the relationships between people in Cleveland at different levels of impairment, the services they received, and how these services were delivered. Our analysis showed:

--As expected, people who are more impaired receive more services than people who are less impaired.

--Public agencies are currently spending less per person for home services than is spent for institutional care regardless of the levels of impairment.

--Eighty-seven percent of older people institutionalized are greatly or extremely impaired compared to 14 percent of those at home.

--Care provided to the greatly or extremely impaired living at home is similar to institutional care.

--Family and friends provide over 50 percent of the services received by older persons at all impairment levels and over 70 percent of the services received by the greatly or extremely impaired.

The cost of the services that older people received in Cleveland should not be considered indicative of what expenditures would be if a comprehensive federally funded program was established to provide home-care services for older people--partially because our analysis was based on services actually received as opposed to services which might be considered as necessary and thus reimbursable under some structured criteria.

Our report, "The Well-being of Older People in Cleveland, Ohio" (HRD-77-70, Apr. 19, 1977), showed that some people did not use services because the services were not available in certain areas of Cleveland or people were not aware of the availability of services.

If Federal funding were increased, more services would become available and their availability would probably be better publicized, resulting in increased use. Also, the availability of services at public expense could result in less services being provided by families, friends, and charitable organizations.

To assist in understanding our analysis, we divided this chapter into the following three sections:

--The methodology section shows how we did our analysis.

--The cost comparison section shows how we determined if the cost of maintaining a person in a home equals that of maintaining a person in an institution.

--The families and friends section shows the significant role they play in supporting an older person in the community.

METHODOLOGY

The information contained in this chapter is based on an extensive data base developed in our review of the well-being of older people in Cleveland, Ohio.

This data base contains information on the characteristics of 1,609 people 65 years and over sampled from the Cleveland population. The dominant characterisitics of those

who are greatly or extremely impaired in Cleveland, Ohio, can be found in appendix II. Further, information on the services these people received has been collected in 2 phases over 1.5 years from 118 agencies.

In studying the well-being status of older people, we used a questionnaire developed by the Duke University Center for the Study of Aging and Human Development in collaboration with the Administration on Aging, the then Social and Rehabilitation Service, and the Health Resources Administration of HEW. Questions were asked about an older person's status in the following areas of functioning (1) social, (2) economic, (3) mental, (4) physical, and (5) activities of daily living.

The older person's responses to questions during the interview were used to categorize his or her status as one of the following: excellent, good, mildly impaired, moderately impaired, severely impaired, or totally impaired. For example, the older person's physical health status was placed in the appropriate category on the following scale after considering his or her responses to 22 detailed questions on physical health:

1. In excellent physical health.
   Engages in vigorous physical activity, either regularly or at least from time to time.

2. In good physical health.
   No significant illnesses or disabilities. Only routine medical care such as annual checkups required.

3. Mildly physically impaired.
   Has only minor illnesses and/or disabilities which might benefit from medical treatment or corrective measures.

4. Moderately physically impaired.
   Has one or more diseases or disabilities which are either painful or require substantial medical treatment.

5. Severely physically impaired.
   Has one or more illnesses or disabilities which are either severely painful or life threatening or require extensive medical treatment.

6. Totally physically impaired.
Confined to bed and requiring full-time medical assistance or nursing care to maintain vital bodily functions.

Although the responses showed a separate status for the five areas of human functioning, we wanted to consider the entire person or what we have defined as the impairment of the person. Therefore, we combined the status in each of the five areas to form the overall well-being of the individual as shown in the following groupings:

Impairment level	Description based on five areas included in Duke University questionnaire
Unimpaired	Excellent or good in all five areas of human functioning.
Slighly impaired	Excellent or good in four areas.
Mildly impaired	Mildly or moderately impaired in two areas or mildly or moderatly impaired in one area and severely or completely impaired in another.
Moderately impaired	Mildly or moderately impaired in three areas and or mildly or moderately impaired in two and severely or completely impaired in one.
Generally impaired	Mildly or moderately impaired in four areas.
Greatly impaired	Mildly or moderately impaired in three areas, and severely or completely impaired in another.
Very greatly impaired	Mildly or moderately impaired in all five areas.
Extremely impaired	Mildly or moderately impaired in four areas and severely or completely impaired in the other, or severely or completely impaired in two or more areas.

To assure ourselves of the representativeness of our results, we compared our data from the first phase with national statistics and similar analyses done in Durham, North Carolina, by Duke University. To assist us in interpreting the results of our analyses in both the prior and current reviews, we used consultants from the fields of gerontology and operations research.

Comparison of the data in Cleveland with similar data gathered in Durham, North Carolina, showed the two samples were similar. The results of the two studies showed both populations were similar in demographic characteristics and individual functional areas. Further, the status and distribution by impairment level of older persons in Cleveland and Durham were similar.

Using the questionnaire responses, we combined the separate status for the five areas into the following seven groupings: (1) unimpaired, (2) slightly impaired, (3) mildly impaired, (4) moderately impaired, (5) generally impaired, (6) greatly impaired, and (7) extremely impaired. The greatly and very greatly impaired groupings used in our prior report were consolidated into the greatly impaired because we found that the overall impairment of people in these two groups were similar.

Using the questionnaire and service information gathered during the first phase of the prior review, we (1) developed the services each person received, (2) determined the source that provided each service, and (3) determined an average usage at each of the seven impairment levels. We then contacted 27 Federal, State, local, and private agencies to discuss service costs and to gather cost data for the period October 1976 to March 1977. From this information, an average cost was developed for each service. These average costs appear reasonable in comparison to similar data from Chicago, Illinois, compiled by the Mayor's Commission on Aging, and Durham, North Carolina.

To develop service costs for each impairment level we combined the four data elements:

--Cost or value of each service.

--Average usage of each service per month.

--Percentage receiving each service from an agency.

--Percentage receiving each service from family or friends.

The cost assigned to services provided by agencies and families and friends was calculated individually for each impairment level.

The agency cost was calculated in terms of an average monthly cost per individual. This calculation included

--percentage receiving service,

--monthly frequency of use of the service, and

--cost of service.

The agency portion was mostly funded through Federal sources and included services provided to older persons by Government and private service providers.

This process was repeated to determine the value of services provided by families and friends. In the absence of family and friends, any services received would have to be from an agency. Therefore, we assigned the same cost to family and friend services that we found for agencies.

The two service costs (agency, family and friends) were added to determine the total cost or value of services provided at each impairment level. The total service costs were plotted by impairment level. The resulting curve was compared to the cost on institutionalization based on January to February 1977 reimbursements to skilled nursing and intermediate care facilities in Ohio.

COST COMPARISON

In comparing the costs to maintain older people in their homes versus an institution, we first analyzed each situation separately. The first group we analyzed was non-institutionalized people (about 95 percent of persons 65 years or over). The second group was institutionalized people. We then compared the costs for both groups to determine at what impairment level the total cost to keep an older person at home (including the value of the service provided by family and friends) equals the cost to institutionalize the person.

While we do not believe that a decision to institutionalize an individual who wants to remain at home should be based on cost comparisons alone, we believe that these comparisons provide some insight as to the economic, physical, and social factors which have influenced such decisions.

Noninstitutionalized people

Several factors contribute to a person's ability to exist outside an institution. One is the level of impairment. People who are more impaired receive more services than people who are less impaired. As the table below shows, transportation, checking (periodic monitoring by telephone or personal contact), and social and recreational services are received by the less impaired. At the more impaired levels, social and recreational services drop drastically while nursing care, personal care, and continuous supervision increase significantly. Eventually the most severely impaired people require almost constant care.

The Primary Services Received At Each Impairment Level

Service	Unimpaired	Slightly	Mildly	Moderately	Severally	Greatly	Extremely
Transportation	x	x	x	x	x	x	x
Checking (periodic monitoring)	x	x	x	x	x	x	x
Social/recreational	x	x	x	x	x		
Homemaker			x	x	x	x	x
Housing			x	x	x	x	x
Administrative/legal				x	x	x	x
Meal preparation				x	x	x	x
Food, groceries				x	x	x	x
Personal care (aiding an individual with dressing, bathing, etc.)						x	x
Continuous supervision (full-time monitoring)							x
Nursing care (skilled care)							x

At the most impaired levels, home-service values increase rapidly and the proportion of care provided by families and friends also increases. The following table shows that the family and friend's portion is significantly higher than the agency's portion at all impairment levels.

Impairment level	(Average monthly cost or value per individual) Family and friends	Agency	Total
Unimpaired	$ 37	$ 26	$ 63
Slightly	63	47	110
Mildly	111	65	176
Moderately	181	78	259
Generally	204	100	304
Greatly	287	120	407
Extremely	673	172	845

An important aspect of institutional care is that a person receives a package of services. Home care also requires a package of services and the care needed by the greatly or extremely impaired living at home is similar to that needed by those in institutions. For example, an arthritic may need physical therapy twice a week but may also need help in getting out of bed or preparing his or her meals. As a person becomes more impaired, more services will be added to the package and the person's use of these services will increase.

Institutionalized people

Five precent or about 1.2 million of the 23 million people 65 years old or over reside in various types of institutions ranging from rest homes to skilled nursing facilities.

Cost data for Ohio's medical nursing homes from January to February 1977, including intermediate care and skilled nursing facilities, showed the average total cost for long-term institutionalization reimbursed under its Medicaid system was $597 per month per individual. However, off-sets from Social Security, pensions, and other income from those individuals reduced the average cost to $458 per month per individual. Although these costs are based on Ohio data and

will vary in other States, we compared them to national averages and found them to be representative.

These costs include room and board, laundry, medical equipment, and supplies, including over-the-counter drugs and supportive devices, personal care, nursing care, supportive rehabilitative services, and social activities. Doctor fees, prescription drugs, and other medical costs are not included in either the costs of institutionalization or home services because medical expenditures are generally related to physical conditions and should be similar for people in institutions and for people living in homes.

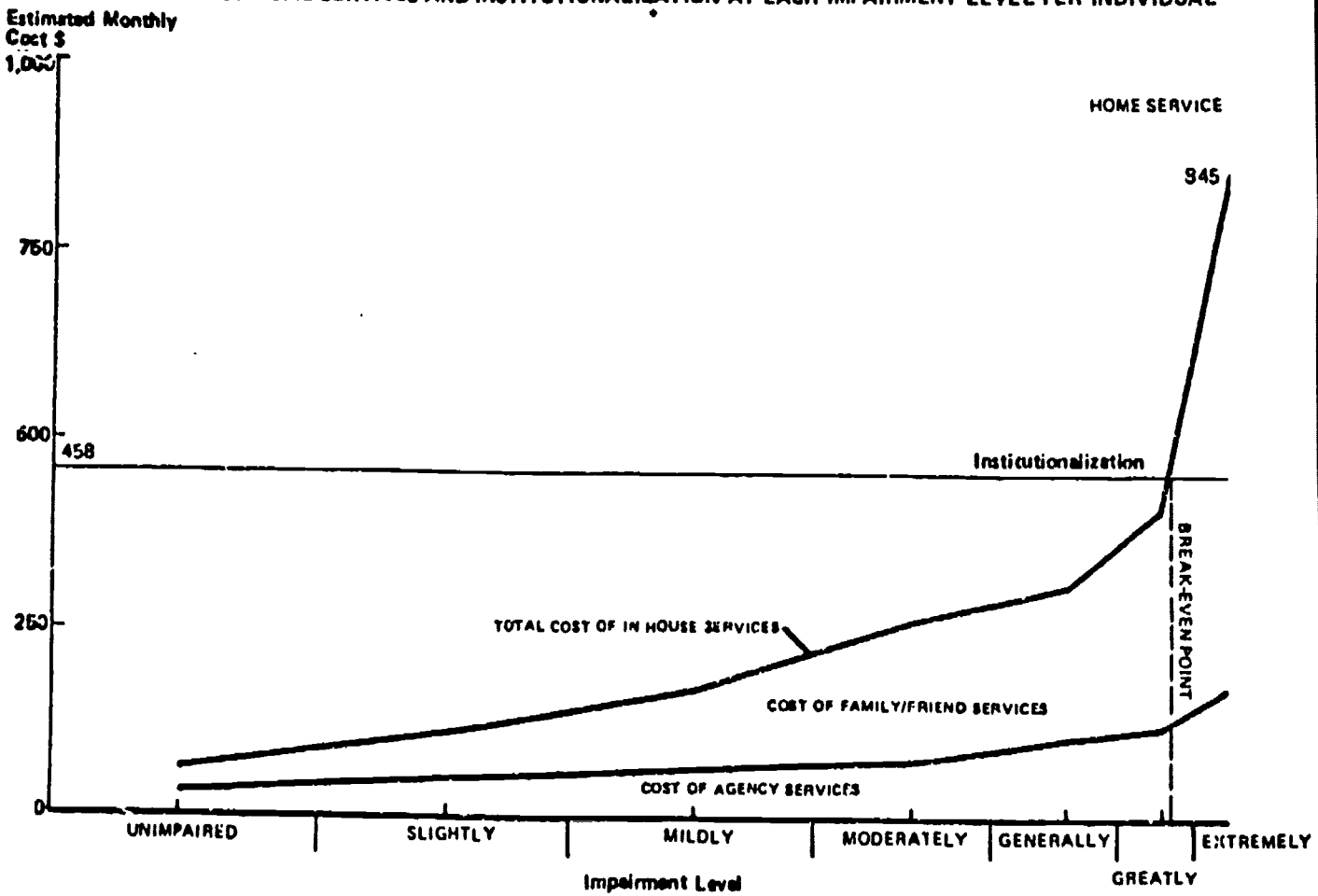
Break-even point

The graph on page 18 compares the cost of home services with institutionalization. As shown, there is a point in the impairment scale when home service costs, including the value of services provided by families and friends, equal institutional costs. Thereafter the cost of home services increases significantly over the cost to institutionalize. This point falls in the greatly impaired level.

About 10 percent of the noninstitutionalized older people fall in the area above the break-even point. However, on the average, it would still cost the public more to institutionalize these people because agencies are spending less per person for home services than for institutional care. Families and friends provide over 50 percent of the services received at all impairment levels. At the greatly impaired level where the break-even point falls, families and friends are providing over $287 per month for services for every $120 being spent by agencies. The families and friends' portion of home services reaches 80 percent at the extremely impaired level, as shown in the following table.

Impairment level	Family and friends	Agency
	(percent)	
Unimpaired	59	41
Slightly	57	43
Mildly	63	37
Moderately	70	30
Generally	67	33
Greatly	71	29
Extremely	80	20

COMPARISON OF EXTIMATED MONTHLY COST
OF HOME SERVICES AND INSTITUTIONALIZATION AT EACH IMPAIRMENT LEVEL PER INDIVIDUAL



FAMILY AND FRIENDS

Services provided by families and friends are similar to those provided by agencies. In all instances, families and friends contribute a large part of the services received by older people at home.

Two major differences emerged when institutionalized and noninstitutionalized people were compared. One is the level of impairment. Older people in institutions are more impaired than those not in institutions. For example, as shown in the following table, 87 percent of the institutionalized people are greatly or extremely impaired while only 14 percent of the noninstitutionalized have the same impairment levels.

Impairment level	Noninstitutionalized people		Institutionalized people (note a)	
	(percent)			
Unimpaired	21		1	
Slightly	21		1	
Mildly	18	86	2	13
Moderately	17		5	
Generally	9		4	
Greatly	7	14	11	87
Extremely	7		76	
	100		100	

a/Based on survey of institutionalized elderly - Pfeiffer, E. (Ed.) "Multidimensional Functional Assessment: The OARS Methodology," Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina.

To determine the percent of the institutionalized, we combined at each impairment level the noninstitutionalized and institutionalized population. Because the characteristics of the Cleveland and Durham populations were similar, we were able to combine them. As the following table shows, a relationship exists between impairment level and institutionalization. The greatest probability of institutionalization exists at the extremely impaired level where 37 percent are in institutions.

Impairment level	Total older population		In institutions
	(percent)		
Unimpaired	20		00.2
Slightly	20		00.2
Mildly	18		00.6
Moderately	16		01.6
Generally	9		02.2
Greatly	7	17	07.8
Extremely	10		37.0
	100		

The second major difference is a person's living arrangement. Few institutionalized people had a spouse or lived with their children at the time they were institutionalized. Seventeen people in our Cleveland sample, or about 1 percent, were institutionalized within 1 year after our data was gathered. The following table compares the 17 institutionalized peopled with the 217 people who were greatly or extremely impaired and illustrates the importance of living arrangements in preventing institutionalization. None of those institutionalized had a spouse or lived with their children, but over three-fourths had lived alone. In comparison, 29 percent of the greatly or extremely impaired people living in the community were married and an additional 25 percent lived with their children.

Lives with	Greatly or extremely impaired		Entered institutions	
	(percent)			
Spouse	29		-	
Offspring	25	54	-	-
Relative	10		18	
Friend	5	15	6	24
No one		31		76
		100		100

Other studies have shown similar results. Data gathered on institutionalized people in Durham showed about 90 percent were unmarried. 1/ Further, a 20-year Duke University study 2/ showed that those who have no spouses or children are more likely to be institutionalized.

Knowing these two major differences, we can examine the status of the noninstitutionalized population and identify those older people that have a high probability of being institutionalized. These people will be the 31 percent of the greatly or extremely impaired who live alone. While they comprise about 5 percent of noninstitutionalized older people, 66 percent of those institutionalized are from this group.

The second phase of our Cleveland study will analyze changes in well-being over time and identify factors contributing to these changes. The data developed during the second phase of the Cleveland study also provided the capability to further examine the people identified as having a high potentiality of being institutionalized to determine which services, if available, may enable these people to remain at home. By relating changes in well-being to services received, such an examination may also identify when it would be less costly to maintain these people at home.

PROPOSAL TO CREATE PUBLIC SERVICE JOBS TO HELP ELDERLY SICK AT HOME

In August 1977, the Administration presented its welfare reform proposals. Included was a proposal to create about 1.4 million public service jobs and training slots, of which 200,000 jobs would be for providing home services to sick older Americans. All low-income families with children would be eligible for these jobs, but the proposal assumes that about 43 percent of the job program participants would be currently receiving welfare under the Aid for Families With Dependent Children program--thus reducing direct welfare costs.

1/Pfeiffer, E. (Ed.) "Multidimensional Functional Assessment: The OARS Methodology," Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina.

2/Palmore, E. (Ed.) "Normal Aging I" Duke University Press, (Durham, 1970).

We believe that if the Congress adopts the public service job portion of these welfare reform proposals, the jobs created for assisting the sick and elderly should be focused on helping those who live alone and who are without family support. Otherwise, such jobs will merely duplicate or augment the existing family and friend networks and would not satisfy the unmet needs of the elderly. However, as one HEW official pointed out, it may be unreasonable to expect that families or friends would continue to provide such services when they become available at public expense.

CONCLUSIONS

The true costs of maintaining the elderly and sick in their own homes have been largely hidden because the greatest portion of such costs represent the services provided by families and friends rather than those provided at public expense. The importance of the family and friend is evidenced by the fact that the greatly or extremely impaired elderly who live with their spouses or children generally are not institutionalized whereas those who live alone usually are. Thus, the potential for home health benefits as an alternative to institutionalization depends largely on a person's living arrangements. The Administration's welfare reform package includes a proposal for the creation of jobs to help the elderly to remain at home. If these jobs were to meet the needs of the sick and elderly who do not have the supportive services of families and friends, it could provide a strong potential for providing an alternative to institutionalization.

RECOMMENDATION TO THE CONGRESS

In its deliberations on the Administration's Welfare Reform proposals, we recommend that the Congress consider focusing the jobs created for assisting the sick and elderly on those older people who live alone and are without family support.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #8

SUBJECT: Cost impact of making changes to home care programs

Attached is information on the cost impact of possible changes to Medicare and Medicaid programs which would increase availability of services and provide services not currently covered by the programs. This information is extracted from a United States General Accounting Office report to the Congress.

SOURCE OF DATA: "Home Health--The Need for a National Policy to Better Provide for the Elderly", United States General Accounting Office report, HRD-78-19, dated December 30, 1977.

COST IMPACT OF MAKING CHANGES TO HOME HEALTH CARE PROGRAMS UNDER MEDICARE AND MEDICAID

The Subcommittee asked for information and our evaluation on the cost impact of possible changes to the Medicare and Medicaid programs which would increase the availability of services and provide services not currently covered by the programs.

We asked HEW to provide the estimated costs for the proposed changes. For one proposed change that would affect Medicaid--the addition of homemaker services--HEW advised us that it was conducting a number of experiments to determine if homemaker services could be a cost-effective substitute for skilled care. HEW personnel stated that until the studies were completed, they could not estimate the cost of adding homemaker services to Medicaid.

Mandatory home health care benefits for all Medicaid eligibles is the other proposed change. Home health care to the medically needy is technically not a requirement under the law, but it is provided in 32 States and jurisdictions that have a medically needy program; therefore, the cost of this proposed change would be minimal.

SSA actuaries estimated that for fiscal year 1978, the additional costs for each of the proposed changes to Medicare, computed separately, would be as follows:

Proposed change	Estimated cost of changes (millions)
Elimination of:	
Limits on number of visits under parts A and B	$ 12.5
Skilled care requirement under parts A and B	1,250.0
Prior hospitalization requirement under part A	12.5
Homebound requirement under parts A and B	92.5
Adding homemaker/chore services	75.0

The above amounts should not be totaled because if more than one limitation were removed, there would be interactions. For example, the estimated $1,250 million for eliminating the skilled care requirement does not include the 1 million persons who consider themselves homebound and in need of home services, but not necessarily skilled care. Most of these are eligible for Medicare and are suitable recipients for homemaker services. The cost of providing this service could result in expenditures of $2 to $3 billion if the skilled care requirement was eliminated and homemaker service was added.

A discussion of each of the proposed changes is presented below.

LIMIT ON NUMBER OF VISITS

For Medicare, a beneficiary is eligible for 100 visits per spell of illness a year following a qualifying inpatient stay under part A and 100 visits per calendar year under part B.

SSA actuaries estimated additional costs of about $12.5 million for an additional 300,000 visits for fiscal year 1978 if these visit limitations were removed--a 2-percent increase in home health benefits costs. This assumes that about 3,000 people would exhaust part B benefits and use an additional 100 visits a year.

According to SSA data, few beneficiaries exhaust the presently allowed number of Medicare home health care visits. This data showed that, as of January 21, 1977, of the 553,941 people who received home health care under part A, 11,849 or about 2 percent exhausted their benefits. For persons receiving part B home health care during the last 3 years, benefits were used as follows:

Year	Number of people who received benefits	Number of people who exhausted benefits
1974	108,460	2,117
1975	165,354	3,118
a/1976	176,392	1,916

a/SSA considered the data for 1976 incomplete.

SSA could not provide information on the number of people who had exhausted both parts A and B benefits.

Because about 97 percent of part A Medicare beneficiaries have part B coverage, we assume that most people who exhausted part A benefits continued to receive services under part B. Thus, very few people (about 3,000) exhaust all available home health benefits under Medicare.

We contacted 36 individuals who exhausted their part B benefits during 1976, or the agencies providing services to them, to find out if they had incurred additional expenses after their Medicare benefits had been exhausted. Thirty-five continued to receive home health services and one was institutionalized to receive physical therapy treatment under Medicare. The additional home health expenses, which ranged from $5.00 per visit in Cleveland to an average of about $33.00 per visit in Jacksonville, Florida, were paid from community funds, absorbed by the local agency, paid partly by the individual, or paid by Medicaid. Only three individuals were able to pay a portion of their costs for the additional benefits received.

Data on the number of additional visits received by all 35 individuals was not available. However, 13 individuals received, on the average, an additional 61 visits during 1976 which indicates to us that the assumption that individuals exhausting benefits would use an additional 100 per year may be a little high.

REMOVING THE REQUIREMENT THAT BENEFICIARIES NEED SKILLED CARE

A beneficiary who needs intermittent skilled nursing care, or physical or speech therapy, and who meets certain other conditions, can also receive a variety of additional services, including home health aides, occupational therapists, and medical social workers, as well as coverage of medical appliances and supplies.

SSA actuaries estimate an increased cost o 1,250 million ($938 million for part A and $312 million in part B) in fiscal year 1978 if only the skilled care requirement were removed.

The estimate of $1,250 million as a first year cost assumes that only care by currently approved home health agencies is reimbursed. It was also assumed, Medicare pays 40 percent of the cost of approved home health agencies. Almost all services are provided to Medicare eligibles. If no expansion of providers occurred, the increased services alone would cost $842 million. The remaining $408 million would allow for a 50-percent increase in the current level of staffing.

ELIMINATION OF PRIOR HOSPITALIZATION REQUIREMENT

To receive home health benefits under part A, a beneficiary has to be an inpatient in a hospital for at least 3 consecutive days (not counting the day of discharge). An SSA actuary estimated the elimination of this requirement alone would cost about $12.5 million in fiscal year 1978. The estimate also considered that this elimination would remove the requirement that treatment received by beneficiaries be related to a post hospital or skilled nursing facility stay.

About $6.2 million of the estimated increased cost would be expected to result because 1.1 million part A beneficiaries who have not purchased part B coverage would have access to home health coverage under part A without being hospitalized.

However, because home health care is limited to individuals under the care of a physician whose services are covered under part B--access to home health services under part A (with or without the prior hospitalization requirement) without part B coverage seems to us to be of limited value.

The remaining increased costs would result because non-hospitalized beneficiaries entitled to both parts A and B would have 200 visits per year instead of 100. The data available does not allow for a very precise determination of the cost of this effect but it is estimated to be $6.3 million.

Because the entire part A benefit structure is built around a benefit period which can only start when a person is hospitalized, this estimate also assumes that the part A limits without prior hospitalization would be 100 visits a year instead of 100 visits a year after the beginning of one benefit period and before the beginning of the next.

We believe that individuals are not encouraged, under present law, to be hospitalized in order to qualify for home health benefits. While HEW has not specifically studied this, SSA did make studies in 1968, 1970, and 1973 to find out if the 3-day hospitalization requirement had caused additional use of hospital admissions merely to provide coverage for skilled nursing facility stays. These studies showed no evidence of any general practice of the use of inpatient hospital stays to qualify patients for skilled nursing benefits.

Also, about 97 percent of Medicare beneficiaries are covered by part B which provides home health benefits with no prior hospitalization requirement. Unless part B benefits are exhausted (which is rare), an individual is not encouraged to seek a hospital admission to qualify for home health care under part A because the part A inpatient hospital deductible is twice as high as the part B deductible.

ELIMINATION OF THE HOMEBOUND REQUIREMENT

To be eligible for home health care, a physician must certify that the patient is confined to his or her home. A homebound person is permitted infrequent or brief absences.

SSA's actuaries estimated that the removal of the homebound requirement would expand benefits to a new category of patients and cost about $92.5 million in fiscal year 1978 if all other requirements remained unchanged. This would represent a 17 percent increase in the cost of home health benefits.

HEW officials said they believed the primary reason people want the homebound requirement eliminated is to cover home dialysis for beneficiaries with kidney failures. Of the $92.5 million, about $36 million would apply to people

receiving home dialysis but who are not homebound. According to the SSA actuary, approximately 9,500 people, each of whom dialysizes about 150 times a year, could use a home health aide to assist in the time-consuming process. 1/ The estimate assumes that an average visit (about $37) would be reimbursed and that each patient would use the 100 visits maximum.

The remaining $56.5 million would allow for home health services to those individuals who are in need of skilled care but are currently not homebound. SSA's actuary estimated that about 10 percent of Medicare beneficiaries would benefit from this change. The estimate, however, did not consider whether individuals in need of skilled care were receiving it from another source. For example, receiving skilled care on an ambulatory basis, in a doctor's office, or in a health clinic.

On September 12, 1977, the House of Representatives passed a bill (H.R. 8423) to make improvements in the end stage renal disease program. One objective of the bill is to provide incentives for the use of lower cost, medically appropriate self-dialysis (particularly home dialysis) as an alternative to high cost institutional dialysis. The Ways and Means Committee report (Report No. 95-549 dated July 29, 1977), noted that the annual cost of facility dialysis (ranging from $15,000 to $30,000) was generally twice the annual cost or home dialysis (ranging from $8,000 to $12,000). But the percent of patients on home dialysis had declined steadily since Medicare had started providing universal coverage for such services. To provide incentives for home dialysis, the bill would provide coverage for periodic home dialysis support services including visits by a qualified provider. The bill would also provide for the implementation of an incentive reimbursement system with respect to the payment for the dialysis of patients dialyzing at home under the supervision of a dialysis facility. Under the bill, HEW would be authorized to, on the basis of a target reimbursement rate, for home dialysis and all necessary home dialysis medical supplies, equipment, and supportive services--including the services of qualified home dialysis aides. We could find nothing in the bill which would require renal disease beneficiaries to be "homebound" to receive such benefits. Thus, for about 40 percent of the $92.5 million in additional cost of eliminating the homebound requirement, there is House approved legislation which would eliminate or

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1/Other HEW data showed that as of June 1977 about 5,000 people were on home dialysis.

significantly dilute the homebound requirement and would reduce costs for a specific class of Medicare beneficiaries.1/ In this connection, the House Ways and Means Committee report on the bill (H.R. 8423) also stated that HEW had informed the Committee that it "anticipates that the accrued savings that will be realized as a result of increased dialysis in the home setting will offset the cost of incentives included in the bill."

We believe that a similar argument to provide disincentives for institutionalization could be made for the Medicare beneficiaries requiring skilled care, but who are not "homebound" and, thus, are ineligible for home health services under Medicare. This assumes that the difficulties in obtaining treatment on an ambulatory basis makes the alternative of institutionalization more appealing.

ADDITION OF HOMEMAKER SERVICES

HEW is currently conducting experiments to determine the cost effectiveness of providing homemaker services (see app. III), and until these experiments are completed we were told that it would be difficult to accurately determine the cost of adding homemaker services, particularly with respect to Medicaid.

For Medicare, SSA's actuaries said that assuming an individual is homebound, in need of skilled care, and that homemaker services are provided only while skilled care was required, additional homemaker services would cost Medicare $75 million in fiscal year 1978. According to SSA's actuary, the homemaker benefits currently perceived are very restrictive and a broader definition would result in higher costs. SSA's actuary estimated that about 50 percent of those receiving skilled care would be eligible for homemaker services.

We obtained the following data on the cost of homemaker/chore services from State officials in California and Georgia.

California provides homemaker/chore services through its title XX program. In its plan the State estimated that about

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1/The bill would not amend the part B home health benefit as such. Thus the 20 percent coinsurance charge would be applicable to these proposed new benefits whereas no coinsurance charge would continue to apply to the regular part B home health benefit.

113,000 aged, blind, and disabled individuals would benefit from the program during the period July 1, 1976. through June 30, 1977. The State estimated the Federal and State costs for homemaker/chore services in California would be $80 million. The State did not estimate any savings on institutionalization resulting from benefits provided under the program.

Georgia's title XX administration is currently evaluating the use and measuring the effectiveness of homemaker/chore services as an alternative to institutional care for the aged, blind or disabled, and mentally retarded adults who are eligible for title XX benefits. An interim report from Georgia's homemaker demonstration project indicates it was preventing institutionalization and reducing overall health care costs. The report showed that during the first 3 months of the project, homemaker services prevented over 2,300 months of institutional care and saved $278,231. The project's 60 homemakers--at a cost of $456,471--enabled more than 900 people to stay home avoiding 851 months of foster care, 1,246 months of intermediate nursing care, 170 months of skilled nursing care, and 114 months of other placements, such as mental institutions all of which would have cost about $735,000.

We did not validate the data supporting this report, but it tends to support the findings in our Cleveland study (discussed in the previous chapter) to the effect that greatly or extremely impaired people require more than nursing services to be maintained in their homes.

ADDITION OF HOME HEALTH CARE BENEFITS UNDER MEDICAID AS A REQUIRED SERVICE

Federal law and HEW regulations require that home health care benefits be provided to all aged, blind, and disabled categorically needy individuals 21 years of age and older. Home health care benefits to the medically needy is technically not a required service under the law. However, 32 States and jurisdictions covering the medically needy are already offering this service--thus, we assume that the cost of this change would be minimal.

CONCLUSIONS

In summary, we believe that the elimination of the limitation on the number of visits under Medicare would not be costly because few people presently exhaust such benefits. The elimination of the prior hospitalization requirement also would not be costly, but the use of institutional services

would be slightly affected because individuals are not encouraged to be hospitalized for such benefits, and most Medicare beneficiaries are already eligible (under part B) to receive such benefits without hospitalization.

The Congress is currently considering the elimination of the homebound requirement in pending legislation for one group of Medicare beneficiaries (those with end stage renal disease) as an incentive for less costly home dialysis in lieu of center or inpatient dialysis. We believe that the elimination of this requirement for all beneficiaries requiring skilled care could well provide similar disincentives to institutionalization.

Although experiments in the program are still continuing, some evidence shows that the addition of homemaker/chore services could provide disincentives to institutionalization for individuals who are greatly or extremely impaired which might help to offset the additional cost of this service.

The elimination of the Medicare's skilled care requirement would substantially affect the cost and the acute care orientation of the program.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #9

SUBJECT: Total national expenditures for nursing home care

Attached is information on the total national expenditures by source for nursing home care (see page 5). This information is extracted from a United States General Accounting Office report to the Congress.

SOURCE OF DATA: "Entering a Nursing Home--Costly Implications for Medicaid and the Elderly", United States General Accounting Office report, PAD-80-12, dated November 26, 1979.

INTRODUCTION

Medicaid, authorized by Title XIX of the Social Security Act, is a Federal/State program in which the Federal Government currently pays for 50 to 78 percent of State costs of providing health services to the poor. 1/ The program's purpose, as stated in the 1965 legislation, was to enable States, "as far as practicable under the conditions in such State," to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 2/ Another objective was to assist recipients to "attain or retain capability for independence or self-care" through the provision of rehabilitation and other services. 3/

When it was created, Medicaid substituted a single program of medical assistance for an ongoing, yet more limited system of vendor payments. The Department of Health, Education and Welfare estimated that if all States fully adopted the provisions in the new legislation, Medicaid would increase Federal expenditures in 1966 by $238 million over the $1.3 billion cost of the vendor payment program. The error in this initial cost estimate was evident after only a few years. Expenditures in FY 1968, with 37 States operating Medicaid programs, were $3.5 billion; 4/ in FY 1978 they increased to $18.6 billion. 5/ Categorized as the "sleeper" of the Social Security Amendments of 1965, Medicaid today is an extensive and costly program.

NURSING HOME COSTS AND UTILIZATION HAVE A SIGNIFICANT IMPACT ON MEDICAID

One of the primary factors which explain the expense of Medicaid is the program's coverage of nursing home care. Davis and Schoen cite "the high cost of institutionalization for an impoverished elderly and disabled population that is unable to meet the demands of daily living without nursing assistance" for a major source of the cost increase. 6/ These costs consumed nearly 41 cents of each Medicaid dollar in FY 1978 or a total of $7.6 billion. 7/ By FY 1984 payments are expected to increase to over $9.5 billion. 8/

Medicaid's funding of nursing home care involves several complex issues. Nursing home costs dominate Medicaid expenditures as more money is spent on this care than on any other medical service. However, only 6 percent of those who received any service under Medicaid in FY 1976 used nursing home services. 9/ Medicaid has also become the predominant payer nationally of nursing home care. In 1976, approximately 60 percent of all days spent in nursing homes were financed either totally or in part by Medicaid. 10/

Finally, payments are being made for some nursing home patients who would have preferred and could have remained in a more independent setting if necessary supportive services had been available. Medicaid funding of community-based services (e.g., home health care), however, was 1 percent of total expenditures in FY 1978. 11/

Medicaid has become the major payer of nursing home care

The impact of Medicaid's nursing home coverage on its budget has been profound. While only a small percentage of all Medicaid recipients are in nursing homes, its high costs make it the service requiring the largest expenditures. As shown in figure 1, in FY 1978, 74 percent of the States (37) spent 40 percent or more of their total Medicaid expenditures (Federal and State) on nursing home care; in 19 States at least half of their budgets went for these services. 12/ These figures underestimate all Medicaid expenditures for patient care in nursing homes because they do not include the cost of physician services, drugs, medical equipment, and other medical services which are also reimbursable for patients in nursing homes.

Medicaid's role in financing nursing home services nationally is significant because it spends more on this care and supports more individuals in nursing homes than any other public or private source. Thirteen percent of nursing home residents (97,000) in 1969 used Medicaid funds as their primary source of payment; 13/ by 1977 this had increased to 48 percent of all residents (623,300). 14/ During this same period there were declines in the proportion of residents using Medicare, their own income, or other public assistance or welfare as the primary source of payment. Most of the decrease in the number of residents supported by "other public assistance or welfare" resulted from the transfer of intermediate care facility services from cash assistance programs to the Medicaid program on January 1, 1972. These changes are shown in figure 2.

Figure 1

Nursing Home Expenditures As a Percentage of Total Medicaid Expenditures by State, FY 1978 (note a)

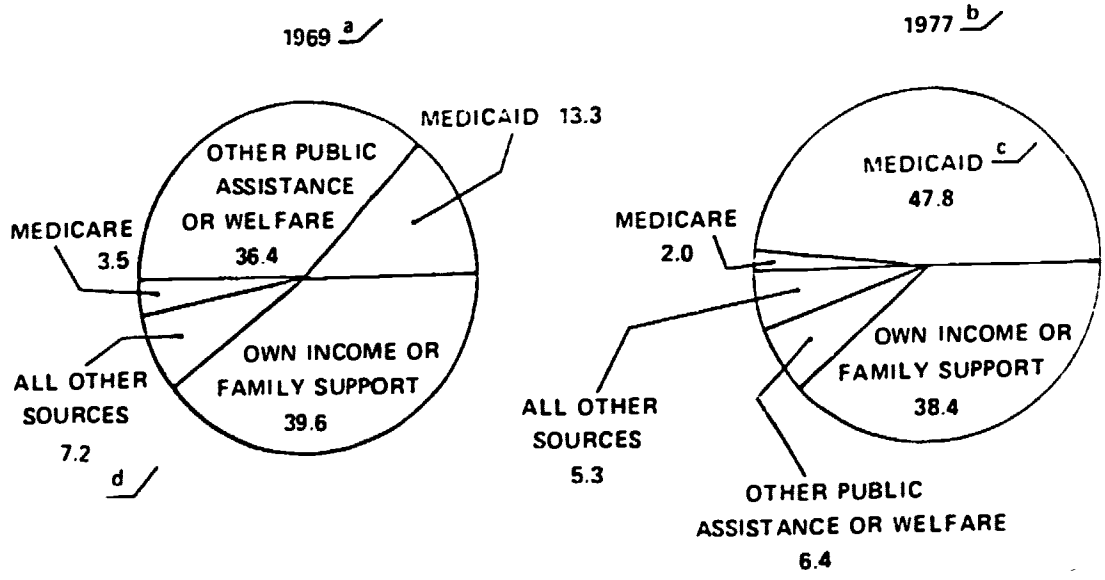
South Dakota	67.8	Alabama	45.8
Minnesota	64.2	Vermont	45.2
Alaska	63.2	Georgia	44.7
New Hampshire	62.2	South Carolina	44.6
Colorado	60.5	New York	44.3
Wyoming	60.5	Kansas	44.2
Iowa	58.1	Hawaii	43.8
Texas	58.1	Rhode Island	43.3
Nebraska	57.8	Kentucky	41.7
Wisconsin	56.9	Mississippi	41.1
Idaho	56.7	Florida	40.3
Arkansas	55.5	Ohio	40.0
Montana	54.0	North Carolina	39.8
North Dakota	53.8	Delaware	39.7
Connecticut	53.1	Michigan	39.3
Indiana	53.1	Missouri	38.8
Oklahoma	52.8	Massachusetts	38.7
Utah	52.5	Washington	38.4
Nevada	51.0	New Jersey	36.4
Oregon	48.9	Maryland	34.3
Maine	48.4	New Mexico	31.3
Pennsylvania	47.6	Illinois	29.5
Louisiana	47.0	California	23.9
Virginia	46.3	West Virginia	22.5
Tennessee	46.0	District of Columbia	13.1

a/Arizona does not have a Medicaid program. Guam, Puerto Rico and the Virgin Islands are not included.

Source: Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 78-03154, Research Report B-5 (FY 78) (Preliminary), June 1979, Table E.

Figure 2

Percentage Distribution of Nursing Home Residents by Primary Source of Payment



a DHEW, National Center for Health Statistics, Charges for Care and Sources of Payment for Residents in Nursing Homes, Series 13, Number 32, August 1973 April 1974, (DHEW Publication No. (PHS)78 1783), p. 23. (Data adjusted to exclude residents of personal care homes)

b DHEW, National Center for Health Statistics, The National Nursing Home Survey. 1977 Summary for the United States, Series 13, No. 43, (DHEW Publication No. (PHS) 79-1794), July 1979, p 99.

c Most of the increase in residents supported by Medicaid resulted from the transfer of intermediate care facility services from "other public assistance or welfare" to the Medicaid program on January 1, 1972.

d This segment includes religious organizations, foundations, volunteer agencies, Veterans Administration contract, initial payment-life funds, and other sources or no charge.

Total national expenditures for nursing home care more than doubled between 1974 and 1978. The two major sources of these expenditures are Medicaid funds and individuals' out-of-pocket payments. Of the 1978 total national nursing home bill of $15.751 billion, Medicaid paid 46 percent ($7.246 billion) and individuals paid 45.6 percent ($7.179 billion); other public funds (Medicare, Veterans Administration and others) paid 7.1 percent ($1.112 billion) and other private funds (private health insurance, philanthropy) paid 1.4 percent ($214 million). 15/ Figure 3 shows a breakdown of these sources. At the national level there is limited control over the increase in Medicaid expenditures for nursing home care because the Federal Government is required to match whatever the States spend on this service.

Medicaid is supporting predominantly elderly residents in nursing homes

Along with rising outlays for nursing home care there has been a corresponding rise in the number of individuals using these institutions. The National Nursing Home (NNH) survey shows that there were about 1,303,100 residents in 18,900 homes in 1977, a 21 percent increase over the 1,075,800 residents in the 1973-74 survey. 16/ The number of nursing home beds has also increased from 1,177,300 in 1973-74 17/ to 1,402,400 in 1977. 18/

As shown in table 1, 86 percent of the nursing home residents in 1977 were elderly: 19/

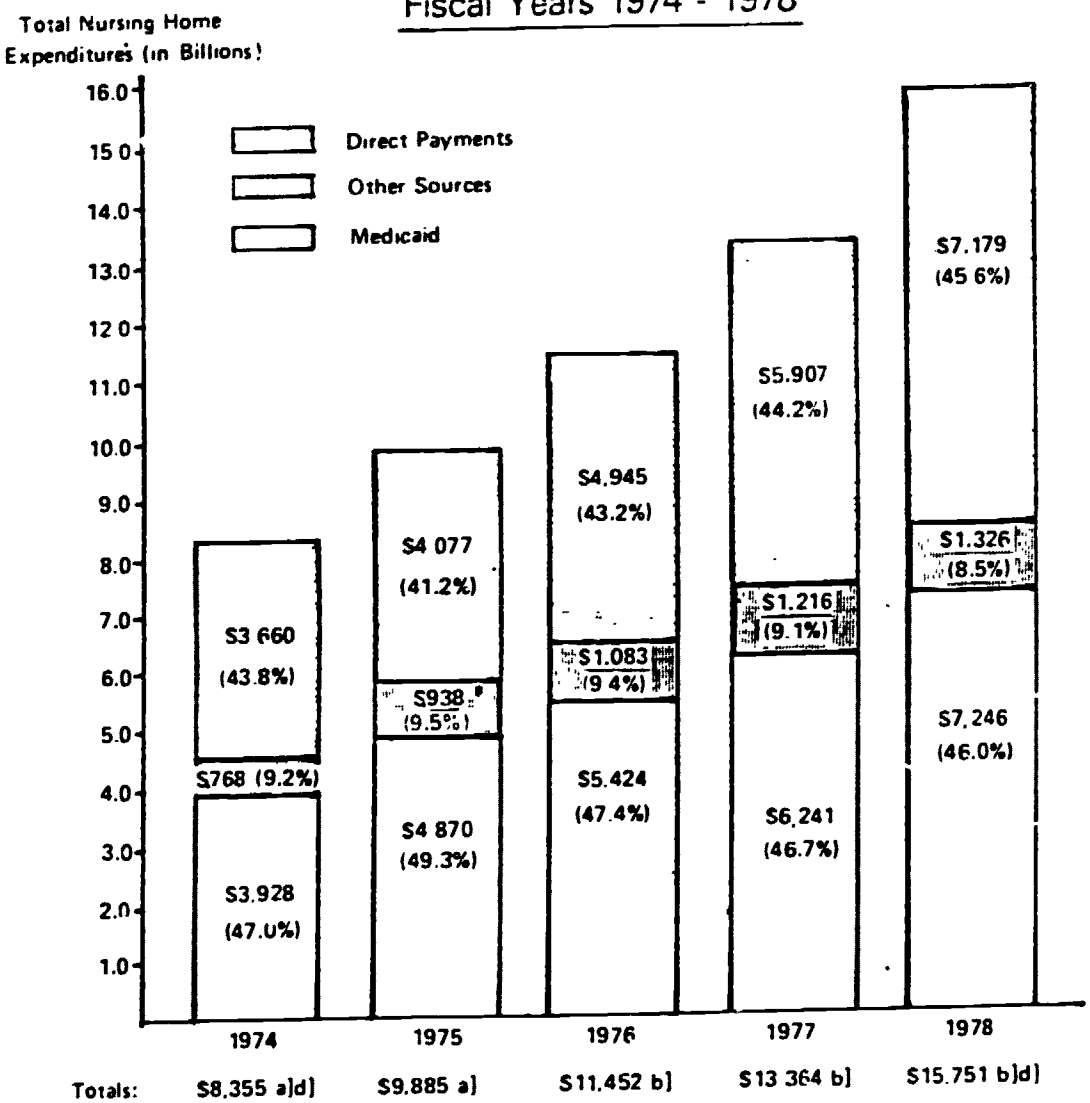
Table 1

Age Distribution of Nursing Home Residents

Nursing home residents (1977 NNH survey)	Number	Percent
Under 65 Years	177,100	13.6
65-74 Years	211,400	16.2
75-84 Years	464,700	35.7
85 Years and Over	449,900	34.5
Total	1,303,100	100.0

Figure 3

Proportion of Nursing Home Expenditures by Source of Payment, Fiscal Years 1974 - 1978



a] Unpublished data obtained from DHEW, Health Care Financing Administration, Office of Research, Demonstrations and Statistics, Washington, D.C.

b] DHEW, Health Care Financing Administration, Health Care Financing Review, Summer 1979, pp. 26 - 28.

c] Other sources of payment: Medicare, Veterans Administration and State and local payments, private health insurance, philanthropy and industrial inplant services.

d] Numbers do not add due to rounding.

The proportion of elderly who are using nursing home services has grown from 2.3 percent of all elderly in 1960 20/ to 5 percent in 1977. 21/ However, these data underrepresent the actual number of elderly admissions. Because the NNH survey is based on a sample of residents in nursing homes on a particular day, it undercounts total utilization during a year's period. It is estimated that 20 to 25 percent of the elderly population will spend some time in a nursing home even though only 5 percent are residents on a given day. 22/

The fact that the elderly are the predominant users of nursing homes is also reflected in the distribution of expenditures by age group for this care. Of total FY 1977 expenditures for nursing home services, 2.7 percent was spent for individuals under 19, 13.8 percent for the age group 19 to 64, and 83.5 percent was spent for the 65 and older age group. 23/ The elderly are also the primary users of Medicaid-supported nursing home care. In FY 1975, 79.1 percent of Medicaid expenditures for skilled nursing home facility (SNF) services and 67.2 percent of expenditures for intermediate care facility (ICF) services were spent on elderly recipients who were 65 or older. 24/*

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* Medicaid pays for intermediate care facility services and skilled nursing facility services which are defined as follows:

--Skilled nursing facility services are services which are required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.

--Intermediate care facility means an institution which is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. 25/

AVOIDABLE INSTITUTIONALIZATION IS COSTLY IN HUMAN AND FINANCIAL TERMS

A critical problem with the elderly's use of nursing homes is that many admissions could have been avoided or were unnecessary. Lawton, in a review of research on utilization, estimated that between 10 and 18 percent of the institutionalized older persons surveyed could live in the community if appropriate support services were available. 26/ Baltay assessed 14 studies of appropriateness of placement in nursing homes and estimated that 10 to 20 percent of skilled nursing facility patients and 20 to 40 percent of intermediate care facility patients were receiving unnecessarily high levels of care. 27/

Placing elderly persons in nursing homes when they have the potential to remain in the community is problematic because:

--It is contrary to the wishes of most elderly and their families.

--Individuals may be provided a more intensive level of care than actually needed.

--It absorbs a costly outlay of public and private funds and is an inefficient use of this service.

Elderly prefer their own homes to institutional care

The elderly, when confronted with a need for long-term health and social services as a result of impairments and functional limitations, usually prefer to receive this care in their own homes rather than entering a nursing home. Brody defines long-term care as referring to

> "One or more services provided on a sustained basis to enable individuals whose functional capacities are chronically impaired to be maintained at their maximum levels of psychological, physical, and social well-being. The recipients of services can reside anywhere along a continuum from their own homes to any type of institutional facility." 28/

A Florida survey of elderly individuals with chronic health problems living in the community and in nursing homes found that regardless of their place of residence, 85 percent of

the sampled "dependent but mentally intact elderly" preferred their own homes to institutional care. 29/

In another study, Noelker and Harel (1978) interviewed 125 ambulatory aged residents who were selected from self-care floors in 14 nursing homes and homes for the aged. Almost half (46 percent) expressed a desire to live elsewhere while 54 percent stated they would prefer to remain in their respective institutions. When residents were questioned about their reasons for wanting to live elsewhere, they responded that they preferred to live in their own homes or with a friend or that they sought more independence in their physical and social activities. Only 12 percent (6) desired to live elsewhere because of their dissatisfaction with the facility in which they lived. 30/

In addition to fearing a loss of independence, many elderly resist nursing home placement because it often means they must give up their lifelong possessions and sever their community ties; others perceive institutionalization as a prelude to death.

Some individuals are admitted to nursing homes when they have the potential to receive care in a setting offering greater independence

Institutionalization is considered appropriate or necessary "when medical or physical needs are so great that the provision of services throughout a 24-hour period is essential." 31/ Another definition adds that the determining factor in nursing home placement should be a severely or irreversibly impaired physical or mental condition which requires constant medical monitoring. 32/ Medicaid authorizes payment for nursing home care for individuals if the physician certifies that it is medically necessary.

Some individuals are admitted to a nursing home, however, not because of their need for medical and nursing home care or their level of impairment but because of insufficient economic and social resources in the community. A recent survey, for example, looked at chronically ill elderly residents of public and private nursing homes and community residents served by a home health agency. After comparing residents by their ability to perform varying functions, such as dressing, eating, and bathing, the study found that the nursing home and community populations had similar impairment levels which ranged from moderately to totally

impaired. The critical variable which explained why these individuals were residing in different settings (nursing home or home) was not level of functioning ability but living arrangement and the presence of a caring unit (primarily in the form of living with spouse and/or children.) 33/

Many elderly, even those with severe disabilities, could appropriately receive long-term care services in their own homes or in congregate settings other than nursing homes. A Texas study concluded that a large elderly population was being supported in nursing homes when in fact their basic requirement was for nonmedical supervision and management. 34/ A survey by the Virginia State Department of Health in 1976 reported that as many as 25 percent of the applicants for Medicaid covered nursing home care in Richmond could have been cared for using community-based services (if available). 35/ The elderly who are placed in nursing homes, not because they need this level of care, but because of a lack of social and economic supports, are deprived of an opportunity to obtain care in a setting which offers maximum reliance on individual potential and resources.

High cost and inefficient use of nursing home care

Nursing home admissions which could have been avoided or deferred result in a substantial commitment of public and private resources. In FY 1977, 43 percent of the $10.536 billion spent on the elderly for nursing home care was paid by private sources. Because most of these payments were met out of personal resources rather than by private health insurance or philanthropy, nursing home costs have become the primary source of catastrophic expense for the elderly.

In addition to high costs, individuals who are in nursing home beds when they could have been cared for in another setting are using a resource which is often more critically needed by other elderly. In many areas of the country there exists a chronic excess demand for nursing home care (specifically subsidized care). As a result, individuals may wait long periods in the community or in more costly acute care hospital beds for admission to a nursing home.

PROBLEMS IN THE NURSING HOME ADMISSIONS PROCESS RESULT IN AVOIDABLE INSTITUTIONALIZATION

Medicaid is directly affected by avoidable nursing home placements. Payment for this care is not only costly but it represents services to individuals which do not promote maximum independence or self-care--a program objective. Medicaid has, therefore, a direct stake in the remedying of any factors which lead to avoidable or premature use of nursing home care.

Problems in the process of admission to a nursing home--in how individuals end up as patients in these facilities--result in avoidable institutionalization. The objective of this study is to examine this process, particularly in respect to the effect Medicaid and other public policies have on the decisions of the elderly and their families to use nursing home care when community-based services would have been appropriate. 36/ We analyzed three areas which impact on the admissions process:

1. Medicaid eligibility policies for individuals using institutional and noninstitutional services.

2. Factors which discourage or prevent the elderly from obtaining community long-term care services in lieu of nursing home care, and

3. Medicaid's screening and assessment procedures for nursing home applicants.

These topics are addressed in chapters 2 through 4. Chapter 5 discusses State and local efforts to counteract problems in the admissions process which lead to premature or avoidable placements and chapter 6 presents conclusions and recommendations.

In conducting this study we reviewed a large volume of literature on Medicaid and the elderly's use of institutional and community-based care services. We interviewed knowledgeable individuals in the Federal and State governments, in private social service and health organizations, and in academic institutions. We also analyzed data on nursing home residents and their relatives collected by the U.S. Bureau of the Census as part of the 1976 Survey of Institutionalized Persons (SIP).

NOTES

1/Medicaid was established by the Social Security Amendments of 1965 (Public Law 89-97) and became effective on January 1, 1966. Federal financial participation is determined by the formula prescribed in section 1905 (42 U.S.C. § 1396b(d)) which authorizes payments of up to 83 percent of State costs.

2/Public Law 89-97, Section 1901.

3/Ibid.

4/Institute for Medicaid Management, Data on the Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-78, DHEW, Washington, D.C., 1978, p. 25. Expenditures for 1968 for Medicaid and Kerr-Mills and related programs have been combined.

5/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, DHEW Publication No. (HCFA) 78-03154, Research Report B-5 (FY 78) (Preliminary), June 1979, Table E.

6/Karen Davis and Cathy Schoen, Health and the War on Poverty - a Ten Year Appraisal. Brookings Institution, Washington, D.C., 1978, pp. 57, 60. Davis and Schoen also identified two other factors which contributed to high Medicaid costs: the increase in the number of Medicaid recipients covered under the Aid to Families with Dependent Children (AFDC) program, and the rise in medical care prices.

7/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, Fig. 1. In FY 1978, 41.9 percent of Medicaid expenditures went to nursing home services followed by: inpatient hospital care (27.7 percent), other services (13.4 percent), physician services (8.8 percent), prescribed drugs (6.0 percent), dental care (2.1 percent).

8/Testimony of Robert A. Derzon, Administrator, Health Care Financing Administration, DHEW, before the Select Committee on Population, House of Representatives, June 1, 1978, pp. 5-6.

9/Health Care Financing Administration, Medicaid State Tables FY 1976 Recipients, Payments and Services, United States Department of Health, Education and Welfare, U.S. Government Printing Office, 1979, p. 11.

10/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, Vital and Health Statistics, Series 13, No. 43, DHEW Publication No. (PHS) 79-1794, July 1979, pp. 9-10.

11/Health Care Financing Administration, Medicaid Statistics Fiscal Year 1978, Table 7.

12/Ibid. Table 8. Medicaid costs are shared by the Federal and State Governments. The Federal share ranges from 50 percent in States with high per capita income to 78 percent in Mississippi, the State with the lowest.

13/National Center for Health Statistics, "Charges for Care and Sources of Payment for Residents in Nursing Homes," U.S. National Nursing Home Survey, August 1973 - April 1974, Vital and Health Statistics, Series 13, No. 32, DHEW, (GPO), November 1977, pp. 22-23.

14/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 99.

15/Robert M. Gibson, "National Health Expenditures, 1978," Health Care Financing Review, Vol. 1 Issue 1, Summer 1979, p. 26.

16/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 8. An earlier NCHS report notes that the increase in nursing home residents is slightly exaggerated because nursing and personal care facilities are included in the 1977 NNH survey while only facilities providing some level of nursing care were included in the 1973-74 survey. See NCHS, "A Comparison of Nursing Home Residents and Discharges from the 1977 National Nursing Home Survey; United States," Advance Data from Vital and Health Statistics, No. 29, Public Health Service, Hyattsville, Maryland, May 17, 1978, p. 2.

17/NCHS, "Utilization of Nursing Homes, United States: National Nursing Home Survey, August 1973 - April 1974," Vital and Health Statistics Series 13, No. 28, Department of Health, Education and Welfare, July 1977, p. 3.

18/NCHS, The National Nursing Home Survey: 1977 Summary for the United States, p. 8.

19/Ibid., p. 43.

20/William Scanlon, Elaine Difederico, Margaret Stassen, Long-Term Care Current Experience and Framework for Analysis, The Urban Institute, Washington, D.C., February 1979, p. 3.

21/National Center for Health Statistics, The National Nursing Home Survey: 1977 Summary for the United States, p. 28. Several factors have been cited to explain the increase in nursing home beds and utilization. Brody lists the following as important: the increase in the elderly population; Federal funds to pay for care (Medicare, Medicaid, Social Security and Kerr-Mills--the forerunner to Medicaid), Federal grants and loans to build and rehabilitate facilities; and a national thrust to deinstitutionalize elderly mental patients from State hospitals to the community. Elaine M. Brody, "The Formal Support Network: Congregate Treatment Setting for Residents with Senescent Brain Dysfunction," paper presented at Conference on the Clinical Aspects of Alzheimer's Disease and Senile Dementia, Bethesda, Maryland, December 1978, p. 8.

22/Burton D. Dunlop, Need for and Utilization of Long-Term Care Among Elderly Americans, The Urban Institute, (200-975-05), Washington, D.C., August 1976, p. 85.

23/Robert M. Gibson and Charles R. Fisher, "Age Differences in Health Care Spending, Fiscal Year 1977," Social Security Bulletin, Vol. 42, No. 1, January 1979, p. 5.

24/Institute for Medicaid Management, pp. 65, 66.

25/Health Care Financing Administration, Title XIX, Grants to States for Medical Assistance Programs, Medicaid Bureau, Department of Health, Education, and Welfare, Washington, D.C., Revised, January 1979, pp. 534, 535.

26/M. Powell Lawton, "Institutions and Alternatives for Older People" Health and Social Work 3(2), 1978, p. 123.

27/Maureen Baltay, Long-Term Care for the Elderly and Disabled, Congressional Budget Office, Government Printing Office, February 1977, p. 18.

28/Elaine M. Brody, p. 1.

29/William G. Bell, "Community Care for the Elderly: An Alternative to Institutionalization," The Gerontologist, Part I (Autumn 1973), p. 352.

30/Linda Noelker and Zev Harel, "Predictors of Well Being and Survival Among Institutionalized Aged," The Gerontologist, Vol. 18, No. 6 (1978), pp. 564-566.

31/Faye Abdellah, "Long-Term Care Policy Issues: Alternatives to Institutional Care," The Annals of th American Academy of Political and Social Science, 438, July 1978, p. 30.

32/Joint Committee on Long-Term Care Alternatives, Well-Being in Old Age: Essential Services, Technical Report IV, Austin, Texas, Fall 1978, p. 19.

33/Stanley J. Brody, Walter Poulshock, Carla F. Masciocchi, "The Family Caring Unit: A Major Consideration in the Long-Term Support System," The Gerontologist, Vol. 18, No. 6 (1978), pp. 558-9.

34/Joint Committee on Long-Term Care Alternatives, Final Report, Austin, Texas, 1978, p. 18.

35/Joint Legislative and Audit Review Commission, The Virginia General Assembly, Long Term Care in Virginia, Richmond, Virginia, March 28, 1978, p. 12.

36/The elderly are defined, for the purposes of this study, as 65 and older.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #10

SUBJECT: Congregate housing

Attached is information on congregate housing in the United States. This executive summary is extracted from a 300 page evaluation performed in 1976. It is the only comprehensive summary on Congregate housing available.

SOURCE OF DATA: "Evaluation of the Effectiveness of Congregate Housing for the Elderly" prepared for U.S. Department of Housing and Urban Development by Urban Systems Research & Engineering, Inc. in October 1976.

evaluation of the effectiveness of congregate housing for the elderly

final report

U.S. Department of Housing and Urban Development, Office of Policy Development and Research

1.0 Research Objectives

The evaluation of congregate housing for the elderly encompassed a variety of research objectives. One dimension of the study was the systematic development of a profile of the elderly living in congregate housing, and comprehensive cataloguing of the range of congregate facilities that exist in the United States today in terms of their management, their service provision, and their design features. A second dimension of the study was the identification of the "needs" of the elderly living in congregate environments. A third dimension was relating the characteristics and needs of the elderly to different types of congregate facilities in order to identify the features and factors of these living environments which best fulfilled elderly's needs, and which appeared to best support the maintenance of their independent lifestyles. Finally, this study examined the financial feasibility of the development and operations of congregate facilities, and of the provision of the "successful" features identified above.

2.0 Research Strategy

Given the research objective of a comprehensive description of existing congregate housing facilities, it was necessary to conduct the study at a widely varied sample of sites. Thus, rather than a probability sample, a stratified sample of sites was chosen, representing a range of sites in terms of their geographic location, their size, their rent levels, and the diversity and extensiveness of services provided on-site. The lowest common denominator of all sample sites was the availability of an on-site meal program, which was the essence of the definition of congregate housing used in this research. Site sampling was conducted by random drawing of sites from five major directories of elderly housing. This activity, conducted within the overall stratification design, led to the selection of twenty-seven study sites.

The study sample represented a broad array of congregate housing sites. Geographically, they were distributed with 6 in the Northeast, 6 in the North Central U.S., 7 in the South, and 8 in the West. In terms of sponsorship, the study sample consisted of 5 conventional low-rent public housing projects, 17 non-profit church organizations, 3 other non-profit entities, and 2 for-profit corporations. The development of 22 of the twenty-seven was sponsored by a variety of HUD programs: Section 202 (original), Section 236, Section 231, as well as the low-rent public housing subsidies. Therefore, 5 sites were constructed with strictly private monies. In terms of size, the study sample of congregate housing facilities was comprised of 9 projects of 70 to 125 units, 9 projects with 126 to 200 units, and 9 projects with over 200 units.

The study sites encompassed a variety of rent levels--ranging from rent payments of less than $100. per month to entrance fees of $5. to $40,000. combined with monthly charges of $600. When this range is divided into high, medium, and low levels, the sample sites distribute themselves into 11 in the high rent category, 7 in the middle rent category, and 9 in the low rent category.

A final criterion along which the sample sites varied considerably is the variety and extensiveness of the services which are offered on-site. These range from meal, housekeeping, and security services, to medical services, social, recreational and educational programs, financial management services, transportation services, protective services, etc. When the range of service packages offered on-site is divided into levels according to the number, scope, and availability of the on-site services, the distribution of study sites is as follows: 6 with high service level, 9 with medium service level, and 12 with low service level.

Three types of data gathering activities were undertaken in order to accomplish the analysis tasks required to meet the research objectives of the study. The first was to provide a complete description of the development history, the management policies and practices, the delivery

of services, and the design features and prosthetic equipment on each site. Each of the twenty-seven sample congregate housing managers and service providers were interviewed. The physical features of the building were observed and recorded at the same time. This data constituted the basis for what was called the Administrative Analysis, which consisted of systematic description of existing congregate housing facilities and cross-site comparisons of their features and characteristics.

The second data gathering effort was the administration of a fully-structured questionnaire to a sample of residents and applicants at a subsample of nineteen of the study sites. The data gathered in the Congregate Housing Survey included descriptive characteristics of the respondents, their activity patterns prior to and during residency in congregate facilities, their expectations of congregate housing, and their evaluations of management performance, services, and design features of the facilities. Analysis of this data provided a profile of the congregate elderly, a description of their needs, a test of the fulfillment of these needs, and an assessment of the impact of congregate housing on respondents' independence. These results were then compared site by site to identify features of congregate housing which best satisfied residents.

The third data gathering effort was the collection of financial data from each project's books in order to accomplish the feasibility and cost analysis objective described above. This data was collected at the time of the Administrative Analysis field visits. The analysis involved the development of cost measures which could be compared across sites with differing characteristics. These three data gathering and analysis efforts provided the results and conclusions to satisfy all the research objectives discussed in the preceding section.

3.0 Research Findings

3.1 Major Findings from the Analysis of Service Provision on Congregate Housing Sites

The most striking and important conclusion from the extensive analysis of service provision in the context of elderly congregate housing facilities is that the congregate mode represents a housing option in which the provision of a service package is the norm. The average of nine different services is provided across the twenty-seven study sites. More specifically: 100% provide a meal service (a prerequisite for inclusion in the sample) and a recreational program; 89% provide social, educational, and security services; 85% supply transportation; 81% offer commercial services; 78% provide a medical program; 67% offer housekeeping assistance; and 59% provide a laundry (linen) service and protective services.

Interestingly, the most prevalent service types appear to be those which stress physical activity and independence. Social, recreational, educational, and transportation service provisions appear with significant consistency in the sample. Another observed pattern is the linkage of physical support services: meals, medical care, housekeeping, and linen services. Over half of the sites which provide one of these provide the other three.

The conclusion that congregate housing represents a combined housing and services package, with considerable emphasis on the latter, is reinforced by an examination across service types of the method of resident payment for services. For every type of service offered, in the majority of sites, payment is included as part of the rental fee (either as part of the undifferentiated total sum, or as a supplementary obligatory payment). This suggests that congregate housing facilities percieve themselves as being in the business of providing not just housing, or even housing plus meals, but housing and a broad array of supplementary services.

In terms of the actual mechanics of service provision, the majority of services are provided directly by the management of the facility. Contracted services are seldom seen outside the context of catered meal

services. Community-provided services constitute a substantial proportion of on-site services, although volunteered and donated services are not solicited actively or along a coordinated plan (except in the case of public housing facilities which are legally unable to provide any but housing services). Community service provision is a resource relatively untapped by the majority of current managers of congregate housing. Instead, there is a distinct preference for direct provision, despite the administrative, direct labor and capital costs this entails--given the multiplicity of services provided on any given site.

The typical congregate housing facility provides an extensive meal service--two or three meals a day, seven days a week. Its medical service package includes frequent (at least once weekly) outpatient clinics and the capabilities for providing personal care for the less mobile sector of the population. Housekeeping and linen services are offered weekly. Opportunities for social, recreational, and educational activities arise on a daily basis, usually emphasizing non-active outlets. This area of provision is complimented by a regular transportation service, servicing shopping and medical destinations at least once weekly. At least a minimal level of security--not unlike that commonly provided in a standard apartment residence-- i.e., night-time limited access--is evident on-site. Protective services are offered only on an informal basis by management staff, if at all. Some type of commercial enterprise, often a beauty/barber shop, is available to residents at an on-site location. This picture presents the average level and mode of service provision within each service area found across all the twenty-seven sample sites.

3.2 Major Findings from the Analysis of Management Policies and Practices on Congregate Housing Sites

Although a variety of development modes, organizational arrangements, and functional characteristics were found across the twenty-seven sites, several common theories were identified which broadly describe the structure of the management system which operates congregate facilities. A surprising element of commonality was the distinct service orientation which

characterizes many of the management decisions, policies, and practices observed at the sample sites. The goal of providing services to the elderly frequently overshadows concerns regarding the financial feasibility of directly operating a diverse group of services which are inherently costly to provide. (This will be expanded in later sections). Providing a combined housing and services package is clearly not a profitable or easily break-even venture--a consideration often found to be irrelevant due to the fundamentally "charity business" approach taken by management. Often inefficient operations lacking in clearcut financial performance standards have been maintained by special fund-raising drives, gifts, bequests--appealing to special income sources on the basis of being a service and charity organization for a "deserving" needy sector.

This central observation explains a variety of management and operation characteristics. For example, the development of congregate facilities is somewhat haphazard. At only two of the twenty-seven sites were any preliminary investigations of the potential market made prior to the decision to develop. In the majority of cases, the owners built what they thought "should" be provided and then expected the demand to respond to the new supply. Similarly, the on-site service level was arbitrarily decided prior to any analysis of the service needs of the target income sector. As a result there is some evidence of mismatching of supply and demand as seen in the occupancy levels of facilities providing a very high level of services.

Similarly, due to the lack of clearcut financial performance standards, and to the service orientation of these facilities, many problems are encountered in providing services. There is a commitment to provide services "at all costs", which is, indeed, what produces year after year of operating deficits. Although administrators are aware of rising costs, they are loath to maintain appropriate and viable pricing policies, since they are constrained by their service and quasi-philanthropic policies. Inefficiencies are found in administrative practices with an excess of unskilled staff who might well be replaced by fewer professionals. Staffing decisions are made often on the basis of

non-professional criteria but rather of family ties, etc. There is clear under-utilization of community (volunteered) services (which could minimize the redundancy and cost of service provision) and of professionally-specialized contracted services--which was particularly surprising given the severe problems encountered in providing a diverse number of services which allow little pooling of staff, a range of large capital investments, etc.

Interestingly, staff professionalization was found to be related to the income of the resident population and to the extensiveness of the service package, increasing as these variables increased. The existence of professionally trained staff furthermore was associated with prior management experience with the elderly--suggesting that experience has proven the benefits of professionals running the major services provided on-site. The large proportion of the on-site labor force, however, is very low-level, unskilled staff. In fact, professionally-trained personnel seldom account for more than one-quarter of the total payroll. Given this staff structure, it is not surprising to observe a high level of centralization of decision-making authority at the owner/manager level. Concommitantly, residents have significantly little impact on management operations and policies across the twenty-seven sites.

3.3 Major Findings from the Analysis of the Design Features of Congregate Housing

Perhaps the most important conclusion reached regarding the physical design of the twenty-seven sample sites was the fact that the design programs of the facilities clearly expresses managements' service orientation and fundamental bias against an institutional environment. (This bias was referred to earlier in the discussion of service provision where it was noted that the most common services across all sites were those which stressed physical activity). For example, although a variety of physical structures were found, a common denominator was the provision of common spaces (for service delivery), at a central core of the design. The allocation of interior space to common areas was directly related to the number of units and size of dwelling units. As these decreased, the common space allocated per occupant increased.

The non-institutional orientation of congregate housing was clearly displayed in the design programs of the study sites. For example, there was a notable lack of prosthetic equipment and special design features provided in the facility. This can largely be explained by clearly articulated intentions on the part of management to avoid an institutional environment within the facility. The criteria for the inclusion of any special features was unobtrusiveness and easy adaptability to conventional structural modules. The only significant consistency of special design features across all twenty-seven sites was barrier-free circulation spaces, i.e., accessibility to all areas without the use of stairways, lack of thresholds, etc.

The non-institutional orientation of congregate housing was also apparent in individual dwelling units. Significantly, the most prevalent types of units among the twenty-seven study sites were efficiency and one-bedroom apartments with private bathrooms and kitchen(ette)s. (In fact, 60% of all units have kitchens or kitchenettes.) Clearly, congregate housing is providing self-contained housekeeping units--an environment conducive to maintaining one's privacy and individual lifestyle. It is also important to note that sites encourage residents to bring their own furniture and to recreate their own living space. Furthermore, plenty of storage space is provided, both in units and in common storage areas, so that residents can retain their own possessions. All of these features contrast with the institutional environments where the individual is given little opportunity to personalize his/her living space.

Interestingly, the layouts of congregate housing sites typically enforce a rigid segregation of the apartment residence and any on-site medical facilities. This is accomplished by architectural barriers such as limited access locations, separate buildings or wings, heavy fire doors, etc. When personal care is offered in the congregate residence, it is usually provided in specially-designed units, which again are segregated from the rest of the apartments. This segregation minimizes the visibility of medical personnel, as well as the ill and infirm, and perpetuates the impression that active healthy people live in the congregate facility.

3.4 Profile of the Elderly Living in Congregate Housing Facilities: Characteristics and Needs

In terms of their socio-demographic characteristics, the congregate housing residents of the study sample generally represent all the major sectors of the national elderly population in terms of age ranges, income status, physical capabilities, marital status, etc. However, the sample has certain characteristics which clearly differentiate it from national distributions. For example, blacks are severely under-represented, comprising only 7% of the population, and women far outweigh males in the resident population. Although elderly of all ages can be found across the twenty-seven sites, the age distribution is significantly weighted toward the very old. Seventy-two and two-tenths percent of the population are over seventy-five years of age. However, the elderly move into congregate facilities while relatively young -- sixty-two to seventy-five years of age. Survey results clearly showed that congregate housing is a place to grow old. Furthermore, there is a preponderance of single and widowed women in the congregate population (80%) and the majority of respondents had lived independently, either in apartments or their own homes prior to moving in. These combined observations may suggest that one reason for choosing age-segregated elderly housing may be loneliness. The fact that the congregate elderly have generally poorer health status than the national elderly suggests that, as a population, they may no longer feel secure living totally independently. Yet the data showed that they do not perceive their health to be a crippling problem, (a majority viewed their health positively) and thus do not think of themselves as requiring the high level of medical care found in an institutional setting. Thus they may have found in congregate housing an appropriate balance of readily available services and of attributes of conventional housing.

The income distribution of the sample of congregate elderly is also revealing. Although all income groups are represented, in comparison with national statistics the income distribution is weighted toward the upper strata and thus, as a whole across all sites, the congregate elderly have higher mean incomes than the U.S. elderly population at large. This explains why congregate residents can afford a combined housing and

services package which is clearly more costly than conventional housing options.

One final distinguishing characteristic of the study population deserves mention. The congregate elderly, as a group, are highly active. Prior to living in congregate facilities, respondents were found to go shopping and to visit their friends nearly every day and over half participated in clubs and activities at similar frequencies. The analysis of activity patterns of the elderly living in congregate facilities demonstrated almost equally high levels of activity. Clearly this group is not in the market for restrictive, regulated environments. This characteristic has the broadest implication regarding the "needs" of this sector which must be fulfilled by the congregate environment. The congregate elderly were found to clearly need an environment which would permit them to maintain their own independent lifestyles. These elderly do not perceive themselves as needing a supportive environment at the time they move into congregate facilities.

However, all congregate elderly respondents made the decision to leave their previous living arrangements, 85% of which had been independent situations. Furthermore, they all chose a housing and services package, which provides a distinctly different environment from totally independent living. These two seemingly contradictory needs, for a housing and services package and for a setting which permits maintenance of an independent lifestyle, were resolved by residents' attitudes towards on-site services. The congregate housing elderly, in effect, need the insurance of life support services. In opting for the congregate package, they are opting for the security of knowing they can depend on on-site services and that they will be cared for when they need the care.

This overriding need for the security of readily available services eclipsed more specific needs. The elderly's need for special safety features and prosthetic equipment was notably understated. Only respondents with fairly advanced health problems betrayed any awareness of the physical environment.

3.5 The Fulfillment of Basic Shelter and Service Needs by Congregate Housing

The basic shelter needs of the congregate elderly are effectively met: the majority of residents are provided with efficiency or one-bedroom apartments with private kitchen(ettes) and private baths. The vast majority of residents are very satisfied with their accommodations in congregate facilities. (The only major dissatisfaction arises among those who are provided with only one room units and those without private kitchens.) Congregate housing is effective along another dimension of this issue of providing for basic shelter needs. For a low income group which had rented housing in central cities, congregate housing represented an amelioration of housing quality in the eyes of residents.

Congregate housing also fulfills most residents' service needs. Patterns of service utilization clearly showed that on-site services could fulfill a variety of specific needs. For the majority of congregate residents who are relatively free of major health problems on-site services are used as conveniences, which release them from performing essential everyday tasks of meal preparation and housekeeping. This release results in dramatic increases in leisure and social activities. For an older, less healthy sector of congregate residents, on-site services perform more essential support functions, and patterns of service utilization among this sector show markedly greater reliance on on-site services than among any other population group.

This service utilization pattern shows that congregate housing effectively fulfills the primary need of security coverage. Although a majority of residents exercise their options to choose if and when to use on-site services, there is clear evidence that as age advances and health status declines, residents' use of and dependence on on-site services steadily increase. Thus, congregate housing appears to provide services and care on an "as-needed" basis, and thereby is a sensitive service delivery mechanism which allows residents to gauge the appropriate level of services, support and care that they require.

An important conclusion that emerged from a site by site analysis of survey data is that a wide range of service packages was found to

fulfill residents' needs for security coverage. Satisfaction of this need was notably not dependent on extensive on-site service provision. The mere availability of on-site staff in case of emergency, and service which can obviate the necessity of having to travel to medical care, or to go shopping for food, or to do housework, seems to be adequate to allay residents' fears regarding emergencies, illness, and disability in the future.

3.6 Performance of Congregate Housing in Offering an Alternative to Institutionalization and in Helping Maintain the Independence of the Elderly

The issue of congregate housing providing an alternative to independent life on the one hand and institutionalized care on the other is intricately involved with defining the wide range of physical capabilities and gradations in independence/dependence levels between the two extremes. Based on the results from the survey of congregate residents and applicants, congregate housing appears to be able to accommodate this large spectrum of elderly needs. The sheer availability of on-site services fulfills the security insurance need of the relatively independent, active sector. The on-site services can provide support to elderly persons whose age or failing health makes food preparation, housekeeping, going to see the doctor in the community, etc., somewhat difficult and physically taxing. Between these two modes of service utilization are a range of use patterns varying by frequency, by number of on-site services used, by the proportion of on- and off-site activity, etc. The fundamental flexibility of congregate housing service policies which eschew obligatory service utilization permits this variable use of services and effectively accommodates individual needs.

The actual range of needs that a facility can fulfill is obviously directly related to the variety and extensiveness of services provided on-site. In turn, the level of services provided on-site depends on the management's decision about the extent to which the facility should accommodate the aging process. Some sites commit themselves to life care, which requires the broadest range of services, with a prerequisite of extensive medical facilities. Inherent in this definition is the assumption that

the congregate complex can obviate a second move to a separate institution. Instead, the resident requiring extensive medical care merely becomes a patient of the on-site facility. Most other facilities serve a far narrower range of needs, usually because they provide limited medical care on-site. Residents requiring more extensive care are obliged to obtain it by moving either to another congregate facility with expanded on-site service capabilities or to an institution.

An important corollary of this issue is whether congregate housing, with its combined housing and services package, effectively permits the elderly to maintain their independent lifestyles. The overwhelming conclusion from the analysis was that congregate housing facilities indeed maintain the independence of the elderly and, in fact, foster its maintenance. There was no observable decline in independent activity as a result of residence in a congregate facility. Instead, there was a marked increased in certain activities.

Observing these trends through time, survey data produced the conclusion that congregate housing can effectively prolong independent activity. The key here is the issue of access. Over time, as individuals grow older and health status declines, getting places becomes increasingly more difficult. This access problem is what finally precludes a high level of activity in the community requiring transportation, planning, and a measure of mobility. In the congregate setting, in contrast, as activity in the community declines, it is substituted by activity within the facility, since services and programs are readily available on-site. The pattern through time shows that eventually as residents grow very old and very feeble, even on-site activity declines. The key point here is that activity has been prolonged effectively with on-site services beyond the point in time when it naturally would have begun to decline (due to the problem of access) were community services the only resource.

3.7 Findings from Cost Analysis of Congregate Housing Operations

Perhaps the most important conclusion from the cost analysis of congregate housing operations was that the provision of services is a highly costly enterprise, with costs rising in direct proportion with the

extensiveness of the services offered. Not only are there considerable direct costs involved with service provision, but also administrative costs rise dramatically with an increase in the level and number of services provided on-site. The cost analysis showed that in-house "direct" service provision has no apparent cost advantage over contracted service provision. Significant administrative cost savings could be realized by greater use of contracted services, and total service provision expenditures could be reduced by taking greater advantage of volunteered labor or community based services.

In general, congregate housing operations are heavily subsidized. Operating costs are not fully met by operating income. For the vast majority of the sites covered by the study, reported operating surpluses could be traced to either non-operating (charitable subsidy) income, or a failure to report the true costs of being in business. By soliciting donations and bequests, by obtaining below market rate financing, by failing to depreciate assets employed in operations, financial statements show positive positions. This reflects a variety of private and public subsidies of congregate housing for the elderly.

Despite these negative cost conclusions regarding congregate housing operations, comparison with the costs of providing institutionalized nursing care produced contrasting results. Congregate facilities offering high and medium levels of service packages on-site appear to be significantly cost effective alternatives to certain levels of institutional care (in particular Skilled Nursing Facilities) and have lower operating costs than the national average for all nursing facilities.

4.0 Implications of Research Findings

The research results presented in the preceding sections all converge in the overwhelming conclusion that congregate housing does indeed effectively meet the needs of its elderly residents. Furthermore, it appears to improve their "quality of life," by helping counteract their social isolation, by providing improved housing for a low income sector, by staving off unnecessary and premature institutionalization, and by

providing a humane environment to grow old in. Congregate housing accommodates to residents' individual lifestyles and allows a large measure of freedom of movement, discretion, and privacy. There are notably few rules and regulations to restrict residents' activity. In other words, the elderly congregate residents generally are treated as independent individuals, and are not subjected to humiliating protective or restrictive policies. Furthermore, congregate facilities provide consumers with the services they require as they need them. Thus residents themselves can match their needs with appropriate levels of care. Until residents decide to use them, services are relatively unobtrusive. This arrangement permits residents to exercise discretion regarding their service utilization, thereby functioning as a highly sensitive service delivery mechanism. Therefore, as a final conclusion, congregate housing is highly useful for a broad spectrum of elderly with an accompanying array of needs. It effectively provides the elderly with shelter and services once they no longer want to live independently, and before their physical capabilities decline to the point of needing constant surveillance and intensive health care.

However, some distributional problems surfaced as the result of the research analyses. Although congregate housing does indeed service a range of elderly persons, it is important to stress that upper income elderly are provided a very different kind of housing and services package than the poor. The distribution of services is determined by the costs of services, as discussed previously. As service levels climb, so do the costs of operations. Clearly, the upper income elderly are the only ones able to pay for the very high costs of extensive services.

Another interesting facet of this issue of the uneven distribution of services among the congregate elderly is the location of different types of facilities. Congregate sites for the moderate and upper income elderly were usually located in suburban and rural locations, while those for low income elderly were in urban areas. As a general rule, respondents moved into congregate sites in neighborhoods similar to the ones they had lived in previously. This is particularly significant since

low income elderly cited the unsafe character of the neighborhood as a reason to move from previous housing. This group experienced no improvement of neighborhood quality in the move to congregate housing.

Therefore, although all sectors of the congregate elderly population are receiving some services as part of their housing package, they are receiving very different services. Of course, upper income residents pay for the luxury of having a high level of services. However, it is important to note that congregate housing is not able to provide a broad array of services at low cost.

Several important conclusions emerged as a result of the analysis of congregate housing as a service delivery mechanism. Its effectiveness in this role lay principally in the fact that on-site service provision 1) obviated the problem of access (which for the elderly is the single largest determinant of an individuals' activity) and 2) fulfilled the elderly's need for a sense of security in case of emergency and in light of the progressive physical decrements which accompany aging. Provision of on-site services in the congregate context appears to be successful for other reasons as well. Characteristically, resident use of services is not mandatory, which has allowed residents to take advantage of on-site services on an as-needed basis. This flexibility allows a wide range of needs to be met. The provision of services at a central point, in this case, the congregate facility, has the effect of creating a focus for community involvement. Furthermore, a final advantage of a centralized service delivery mechanism is that, in the context of elderly congregate housing, shared services in common spaces provide an important opportunity and focus for social interaction.

There are, however, problems in providing services on-site at congregate facilities. There are no discernible advantages, in terms of reducing expenditures, that accrue from a centralized service delivery system. Each service requires its own staff, its own specialized spaces, and its own capital equipment. There is very little potential for pooling these resources, all of which represent substantial cost elements.

The other major problem inherent to the service delivery systems seen in the congregate context is their flexibility and the resultant drop-in nature of their utilization. This causes a highly unstable

demand and consequent unnecessary expenditures. Managements at many sites have instituted pre-paid service payment plans, in order to stabilize demand and insure income for operations. Such an initiative does indeed provide an incentive for service utilization; however, it does not provide a guarantee. More stringent policies regarding service utilization would violate the non-institutional atmosphere which encourages residents to maintain their independent lifestyles as long as they are physically able.

X.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #11

SUBJECT: Crime and the elderly

Attached is information on crime and the elderly prepared for the Senate Special Committee on Aging.

SOURCE OF DATA: "Developments in Aging: 1979", Part I, A Report of the Special Committee on Aging, United States Senate, dated February 28, 1980.

Senators Lawton Chiles, Pete V. Domenici, Frank Church, John Melcher, David H. Pryor, Bill Bradley, Quentin N. Burdick, and John Glenn of the Special Committee on Aging introduced S. 1060, which provided elderly households with a special medical deduction for allowable medical expenses above $35 a month.

Senator Chiles, upon introducing the bill on May 2, explained:

> Those people with relatively low medical bills would be able to deduct such expenses within the allowable $65 standard deduction. But those people with high medical expenses, who have received no deduction under the new law, would be able to deduct these expenses when computing their net income which determines their coupon allotment.

The Senate Committee on Agriculture, Nutrition, and Forestry combined this medical deduction provision with a provision that eliminated the $80 ceiling on shelter deductions for households with an elderly member. This measure, approved by the full Senate, was amended in conference to include severely disabled persons among those eligible for the special deductions. This measure was signed into law on August 14, 1979 (Public Law 96-58).

Realizing the need to implement this measure promptly, USDA promulgated final rulemaking regulations expeditiously on September 25, 1979 (7 CFR, parts 272 and 273, vol. 44, No. 187). These final regulations allowed the States to implement the new deductions between the issuance date of the regulations and January 1980. Most States planned implementation for January 1980 with several putting the new regulations into effect in December 1979.

In a related matter, the USDA issued proposed regulations on December 7, 1979 (7 CFR, part 273, vol. 44, No. 237), to implement a provision in the 1977 amendments to the food stamp program regarding application procedures. Specifically, the proposed rules carry out the change in the 1977 law to allow SSI households to apply for food stamp benefits at local or district social security offices and to be certified on the basis of information contained in the social security files. This would simplify the application process for aged, blind and disabled persons by allowing a "one-stop" application and certification process, instead of the current process which requires personal visits to at least two administrative offices.

Final promulgation of these regulations is expected in February 1980.

IV. CRIME AND THE ELDERLY

The increasing political activity of senior citizens in combination with the present trends towards crime prevention is resulting in higher priorities for legislative issues concerning crime and the elderly. Although available statistics have not substantiated claims of greater senior citizen victimization as compared to younger persons in all the traditional categories of crime, the elderly have been shown to suffer a disproportionate number of predatory crimes (robbery, larceny, fraud) for their numbers.

The physical, psychological, and economic aspects of victimization and the even more debilitating effects of fear of crime, are beginning to be addressed. National programs and Federal legislation are presently directed towards victim assistance, crime prevention, and education programs.

A. General Status/Background

Although it has generally been advanced that senior citizens are especially vulnerable to crime, the rate of criminal victimization of older adults, as compared with the entire population, is still a matter of debate.

Victimization studies conducted by the Law Enforcement Assistance Administration (LEAA),[5] the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP),[6] and the National Crime Survey (NCS)[7] all generally agree that older persons are not disproportionately represented as crime victims when all serious crimes and all age groups are considered. The pattern would, at first glance, indicate that the young are more likely to be victimized than the old. A closer inspection, however, reveals that while the young are indeed more prone to becoming victims of personal crimes such as rape and homicide, it appears that the rates of personal larceny, robbery, and fraud are as high or higher for the elderly when compared with younger groups. In fact, it is contended that the elderly who live in the inner city are victimized out of proportion to their relative numbers.[8]

According to one study, the aggregate data of official statistics and victimization surveys is often misleading as to the true extent of the problems and underestimates seriously the impact of the problem on many individuals and communities. "What little information is available would substantiate the impression of many that such victimization is on the increase."[9]

B. Types of Crimes

The nature of crimes against the elderly are primarily of the predatory type, rather than the violent type. One of the best studies of traditional crime categories, conducted in Kansas City, found that among the elderly burglary was the most frequent crime (55.9 percent), followed by robbery (24.6 percent), larceny (13.9 percent), assault (2.5 percent), and fraud (2.3 percent) with rape, homicide, and all other crimes under (0.52 percent).[10]

The following tables, taken from the Department of Justice's national crime survey report, illustrate the frequency of elderly victimization in comparison to other age groups.[11]

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[5] U.S. Department of Justice. Law Enforcement Assistance Administration. Criminal Victimization Studies in the Nation's Five Largest Cities. [Washington. 1975.]
[6] NRTA/AARP. Crime Prevention Program. [Washington: NRTA/AARP, 1977.]
[7] John J. Gibbs. Crimes Against Persons. [Washington: LEAA, 1979.]
[8] Robert J. Smith. Crimes Against the Elderly: Implications for Policy-Makers and Practitioners. [Washington: The International Federation on Aging, 1979], p. 7.
[9] Ibid.
[10] Ibid., p. 9.
[11] U.S. Department of Justice. Law Enforcement Assistance Administration. National Criminal Justice Information and Statistics Service. Service Book of Criminal Justice Statistics—1978 (Washington, 1978) p. 380. pp. 382. 383.

ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY AGE OF VICTIM AND TYPE OF VICTIMIZATION, UNITED STATES, 1976[1]

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
Base	16,349,800	16,487,000	19,032,700	31,800,200	34,479,300	31,825,400	21,926,100
Rape and attempted rape	185	289	259	123	4	9	5
Robbery	988	935	1,028	637	518	452	342
Robbery and attempted robbery with injury	288	321	281	218	179	190	138
Serious assault	81	177	145	93	81	102	70
Minor assault	127	144	136	125	98	88	68
Robbery without injury	448	336	445	257	262	171	159
Attempted robbery without injury	342	278	302	162	130	91	84
Assault	4,092	5,515	4,563	3,303	1,488	761	414
Aggravated assault	1,284	2,340	1,828	1,316	564	344	147
With injury	465	924	684	414	187	92	23
Attempted assault with weapon	799	1,417	1,142	903	378	252	124
Simple assault	2,828	3,175	2,737	1,987	924	416	267
With injury	836	1,019	860	426	158	57	70
Attempted assault without weapon	1,992	2,155	1,877	1,561	766	360	198
Personal larceny with contact	222	408	384	277	214	224	326
Purse snatching	7	51	70	47	44	76	74
Attempted purse snatching	8	22	40	32	45	27	46
Pocket picking	215	335	274	198	125	177	206
Personal larceny without contact	14,648	14,286	14,241	11,062	8,045	5,588	2,277

[1] Subcategories may not sum to total because of rounding.

Source: Table constructed by Sourcebook staff from data provided by the National Criminal Justice Information and Statistics Service of the Law Enforcement Assistance Administration.

ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY SEX, RACE, AND AGE OF VICTIM, AND TYPE OF VICTIMIZATION, UNITED STATES, 1976[1]

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization and race of victim	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
SEX OF VICTIM: MALE							
Base:							
White	7,037,700	6,985,300	8,109,100	13,808,700	14,834,200	13,655,600	8,151,200
Black and other races	1,300,500	1,206,200	1,201,800	1,797,600	1,894,900	1,468,200	877,100
Rape and attempted rape:							
White	0	21	78	27	0	9	13
Black and other races	8	8	8	8	8	8	8
Robbery:							
White	1,508	1,198	1,135	711	582	408	545
Black and other races	2,375	1,972	2,186	1,772	1,505	2,304	980
Robbery and attempted robbery with injury:							
White	230	400	280	230	190	169	131
Black and other races	680	417	428	529	230	772	463
Serious assault:							
White	136	282	190	130	67	141	63
Black and other races	190	114	286	259	230	421	463
Minor assault:							
White	103	177	90	100	123	28	68
Black and other races	490	304	133	270	0	351	0
Robbery without injury:							
White	722	384	422	238	212	146	280
Black and other races	1,109	965	1,171	792	982	1,262	537
Attempted robbery without injury:							
White	546	344	425	245	180	84	146
Black and other races	586	580	557	450	384	270	0
Assault:							
White	5,215	7,623	5,919	4,342	1,857	948	681
Black and other races	3,908	5,212	5,712	5,281	1,244	1,282	316
Aggravated assault:							
White	1,624	3,456	2,622	1,773	758	447	219
Black and other races	1,796	3,063	3,219	2,782	847	907	316
With injury:							
White	633	1,393	1,019	521	266	101	31
Black and other races	872	1,217	1,309	977	286	281	0
Attempted assault with weapon:							
White	991	2,063	1,603	1,251	493	346	189
Black and other races	926	1,848	1,910	1,805	550	626	316
Simple assault:							
White	3,591	4,167	3,296	2,569	1,109	501	462
Black and other races	2,191	2,147	2,493	2,488	387	376	0
With injury:							
White	1,146	1,317	1,081	486	187	83	93
Black and other races	438	361	390	325	0	80	0
Attempted assault without weapon:							
White	2,445	2,850	2,215	2,109	922	438	369
Black and other races	1,752	1,786	2,103	2,174	387	295	0
Personal larceny with contact:							
White	356	441	222	186	143	148	189
Black and other races	325	917	1,219	487	306	609	529
Purse snatching:							
White	0	0	0	0	0	0	0
Black and other races	0	0	0	0	0	0	0
Attempted purse snatching:							
White	0	0	0	0	0	0	0
Black and other races	0	0	0	0	0	0	0
Pocket picking:							
White	356	441	222	186	143	148	189
Black and other races	325	917	1,219	487	306	609	529
Personal larceny without contact:							
White	16,498	15,895	16,347	12,052	8,559	6,263	2,970
Black and other races	10,005	10,758	14,330	11,683	7,448	6,978	2,470

[1] See footnotes at end of table.

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ESTIMATED RATE (PER 100,000 PERSONS 12 YR OF AGE OR OLDER) OF PERSONAL VICTIMIZATION, BY SEX, RACE, AND AGE OF VICTIM, AND TYPE OF VICTIMIZATION, UNITED STATES, 1976 [1]—Continued

[Rate per 100,000 persons 12 yr of age or older]

Type of victimization and race of victim	Age of victim						
	12 to 15	16 to 19	20 to 24	25 to 34	35 to 49	50 to 64	65 or older
SEX OF VICTIM: FEMALE							
Base:							
White	6,721,800	7,016,700	8,286,100	13,975,600	15,428,900	14,988,400	11,726,300
Black and other races	1,289,800	1,278,800	1,435,700	2,218,400	2,321,300	1,713,200	1,171,500
Rape and attempted rape:							
White	190	295	402	204	8	0	0
Black and other races	340	965	536	306	0	96	0
Robbery:							
White	332	518	593	350	313	296	141
Black and other races	303	812	1,964	1,068	556	571	458
Robbery and attempted robbery with injury:							
White	87	182	244	136	149	148	85
Black and other races	193	293	332	411	267	220	329
Serious assault:							
White	18	73	105	43	71	48	53
Black and other races	0	179	0	48	110	65	0
Minor assault:							
White	69	89	139	93	78	108	32
Black and other races	193	114	332	364	158	156	329
Robbery without injury:							
White	120	146	212	154	93	73	57
Black and other races	0	519	1,313	603	249	251	129
Attempted robbery without injury:							
White	125	210	137	80	71	74	0
Black and other races	110	0	319	54	0	61	0
Assault:							
White	3,103	3,708	3,174	2,075	1,220	905	195
Black and other races	3,221	4,205	3,973	2,980	1,046	1,060	821
Aggravated assault:							
White	691	1,209	863	632	338	178	43
Black and other races	1,749	1,770	1,723	1,597	598	492	556
With injury:							
White	175	421	272	195	93	47	22
Black and other races	656	845	642	662	216	245	0
Attempted assault with weapon:							
White	516	788	590	437	246	131	21
Black and other races	1,093	925	1,081	935	382	247	556
Simple assault:							
White	2,412	2,499	2,311	1,443	882	326	152
Black and other races	1,472	2,435	2,249	1,383	449	568	265
With injury:							
White	693	855	720	402	173	41	53
Black and other races	284	929	815	412	0	126	127
Attempted assault without weapon:							
White	1,718	1,644	1,591	1,041	709	286	98
Black and other races	1,187	1,506	1,435	971	449	442	139
Personal larceny with contact:							
White	105	351	355	287	203	308	351
Black and other races	0	174	771	798	663	698	935
Purse snatching:							
White	17	89	104	68	47	119	117
Black and other races	0	174	323	251	336	263	214
Attempted purse snatching:							
White	0	51	78	53	70	49	86
Black and other races	0	0	86	124	208	68	0
Pocket picking:							
White	88	191	173	186	86	140	148
Black and other races	0	0	362	422	119	367	721
Personal larceny without contact:							
White	14,575	14,235	13,148	10,245	7,869	5,078	1,789
Black and other races	9,621	9,108	8,582	9,247	6,413	3,337	2,185

[1] Subcategories may not sum to total because of rounding.

Source: Table constructed by Sourcebook staff from data provided by the National Criminal Justice Information and Statistics Service of the Law Enforcement Assistance Administration.

Although it is the brutal and often sensational acts of violence that receive the most publicity and generate the most fear, these crimes are not numerically the most important. This quantitative conclusion should not diminish attempts to prevent such offenses. However, focus is now being directed to the less sensational, but numerically more important and often socially, psychologically, and physically more damaging nonviolent crimes [12] against older persons.

C. Social and Physical Environment

Several factors combine to render older persons particularly susceptible to the incidence and aftermath of crime. The most potent factor accounting for victimization, however, is the composition of the neighborhood in which the older person resides. The tragedy in American cities that have been studied is that older citizens tend to be concentrated in the inner city, where crime rates in general are higher.

This fact raises the question of why older Americans live in these high crime areas; it is obviously more than a matter of simple choice. Many are original residents of the neighborhood, regard it as their home, and are reluctant to leave. Others come there because of their need for low-cost housing and for the services which are available in densely concentrated housing. Still others may wish to leave, but their low incomes prevent them from resettling in outlying safer areas.[13]

The concentration of older people in the inner city could be a causative factor in the increase in crime because they are often trapped into close and unavoidable contact with that element of society most likely to attack or steal from them—young unemployed males who also tend to inhabit the inner city. The irony is that high rise, low-cost housing has been actively sought in the past by senior groups, churches, and organizations for older people, but the problem of security was not carefully reviewed at the planning or building stage. As a result, apartments, homes, and the immediate neighborhood surrounding the older people's dwellings often become high crime areas, if they were not so before.[14]

It might be noted that according to the aforementioned Kansas City study, in 80 percent of the serious crimes studied, the elderly victims were in their own homes or in the immediate vicinity. It might additionally be assumed that the greater percentage of instances of fraud also take place in or near the home of the victim. The fact that so much of the victimization of the elderly usually takes place in or near the home add to the trauma of victimization, since the home is usually regarded as a refuge. This situation undoubtedly contributes to the great fear of victimization expressed by many older people.

A perceived threat can be just as debilitating to the general well-being of the individual as a real threat—in some cases even more so. Even in the cases where fears may be largely unwarranted, the effect is just as severe on the older person's behavior as when the fears are objectively justified.[15]

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[12] Smith, p. 11.
[13] Ibid., p. 12.
[14] Ibid.
[15] Ibid., p. 21.

D. Impact of Victimization

Robert J. Smith's "Crime Against the Elderly: Implications for Policymakers and Practitioners" (pp. 17–18) contains a comprehensive overview of the quantitative and qualitative aspects of victimization experienced by older persons.

"The physical, financial, psychological, and behavioral scars suffered by the elderly victim are often profound, and the cost to society is multifaceted and immense. Until recently, the impact of crime on the victim had not been a major consideration of the criminal justice system. The individual suffering most from crime, the victim, has been called "the forgotten element of the criminal justice system." Of all persons who, in one way or another, become targets of a criminal act, many contend that the elderly usually suffer most. Many reasons are offered as to why the impact of a crime on an older adult should be viewed differently in comparison to a similar victimization of a younger person. Jack Goldsmith, author of several publications dealing with crime and the elderly, has offered 11 reasons why a special approach should be taken toward victimization of the elderly:

(1) There is a high incidence of reduced or low income among the elderly. Thus, the impact of any loss of economic resources is relatively greater.

(2) Older people are more likely to be victimized repeatedly, often by the same crime and the same offender.

(3) Older people are more likely to live alone. Social isolation increases vulnerability to crime.

(4) Older people have diminished physical strength and stamina; hence they are less able to defend themselves or to escape from threatening situations.

(5) Older people are more likely to suffer from physical ailments such as loss of hearing or sight, arthritis, and circulatory problems which increase their vulnerability.

(6) Older people are physically more fragile and more easily hurt should they opt to defend themselves. For example, bones are more easily broken and recovery is more difficult. Thus, they are less likely to resist attackers.

(7) Potential criminals are aware of the diminished physical capacity and the physical vulnerability of the elderly and thus are more likely to seek out an elderly target (whose aged status is easily visible).

(8) There is a greater likelihood that older people will live in high crime neighborhoods, rather than in suburbs as a result of diminished income and of being rooted in central cities. Thus, they find themselves in close proximity to the groups most likely to victimize them—the teenage dropouts.

(9) The dates of receipt by mail of monthly social security and other benefit checks (and hence the dates when older people are most likely to have cash on their person or in their dwelling) are widely known.

(10) Dependency on walking or on public transportation is more likely among older people who, for physical, financial, or other reasons, are less likely to drive or own a private automobile.

(11) There is evidence that older people are particularly susceptible to fraud and confidence games.

(12) Older people have the highest rates of crime of personal larceny with contact (theft of purse, wallet, or cash directly from the person of the victim, including a tempted purse snatch).

(13) Awareness of increased vulnerability to criminal behavior has a chilling effect upon the freedom of movement of older Americans. Fear of criminal victimization causes self-imposed "house arrest" among older people who may refuse to venture out of doors. Furthermore, even in those situations where the fear of being victimized may be somewhat exaggerated or unwarranted by local conditions, the effect on the older person is just as severe as when the fears are justified.

(14) Because of the loss of status and decreased sense of personal efficacy associated in American culture with being old, older people may be less likely to process complaints through the criminal justice bureaucracy and to draw upon available community resources for protection and redress.[16]

Thus, although the elderly generally may not experience abnormally high victimization rates, the effect of such victimization—financial, physical, and behavioral—can be far more devastating to the older adult than to younger members of society.

What is needed is to change the concept of criminal victimization of the elderly. The physical, economic, behavioral, and environmental consequences associated with the older victim make such special attention necessary. Due in part to their special vulnerability and the differential impact of crime, fear of criminal victimization can be particularly pervasive among older persons. The crime problem has two aspects: The actual victimization and the fear of victimization.

Many experts believe that the fear of victimization and its behavioral ramifications are even greater problems than victimization itself. The psychological effects of victimization for victim and nonvictim alike, include a great increase in fear and anxiety, and a decrease in morale, ultimately resulting in a restriction of activities.

The social and psychological costs to a community of the victimization of its elderly residents are inestimable. If older people are prevented from participating in community life because of the effects of victimization itself or the fear of it, the community loses the contributions of many individuals who have much to give.[17]

E. Focus: Legislative Activity—Victim Assistance and Crime Prevention

The active participation of older people in advocating breakdown of traditional stereotyping has resulted in the older person being portrayed with greater dignity and more realism. This trend, when combined with recent citizen action to prevent crime before it happens, has resulted in Federal legislation raising the crime prevention needs of the elderly to a higher priority.

Legislative activities during the past year have included both preincident (prevention) and postincident (victim assistance) innovations. Though the future of most of the newly introduced legislation remains uncertain, the new policy of giving formal recognition to the once-forgotten victims of crime in the Federal Government's anticrime programs has been established.

[16] Jack Goldsmith and N. E. Thomas, "Crimes Against the Elderly: A Continuing National Crisis," Aging (June–July 1974), 236: 10–17.
[17] Ibid., p. 22.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #12

SUBJECT: Provision of services to older people

Attached is information on the various services provided to older people. This information is extracted from a United States General Accounting Office report to the Congress.

SOURCE OF DATA: "The Well-being of Older People in Cleveland, Ohio", United States General Accounting Office report, HRD-77-70, dated April 19, 1977.

HOW SERVICES ARE DELIVERED

Using a multiprogram approach, we were able to study many programs designed to help older people. The following describes some of our results and suggests ways that they can be used by Federal agencies in administering the programs. Data showed that

--many social service agencies provide certain kinds of service which lend themselves to centralized administration;

--family and friends are a large source of service for many older people;

--many low income older people live in higher-income neighborhoods served by few social service agencies and, as a result, they may not be receiving agency services;

--many social service agencies emphasize public housing sites and as a result do not reach some older people who could benefit from multiple services;

--many older people who are eligible for assistance under certain Federal programs are not receiving that assistance;

--many low-income older people who own their homes do not get financial help;

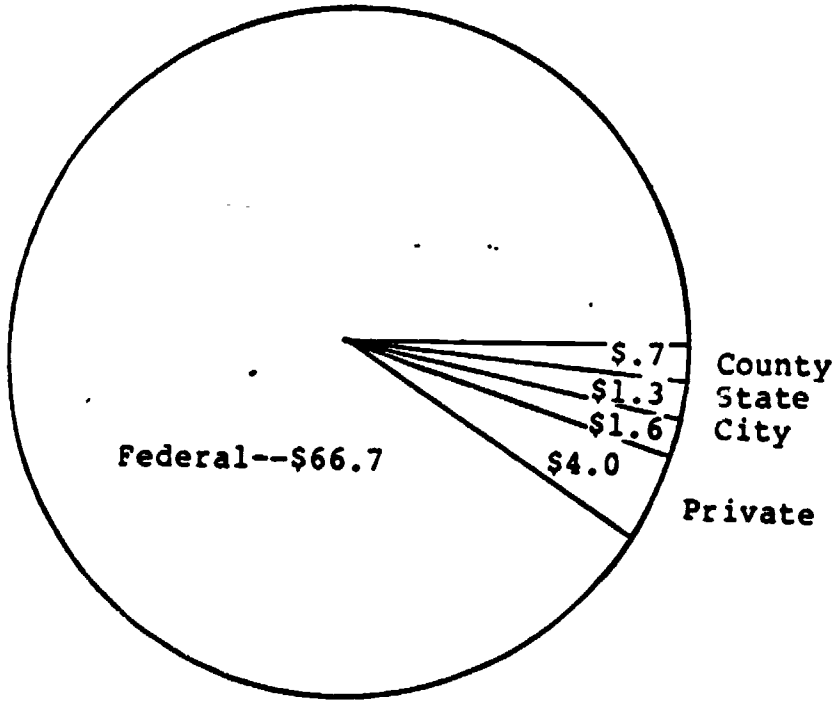
--older people are likely to recognize a need for certain services but not for other services;

--provision of more assessment and referral type services could lead to more older people receiving all appropriate services; and

--many impaired older people do not receive social/recreational services.

CENTRALIZING SERVICES

Over $74 million was spent in Cleveland in 1975 to provide services through social service agencies and health services under Medicaid and Medicare, as follows:



Total funds--$74.3 million

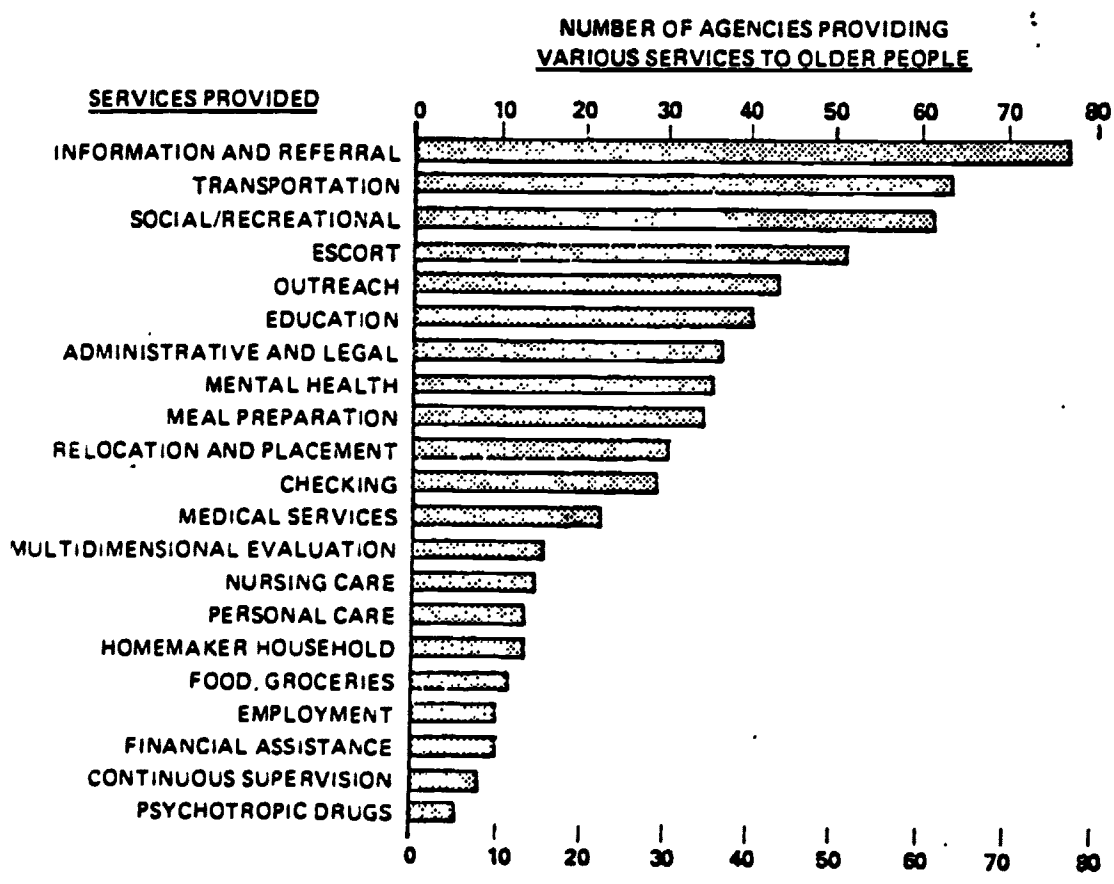
Of the $74.3 million, $58.6 million was for health services under Medicaid and Medicare and subsistence under Supplemental Security Income. The remaining $15.7 million, which was spent by the 118 social service agencies, came from the following sources:

Source of funds	Amount (millions)	Percent
Federal	$ 9.4	60
County	.7	4
City	1.6	10
Private	4.0	26
Total	$15.7	100

The $9.4 million of Federal funds went to 84 of the 118 agencies and came from 23 Federal programs administered by 7 Federal agencies, including the Departments of Agriculture; Health, Education, and Welfare; Housing and Urban Development; Labor; and Transportation. (App. VI shows the Federal agencies and programs funding services in Cleveland, and funding levels for fiscal year 1975.)

The 1975 annual funding level of most agencies was less than $100,000. Of the 118 agencies, 92 (78 percent) receive less than $100,000 each in Federal funds annually.

Many of the agencies provide similar services. For example, the most offered services are information and referral (77 agencies), transportation (63), social/recreational (61), escort (51), and outreach (43). Information on the number of agencies providing each service is shown in the following graph.



NOTE Seven services provided by fewer than five agencies are not shown. Also, most agencies provided more than one service.

Opportunities for centralizing the administration of services are apparent, considering the number of agencies providing similar services. Particular services which may by their nature lend themselves to consolidation and centralization of administration include four of the five most-offered services--information and referral, transportation, escort, and outreach.

FAMILY AND FRIENDS PROVIDE CERTAIN SERVICES TO MANY OLDER PEOPLE

For the most part, home help types of service and transportation were provided by the family or friends. Medical and social/recreational services were provided mostly by agencies. Financial assistance and assessment and referral services were split about evenly between family and friends and an agency. The table on the following page shows the percent of sampled people receiving each individual service by source.

Medical services	Source: Family/ friends	Agency	Both	Total
	----------(Percent)-------			
Medical care	-	75	-	75
Psychotropic drugs	-	20	-	20
Supportive devices	-	15	-	15
Nursing care	3	3	1	7
Physical therapy	-	4	-	4
Mental health	-	3	-	3
Home help services				
Personal care	56	1	1	58
Checking	44	1	1	46
Homemaker	20	5	1	26
Administrative and legal	15	7	1	23
Meal preparation	13	8	1	22
Continuous supervision	6	1	1	8
Financial assistance				
General financial	2	7	-	9
Housing	12	10	-	22
Groceries and food stamps	7	8	-	15
Assessment and referral				
Coordination, information, and referral	8	3	1	12
Overall evalution	-	8	-	8
Outreach	-	5	-	5
Social/recreational (formal, organized activities outside the home)	-	30	-	30
Transportation	60	3	5	68

Most older people have someone available to help

We asked each sampled older person if he or she had a primary source of help if he or she became sick or disabled. Eighty-seven percent said they did. Most said they had someone who would take care of them as long as needed.

The most frequent primary source of available help was the older person's children--42 percent of those who said they had help available mentioned their children. The next most frequent source was the husband or wife--27 percent said the help would come from their spouse--followed by brother or sister (10 percent), other relative (9 percent), and friend (8 percent). The remaining percentage included all others.

Since the family and friends are now providing home help and transportation services, it may well be that the family and friends of other older people could be encouraged and trained to provide similar services. Ways to encourage family and friends to help older people could be identified, developed, and tested. These could include training for family and friends and financial incentives through the income tax system or direct payments. However, any such effort should be structured to encourage and support the many family members or friends who are currently serving older people.

OLDER PEOPLE MAY NOT RECEIVE SERVICES BECAUSE AGENCIES SERVE ONLY CERTAIN NEIGHBORHOODS

The availability of agency services in a neighborhood could be affecting receipt of services. Older people who lived in neighborhoods served by few agencies received considerably fewer services than those living where many agencies provided services.

To illustrate, when considering only the sampled older people who were assessed as generally impaired or worse, only 41 percent of those living in neighborhoods served by only 2 agencies received 2 or more types of service from the agencies. This compares to 64 percent of those living in neighborhoods served by 15 agencies, as shown in the following table:

Agency service level in neighborhood	Average number of agencies serving neighborhood	Percent of sampled people generally impaired or worse receiving two or more services from agencies
Very low	2	41
Low	5	58
Medium	10	63
High	15	64

Further, the family and friends of older people are apparently not compensating for the unavailability of services. Looking at services received from both agencies and the family and friends, only 15 percent of those living in neighborhoods with a very low agency service level received five or more services. This compares to 34 percent of those in neighborhoods with a high agency service level, as shown below.

Agency service level in neighborhood	Percent of sampled older people generally impaired or worse receiving five or more service types
Very low	15
Low	19
Medium	19
High	34

Agencies located in inner city

Most neighborhoods with a high agency service level were located in the low-income, inner portion of the city. Those with a very low service level were mostly in the higher income areas of the city. Thus, it appears that many agencies have focused on the low-income neighborhoods with the idea that low-income older people could benefit most from services.

However, many older people living in higher income neighborhoods have both low income and an assessed well-being that indicates they could benefit from services. To illustrate, there are a projected 4,750 older people who have annual incomes less than $3,000 living in neighborhoods with a very low service level, compared to only a few more--a total of 5,000--in neighborhoods with a high service level. Also, there are a projected 4,050 people with an assessed well-being of generally impaired or worse living in neighborhoods with a very low service level,

compared to 2,960 in the high service level neighborhoods, as shown below.

Service level in neighborhood	Projected number of older people with less than $3,000 annual income	Projected number of older people generally impaired or worse
Very low	4,750	4,050
Low	4,550	4,100
Medium	3,700	3,070
High	5,000	2,960

The data presented raises questions about where new or expanded services should be located. This data could be used in planning the locations of new agencies or the expansion of existing agencies.

One possible way to identify those neighborhoods where agencies should focus is to project the number of older people in each neighborhood who are impaired in a particular area of functioning and are not receiving a related service. For example, we projected the number of older people in Cleveland who are mildly or worse impaired socially and are not receiving social/recreational services. We found more socially impaired older people (5,050) in neighborhoods with very low service levels than in neighborhoods with a high level (2,700). The following table shows our projections.

Service level in neighborhood	Projected number of older people impaired socially and not receiving social/recreational services	
	Number	Percent
Very low	5,050	33
Low	4,000	26
Medium	3,400	23
High	2,700	18
Total	15,150	100

A similar technique could be used for other services also. The table on the following page shows our projections by service level of the number of older people in Cleveland who are impaired in the other four areas of functioning and not receiving a related service:

Service level in neighborhood	Projected number of people impaired and not receiving a related service (note a)			
	Economic status	Mental health	Physical health	Active daily living
Very low	4,350	3,500	1,350	400
Low	4,200	3,700	1,050	250
Medium	3,800	3,050	900	250
High	2,700	2,650	800	350
Total	15,050	12,900	4,100	1,250

a/Related services were defined as (1) Economic: Financial assistance, groceries or food stamps, housing; (2) Mental: Mental health services, psychotropic drugs; (3) Physical: Medical care, physical therapy, supportive devices, nursing care; and (4) Active daily living: Personal care, meal preparation, homemaker household, administrative and legal.

Using this technique in the second phase of this study, we will attempt to attribute changes in assessed well-being to services and project the number of older people not receiving services who could benefit from them.

EMPHASIS ON PUBLIC HOUSING

Older people living in public housing are much more likely to receive multiple services which could be appropriate to their assessed well-being than older people who own their homes or rent. Examining those in the sample who were generally impaired or worse, we found that 84 percent of those living in public housing received four or more types of service, compared to 53 percent of those who rent and 39 percent of those who own their homes.

The difference is in the services provided by the agencies. Older people in public housing received as many services from their family or friends as those not in public housing. However, more than half (58 percent) of those in public housing received three or more services from an agency compared to only 5 percent of those not in public housing. The table on the following page shows this in detail.

Number of services received (note a)	People in public housing Source of service Family and friends	Agencies	People not in public housing Source of service Family and friends	Agencies
None	11	-	13	50
1 or 2	72	42	69	45
3 or more	17	58	18	5
Total	100	100	100	100
Number of sampled people	124	124	1,485	1,485

a/Not including medical type services.

As the above data indicates, multiple services are available primarily at public housing sites. However, about 9 percent of our sample, a projected 5,718 older people in Cleveland, are not living in public housing but could benefit from multiple services and are not receiving them. Conversely, many older people in public housing may not need multiple services--27 percent of our sample who lived in public housing, a projected 1,284 people, were unimpaired or only slightly impaired.

One way to make multiple services available to those who need them most could be to expand the eligibility criteria for public housing to give preference to older people who could benefit the most from multiple services. Currently, eligibility is based primarily on economic consideration. Also, a way could be developed to provide multiple services to older people who do not live in public housing.

MANY OLDER PEOPLE DO NOT USE FEDERAL PROGRAMS

Many older persons in our sample had income low enough to be eligible for Federal programs. Although eligible, many were not using the services from these programs even though their low income indicates they could benefit from some services.

Using our sample and applying the income criteria for four Federal programs, we determined the percent of eligible persons who were receiving benefits. More than half of the eligibles were not using 3 programs and 29 percent were not using the fourth program as shown below.

Program	Number in sample eligible	Number not eligible	Percent of eligible not receiving
Public Housing	1078	954	89
Food Stamps	566	433	77
Supplemental Security Income (SSI)	146	76	52
Medicaid	77	22	29

Some of the reasons for not using these services could be lack of public housing units, unawareness of services, or hesitancy to use the services. Attempts could be made to determine the reasons and then modify these programs accordingly.

HOMEOWNERS NOT RECEIVING FINANCIAL HELP

Older people who own their homes are much less likely to be receiving financial services than those who rent. To illustrate, of those with less than $2,000 income, only 46 percent of the homeowners received financial services, compared to 87 percent of the renters. Also, of those with income between $2,000 and $4,000, only 12 percent of the homeowners received financial services, compared to 57 percent of the renters.

Homeowners were less likely to receive financial help from either their family and friends or from an agency. To illustrate, of those with less than $2,000 income only 29 percent of the homeowners received financial services from their family and friends, compared to 51 percent of the renters. Of those with less than $2,000 income, only 20 percent of the homeowners received financial services from an agency, compared to 62 percent of the renters.

One possible explanation for this is that many families and friends provide financial services to older people by encouraging the older people to move into their homes. Another could be that older homeowners are hesitant to to accept financial services from agencies.

OLDER PEOPLE SEE BENEFITS OF SOME SERVICES BUT NOT OTHERS

Older persons' responses to the questionnaires indicate recognition that they could benefit from certain services but do not see the benefit of others. The data suggests that older people may be willing to accept certain services and not others and that outreach efforts may have to be designed accordingly.

Generally, older people who might benefit, as indicated by their responses, from a home help type of service did express a need 1/ for one or more of such services. But, older people who might benefit from social/recreational services and mental health services (including psychotropic drugs) generally did not express a need for them. Only about half of those who might benefit from financial services expressed a need.

Most older people who could benefit from home help services expressed a need for them. Forty-six of the 50 people who were unable to dress without help expressed a need for personal care, as did 20 of the 23 who could not eat without help, 47 of the 53 who could not take care of their appearance without help, and 141 of the 166 who could not take a bath or shower without help. Also, 344 of the 484 people who were unable to do housework expressed a need for homemaker-household service, 177 of the 218 who were unable to prepare meals expressed a need for meal preparation, and 134 of the 176 who were unable to handle money expressed a need for administrative and legal service.

1/In this chapter and throughout the report we use the word "need" only to indicate that an older person said he or she "needed" a service. The word is used in such instances because it was also used on the questionnaire. (See app. IV.) We have generally avoided the word because it has many meanings and can be used ambiguously. In general we have tried to replace the word "need" by the word "benefit"; that is, instead of saying an older person "needs a service," we have said an older person "could benefit from a service." In the second phase, an older person will be said to "need" a service if he or she is not receiving a service and we find evidence that older people with the same well-being status benefited from the service.

Because older people are willing to express a need for home help services, they may be willing to accept and even seek out such services. Thus, efforts to encourage people to use home help services may be successful if the older persons are merely made aware that the service exists.

Of those who were impaired economically, only 52 percent expressed a need for more financial aid or food stamps. Possible explanations are that older people (1) hesitate to accept financial help from others, (2) do not recognize their economic status, or (3) have learned to cope with it.

If nearly half of those older people who could benefit from financial services are not willing to express a need, they probably will not take steps to obtain them. Thus outreach efforts for financial services apparently must involve more than merely making older people aware that the services are available.

Only 21 percent of those older people who were impaired in social functioning expressed a need for social/recreational services. Outreach efforts may have to be specifically tailored to deal with the special problems associated with social-impaired older persons.

Of those who were impaired in mental health, only 8 percent expressed a need for mental health services in general and only 35 percent said they needed psychotropic drugs. Again outreach efforts may have to be specifically designed for mentally impaired older people.

ASSESSMENT AND REFERRAL SERVICES AIDS IN USING OTHER APPROPRIATE SERVICES

Assessment and referral services may be enabling older persons to receive other types of service. Considering only those who were generally impaired or worse, 56 percent of those who received assessment and referral services received four or more other service types, compared to only 40 percent of those who did not receive assessment and referral services, as shown on the next page.

Number of other five service types received	Assessment and referral for generally impaired older people: Percent who received	Percent who did not receive
0	-	2
1	3	4
2	6	12
3	35	42
4	36 } 56	34 } 40
5	20 }	6 }
Total	100	100
Number of sampled people	110	254

Except for medical and home help, older people were much more likely to receive each type of service if they were also receiving assessment and referral. For example, considering only those who were impaired in social functioning, 28 percent of those who received assessment and referral services also received social/recreational services, compared to 16 percent of those who did not receive assessment and referral services. The following table illustrates this for all service types.

Type of service received in addition to assessment and referral	Functional impairment accounted for	Assessment and referral: Percent who received	Percent who did not receive
Social/recreational	Social	28	16
Financial	Economic	61	47
Medical	Physical health	94	87
Transportation	None	81	65
Home help	Active daily living	98	96

The data presented above indicates that older people who receive assessment and referral are more likely to receive other appropriate services. Therefore, increased efforts to provide more assessment and referral types of service could lead to more older people receiving all appropriate types of service.

IMPAIRED OLDER PEOPLE DO NOT RECEIVE SOCIAL/ RECREATIONAL SERVICES

Older people who were impaired in any of the five functional areas were less likely to receive social/ recreational services than those who were unimpaired. The level of impairment could also make a difference.

The following table shows the likelihood of an older person receiving social/recreational services by level of impairment for five functional areas. To illustrate, the table shows that only 8 percent of those who were severely or completely impaired in active daily living received social/recreational services, compared to 26 percent of those who were mildly or moderately impaired, and 33 percent of those who were unimpaired (good or excellent).

	Percent receiving social/ recreational services		
Area of functioning	Good or excellent	Mildly or moderately impaired	Severely or completely impaired
Active daily living	33	26	8
Physical health	34	28	15
Economic status	32	28	11
Mental health	34	23	2
Social status	35	18	20

The above indicates that older people who are impaired in any functional area may have problems in taking part in social/recreational services. For example, socially impaired older people may have certain characteristics that make them difficult to locate and/or difficult to communicate with.

Thus, outreach efforts and social/recreation services may have to be specially designed to deal with such problems. Also, efforts directed toward mildly or moderately impaired older people may be more successful than those directed toward the severely or completely impaired.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #13

SUBJECT: Older people's share of health resources

Attached is information on older people's consumption of health resources. This information is extracted from the United States General Accounting Office briefing on the nutritional health of older people provided to the staff of the House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition

SOURCE OF DATA: "Information on the Nutritional Health of the Elderly", United States General Accounting Office Briefing, House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition, June 1980.

OLDER PEOPLE CONSUME A LARGE SHARE OF ALL HEALTH RESOURCES

The age distribution of the population has a direct bearing on the amount and distribution of the Nation's health care expenditures. Per capita expenditures for people 65 years of age and over, nearly all of whom are covered by Medicare, are higher than per capita expenditures for those under 65 years of age. The difference between the two age groups generally reflects the more serious nature of illness and greater prevalence of chronic conditions among older people. They are hospitalized more frequently than younger people and they stay longer when they are admitted.

In 1980, an estimated $215.5 billion will be spent for personal health care services (i.e., the health services and supplies received directly by individuals). Personal health care estimates are derived by subtracting from total national health expenditures amounts devoted to research and medical facilities construction, administrative costs of government health programs, private fundraising activities for health, and retained earnings of private health insurers. Based on 1976-77 experience we can expect that of the $215.5 billion, about 30 percent or $64.7 billion will be spent for people 65 years of age and over.

The Federal government will pay an estimated $31.5 billion for medical care provided to older people in fiscal year 1980. About 3.7 million persons aged 65 and over will receive medical assistance under Medicaid programs. Most of the care will be provided in skilled nursing homes and intermediary care facilities.

Medicare beneficiaries aged 65 and over, an estimated 24 million persons, will incur most of their Medicare financial health care costs as hospital inpatients.

Estimated Federal payments for: a/	Fiscal year 1980 Medicaid	Medicare
	- - - - 000 omitted - - -	
Inpatient hospital	$ 376,700	$19,104,600
Skilled nursing home	1,146,600	365,000
Intermediary care facility	1,382,900	
Physician services	132,100	5,940,000
Dental services	24,000	
Other Practitioner's services	23,300	
Outpatient care	29,700	1,149,000
Home health care	8,500	689,000
Clinic services	4,600	
Laboratory and Radiology	18,500	
Prescribed drugs	299,700	
Other care	40,600	739,000
Total	$3,487,200	$27,986,600

a/ Persons aged 65 and over. Medicaid estimate based on fiscal years 1976 and 1977 ratios of payments for beneficiaries aged 65 and over to payments for all beneficiaries.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #14

SUBJECT: Nutritional health status of older people

Attached is information on the nutritional health status of older people. This information is extracted from the United States General Accounting Office briefing on the nutritional health of older people provided to the staff of the House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition.

SOURCE OF DATA: "Information on the Nutritional Health of the Elderly", United States General Accounting Office Briefing, House of Representatives Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition, June 1980.

WHAT IS THE NUTRITIONAL HEALTH STATUS OF OLDER AMERICANS?

Although hospitalization statistics indicate that few older Americans suffer from diseases directly associated with inadequate nutrition, chronic and degenerative diseases predominate and are the primary cause of death for the elderly, as well as the major diagnosis for their illness. Many of these diseases are thought to be rooted in malnutrition. Not enough data exists to show that proper nutrition during old age has direct benefits on the overall health status of the elderly however, an adequate diet throughout life is an effective means to maintain good health and minimize chronic and degenerative diseases.

FEW OLDER AMERICANS ARE HOSPITALIZED FOR DISEASES CAUSED BY INADEQUATE NUTRITION

Malnutrition--inadequate or excessive food and nutrient intake--affects the elderly by contributing to or worsening chronic and acute diseases, speeding the development of some diseases, and increasing the susceptibility to and delaying recovery from illness. Malnutrition may occur with or without dietary involvement; it may arise from changes in the absorption, storage, or metabolism of nutrients; or result from chronic dietary excesses. It has also been caused by various drugs and modes of disease therapy, and can be caused by physical, psychological, or socio-economic barriers to optimal dietary intake.

To determine the incidence of diseases associated with inadequate nutrition in older Americans we analyzed the data collected for Federal patients aged 60 or over by the Professional

Standards Review Organization[1/] (PSRO) Management Information System in 1978. Each PSRO is required to collect information for all Medicare and Medicaid beneficiaries discharged from short stay general hospitals and freestanding specialty hospitals where the PSRO has implemented quality and utilization review. The data record for each discharge identifies the principal and as many as four secondary diagnoses. The principal diagnosis is defined as: The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. Secondary diagnoses are conditions that coexisted at the time of admission, or developed subsequently, which affected the treatment received and/or the length of stay.

An analysis of about 4.3 million hospital discharges in 1978, applicable to persons aged 60 and over, shows that less than three percent of those discharges were related to diseases associated with inadequate nutrition.

[1/] Operating under the 1972 amendment to the Social Security Act (Public Law 92-603), PSROs determine whether services provided to patients in hospitals and long-term care facilities are (1) medically necessary, (2) provided in accordance with professional standards, and (3) provided in the appropriate setting.

	Patients	Days of Care
All discharges	4,253,572 (100%)	46,711,581 (100%)
Patients discharged:		
with a principal diagnosis related to inadequate nutrition	57,346 (1.3%)	758,344 (1.6%)
with a secondary diagnoses related to inadequate nutrition	36,483 (0.9%)	535,531 (1.2%)

We found that when a patient had a secondary diagnosis related to inadequate nutrition the most common principal diagnosis was a disease of the circulatory system (25 percent of the cases), followed by diseases of the digestive system (15 percent), and malignant and benign tumors (11 percent). Injury by external causes was the primary diagnosis in less than 9 percent of the cases for patients with a secondary diagnosis related to inadequate nutrition.

MOST OF THE ELDERLY SUFFER FROM CHRONIC DISEASES-- LEADING CAUSES OF DEATH LINKED TO EXCESS NUTRITION

The National Center for Health Statistics estimates that 81 percent of all persons aged 65 and over have chronic conditions. Circulatory conditions, including heart disease, hypertension and cerebrovascular disease (stroke) affect over 11.1 million elderly. Musculaskeletal conditions including arthritis effect over 8 million. Information the the number of elderly with chronic

conditions--by condition, is shown below.

Chronic Conditions:	Persons aged 65 and over: Thousands	Persons aged 65 and over: incidence per thousand
Circulatory		
Heart conditions [a]	3,959	198.7
Hypertensive disorders [b]	3,972	199.4
Coronary heart disease	1,674	84.0
Cerebrovascular disease	960	48.2
Arteriosclerosis	512	25.7
Musculoskeletal		
Arthritis	7,095	380.3
Paralysis	446	23.1
Rheumatism	432	23.2
Diseases of the bone	181	9.7
Respiratory		
Chronic bronchitis	782	41.2
Emphysema	602	31.7
Digestive		
Constipation	1,775	96.3
Abdominal cavity hernia	1,084	58.8
Upper gastrointestinal disorder	695	37.7
Enteritis and colitis	627	34.0
Gallbladder condition	605	32.8
Duodenal and stomach ulcer	535	29.0
Gastritis and duodenitis	442	24.0

[a] Includes: heart conditions, acute and chronic rheumatic fever, hypertensive heart disease, other specific heart disease, unspecified disorders of heart rhythm, and heart trouble not otherwise specified.

[b] Hypertensive disease not classified elsewhere.

As shown in the following table, among the elderly, seven of the 10 major causes of death are chronic diseases.

Leading Causes of Death for Persons Aged 65 and over:	Rank	Rate per 100,000 population
Chronic disease		
Heart Disease	1	2334.1
Stroke	3	658.2
Arteriosclerosis	5	116.5
Bronchitis, Emphysema and Asthma	8	69.3
Cancer	2	988.5
Diabetes Mellitus	6	100.5
Cirrhosis of the Liver	9	36.7
Infectious Disease		
Influenza and Pneumonia	4	169.7
Trauma		
Motor Vehicle Accidents	10	24.5
All Other Accidents	7	78.1

Although diseases related to inadequate nutrition are not among the 10 major causes of death, most all of the health problems underlying the leading causes of death are thought to be related to excess nutrition and could be modified by improvements in diet.

The Surgeon General reported in 1979 that today's nutrition problems are more likely to be associated with eating too much and with an imbalance in the kinds of foods eaten than with eating too little. In testimony presented in 1976 before the Senate Select Committee on Nutrition and Human Needs, Dr. Mark Hegsted, Harvard School of Public Health, stated that from a public health point of

view, nutritional deficiency is a relatively minor problem--severe deficiency disease is very rare, even among low-income groups. In Dr. Hegsted's opinion, the primary nutritional problems are those associated with over-consumption.

About two in every five persons aged 65 and over are obese, a state which elevates their risk of and exacerbares many chronic conditions. Thirty-five percent of the women between ages 45 and 64 with incomes below poverty level, and 29 percent of those with incomes above, are considered obese according to the National Center for Health Statistics. The comparable figures for men are 5 and 13 percent.

Obesity is clearly related to diabetes, gallbladder disease, and high blood pressure. In association with other risk factors, it can contribute significantly to heart disease. Obesity is not the only nutrition-related health problem. Cardiovascular disease and cancer are other public health concerns that may be diet-related.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #15

SUBJECT: Need for national information system

Attached is the digest of the General Accounting Office report on "Conditions of Older People: National Information System Needed".

This system could be the basis for furthering research in the field of aging. This system could provide information on the differences in the well being of older people of minorities and the general population, and older people living in rural and urban environments.

SOURCE OF DATA: "Conditions of Older People: National Information System Needed", United States General Accounting Office report, HRD-79-95, dated September 20, 1979.

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

CONDITIONS OF OLDER PEOPLE:
NATIONAL INFORMATION
SYSTEM NEEDED

D I G E S T

This report describes personal conditions, changes in those conditions, and differences help can make in the lives of older people. It is the second of two based on experiences of older people in Cleveland, Ohio. The report demonstrates that

--changes in selected personal conditions of older people can be defined and measured,

--their unmet needs can be identified,

--beneficial effects of expanding help can be shown,

--cost of help to older people over time can be projected, and

--costs and benefits of alternative services for older people can be compared.

NATIONAL INFORMATION SYSTEM NEEDED

The reason that a national information system is needed is expressed no more clearly than by Dr. Eric Pfeiffer of the University of South Florida:

> "Older persons have lived a long time, but more importantly, they are facing problems head-on now and personally, that the rest of us as a society will face a little ways down the road. They are facing problems of access to health care, of transportation, of loneliness in the midst of lots of people * * * and they are trying to work out for themselves some kinds of answers to these problems. I think we have an opportunity to work with them to see what will suffice. I think they are

pioneers in the sense that if you design a health care system which is adequate for the aging population, it will be superb for the rest of the population. If you develop a transportation system that will meet the needs of the elderly, it will meet the needs of all the people. If you design communities that are truly communities with interaction for the elderly, you will have learned how to design communities for all of us, and in this sense I think aging can be considered not a national disgrace but a cause for a national celebration. * * *"

To design and plan for the delivery of services to older persons, society, the Congress, and the executive branch need information on their well-being, the factors that make a difference in their lives, and the impact of services on them. Currently, this information is spread piecemeal throughout Federal, State, local, and private agencies. The result: Federal agencies have not evaluated the combined effect of these services, and in the absence of such information, assessing the impact of various laws on the lives of older people is difficult.

GAO could not obtain national estimates of conditions, problems, and help as they applied to older people. Further, the results of GAO's work are not statistically projectable to the entire country. However, to illustrate the information that could be obtained from a national information system, GAO made national estimates for the 21 million non-institutionalized older people 65 years old and older in 1975 based on the Cleveland results. These estimates, for illustrative purposes only, demonstrate the role that such a national information system could play in major policy decisions.

People's conditions, problems, services, and unmet needs can be measured

Certain personal conditions--health, security, loneliness, and outlook on life--of older people are measurable and dynamic. For example, in 1975, about a third of the older people in GAO's sample were in the best overall condition as defined by GAO. By 1976, the personal conditions of 18 percent of these persons had improved, but the conditions of another 18 percent had worsened. The ability to measure this kind of change is important in an information system. (See p. 6.)

The conditions of older people decline over time, because of various problems. GAO used available data to identify as many of these problems as possible because it is through treatment of these problems that service providers try to improve or maintain the personal conditions of older people. GAO identified problems relating to health, security, and loneliness conditions. GAO did not have sufficient data to identify other problems that could affect personal conditions but believe that more data on other problems could be added when establishing a national information system. (See p. 9.)

Older people do receive help. GAO estimates that an average of $6,617 in help is provided to each older person annually. About 70 percent of this amount is provided through Federal, State, local, and private agencies. Most is federally funded. The ability to measure these sources of help is another important element in an information system. (See p. 10.)

GAO also demonstrated that certain unmet needs of older persons can be identified by using its data base. Overall, 65 percent of GAO's sample were defined as needing some kind of help--only 8 percent were defined as receiving all the help needed, while 57 percent needed

additional help. Information on what portion of society is not helped by services is another important part of any information system. (See p. 15.)

The future costs of expanded help to all older people can also be estimated. Expanding help to all older people would initially cost an estimated $1,601 for each older person annually. If the family and friends of older people do not absorb any of the increase, public costs would have to increase by more than a third to expand help to all those in need. However, if the family and friends could be encouraged to provide more compensatory help (in the same proportion as they did in 1975), public costs would have to be increased by much less. (See p. 17.)

Potential effects and long-run cost of proposed help can be estimated

Because GAO's model was designed to estimate the effects of help provided in an operational environment, it involved statistical analysis of data collected under uncontrolled circumstances. The model was developed using a data base which emphasizes health data and lends itself more to estimating the effects of some kinds of help than to others. Also, GAO's results are based on changes observed in a sample of older people in Cleveland, Ohio, over only a 1-year period. However, GAO believes its methods can provide valuable estimates of the potential effects of help on older people and represent a major step toward providing insights into the effects of help on older people. (See p. 20.)

GAO used its data base to measure the changes in certain conditions and problems of older people, and it related services to these changes. Using this analysis, GAO estimated the potential effect of expanded services on older people based on the changes observed over 1 year. These estimates show that a large part of the older population would benefit from expanded

help. The greatest benefit is estimated in their illness situation--a potential 9.2 percent of the sample could have been in a better situation in 1976 had they been treated for all their illnesses. The ability to estimate potential benefits from an information system would help considerably in formulating and considering proposed legislation. (See p. 23.)

Based on the estimated effect of expanded medical treatment, GAO's methods suggest that the first year cost of expanded help would be reduced considerably due to early improvement in conditions and problems of older people who, as a result, could require less future help. If an information system can estimate the long-run cost of services that benefit older people, farsighted decisions can be made. (See p. 27.)

The Congress needs alternatives to choose from. A national information system could estimate what percentages of older people receiving various kinds of help are benefiting. For example, based on GAO's sample, one of every two people who would receive expanded medical help would be in a better illness condition as a result. (See p. 28.)

RECOMMENDATIONS

The Secretary of Health, Education, and Welfare (HEW) should direct the Office of Human Development Services to establish a comprehensive national information system that determines the personal conditions of, problems of, and help available to older people. Information collected for this system should be available to the Congress for its analyses. The system should be expanded over time to include information necessary to study why older people do not receive the help they need and how family and friends can be encouraged to provide such help. (See pp. 31 and 32.)

AGENCY COMMENTS

HEW commented that the research done for this report has contributed greatly to an understanding of the problems of older people and the impact of various types of help they receive. However, the Department preferred not to implement the GAO recommendation for two main reasons. First, it would like to wait until current research, data bases, and information-gathering mechanisms are more developed or advanced. Second, it believes the report understates the costs of a national information system.

GAO believes the Department should begin to develop a national information system now. This report demonstrates that the capability to report on the conditions, problems, and help available to older people, and the differences this help can make, exists. GAO believes that, just as it built on HEW-funded research, so too could HEW build on GAO's methodology. Further, by modifying and using its existing mechanisms and data bases wherever possible, the Department can enhance GAO's model and develop it into a national information system.

GAO's cost benchmark of $750,000 was based on the cost of interviews with a sample of 15,000 older people. The benchmark did not include the cost of analyzing the data or obtaining data from agencies on a selected basis because these costs would vary depending on the level of analysis performed and the specific techniques used in obtaining and handling the data. At any rate, the alternative to a national information system is far more costly. (See p. 32.)

Responding to a request by HEW's Administration on Aging, GAO has agreed to provide technical assistance in using its model, concepts, and techniques and to transfer its data base.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #16

SUBJECT: Home services for older people

In 1975, the 7.8 million people 75 years old and older (not institutionalized) received $25.2 billion in home services (compensatory help). Annually this amounts to $3,232 per person ($2,492 is services from family/friends and $740 is services from agencies). (See page 133 of attached Brief #4).

In 1975, the 13.2 million people 65 to 74 years old and older (not institutionalized) received $25.2 billion in home services (compensatory help). Annually this amounts to $1,909 per person ($1,424 from family/friends and $485 from agencies). This information was derived from backing out data shown in Brief #4 from data contained in our report on page 14.

SOURCE OF DATA: "Conditions of Older People: National Information System Needed," United States General Accounting Office, HRD-79-95 dated September 20, 1979.

"Future Directions for Aging Policy: A Human Service Model", Subcommittee on Human Services of the Select Committee on Aging, U.S. House of Representatives, Committee Publication Number 96-226, May 1980.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF

SUBJECT: Home Helps For Older People

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HOME HELP SERVICES

In our report entitled "Conditions of Older People: National Information System Needed" (HRD-79-95, dated September 20, 1979), we estimated that more than a third of all the help provided to people 65 years old and older was in the form of help in performing activities of daily living, such as meal preparation or housework. An average $2,400 of this kind of help was provided each older person in our sample population in Cleveland in 1975.

To more specifically identify the kind and nature of home help needed by the older population, we analyzed our data collected on the conditions, problems, and helps of a random sample from the over 80,000 older people in Cleveland, Ohio in 1975 and 1976. Our analysis was designed to answer the following questions:

--How many older people have a need for home help and what specific kinds of home help do they need?

--What portion of the need for home help is being met? By whom is it being met--family and friends or public agencies?

--What is the cost of existing home help and who is bearing the cost?

--What would it cost to expand home help to all older people in need?

--How many older people would get all their needs met by expanding the different kinds of home help?

Although our analysis is based on data obtained on older people in Cleveland, we believe that by knowing about older people in Cleveland, a person can form a mental image of older people--their problems and services needed.

Home help for our purposes is defined as compensatory help, that is, help designed to compensate for an older person's inability to do daily tasks such as housework or meal preparation. (See page 10 for a description of how we matched helps and daily tasks.)

How many older people need home help?

Overall 40 percent of our Cleveland sample could not do one or more of 13 daily tasks. Of the 40 percent, more than half were receiving help, mostly from families and friends. The remaining people needed more compensatory help to do daily tasks. More people needed help with housework than any other daily task. The next most needed was help with shopping, then help getting places out of walking distance. The following shows the percent of people in our sample who needed help by daily task.

Daily task	People needing help	
	percent	number
Housework	38	20,500
Shopping	26	16,400
Getting places out of walking distance	24	14,800
Using telephone or taking medicine	14	8,900
Preparing meals	12	7,800
Physical tasks (eating, dressing, taking care of appearance, walking, bathing, getting out of bed)	14	8,600
Handling money	12	7,200

Considering the need for help in combination, many people had a need for multiple kinds of help. Nearly one in every three older people (30 percent of our sample) needed help with more than one daily task as shown in the table below.

Number of daily tasks person needs help with	Percent of sample	Number of people in Cleveland
none	60	37,600
one	11	6,900
two	7	4,400
three	6	3,700
four	4	2,500
five	4	2,500
six	3	1,900
seven or more	5	3,100
	100	62,600 a/

a/Total does not include all older people in Cleveland because the projections are based on only those who responded during interviews and does not include those in institutions.

What portion of the need for home help is being met?

As stated previously, 18 percent of the sample (228 people) needed more compensatory help to do daily tasks. Three-fourths of the 228 people needed more help with only one daily task. Help with housework was the most unmet need as shown in the following table.

Number of daily tasks	Number of people with unmet need	Number of people in Cleveland
One daily task		
Housework	90	4,300
Physical tasks	22	1,000
Handling money	21	1,000
Shopping	18	900
Getting places out of walking distance	11	500
Using telephone or taking medicine	10	500
Subtotal	172	8,200
More than one daily task	56	2,700
Total	228	10,900

Home help is provided to older people by two primary sources. The first, and largest source are the families and friends of older people. The other major source is public agencies. To examine the relative importance of these two sources, we analyzed our Cleveland data to see which source was providing home help to the most older people. We found that most home help was coming from families and friends. Seventeen percent of the people in our sample were getting all their needs for home help met by family or friends.

Public agencies were playing an important but smaller role in providing home help to older people. When home help from public agencies was considered, another 5 percent of the sample had all their needs met. Thus, when considering help from both sources--families/friends and public agencies--22 percent of the sample had a need for home help and were receiving all the help they needed.

What is the cost of home help?

To estimate cost of home help, we gathered and quantified data on home help provided by 120 social service agencies and families and friends. We than developed an average unit cost for each kind of help based on 1976 Cleveland cost data and applied it to the units of help provided (see p. 9). We used these methods to estimate the cost of home help currently being provided to the older people in our sample and to estimate the cost of expanding help to all those in need.

We estimate that each older person in Cleveland received an average of $429 of home help in 1976. Families and friends provided more than four-fifths of the help with agencies providing the other fifth. We estimate the families and friends of older people provided an average $349 of home help for each older person and agencies provided another $80 per person.

To expand home help to all older people would nearly double the cost of existing home help--or cost an additional $423 for each older person in our sample. This expanded help when added to the $429 cost of existing help would average $852 for each older person each year.

The bulk of this additional cost--93 percent--would be to provide help to older people who cannot do one of the physical tasks or who cannot do housework. We estimate that to expand help to all older people who could not do one or more of the physical tasks without help would cost an additional $234 for each older person annually. Our comparable estimate for those who could not do housework without help was $160 for each older person annually.

How many older people would have all their needs met by expanding the different kinds of home help?

To identify the benefits of expanding the different kinds of home help, we considered how many people would have all their needs for home help met if each kind of help were expanded. We first identified the number of additional people who would have all their needs met if help with housework were expanded to all those in need. We chose housework first because help with housework was needed by more older people than any other kind of help. We then considered how many more people would have all their needs met if both help with housework and help with shopping were expanded. We then added the other kinds of help into the analysis until we had considered all seven kinds of help.

The following table shows the results of our analysis for the estimated 62,600 noninstitutionalized older people in Cleveland in 1976. To illustrate, if help with housework were expanded to all the older people in Cleveland who needed but were not getting such help an additional 4,300 older people would be receiving all the home help needed. Similarly, if help with shopping were

expanded (in addition to help with housework), another 1,600 older people would have all their needs met. The remainder of the table shows a comparable analysis for help with other daily tasks as expanded incrementally.

Kind of daily task helped	Estimated additional older people receiving all needed help
Housework	4,300
Shopping	1,600
Physical tasks	1,500
Using telephone or taking medicine	700
Handling money	1,500
Preparing meals	600
Getting places out of walking distance	700
Total	10,900

Using our Cleveland data we then estimated the cost to expand the different kinds of help and related it to the number of additional people who would have all their needs met if each kind were expanded incrementally. The following table shows that it would cost an estimated $13.5 million to provide help with housework to all the older people in Cleveland who needed such help and, as a result, an additional 4,300 older people would be receiving all help needed. Similarly, if help with shopping were expanded, in addition to help with housework, it would cost another $1.7 million and another 1,600 older people would have all their needs met. The remainder of the table shows a comparable analysis for help with other daily tasks as expanded incrementally.

Kind of daily task helped	Estimated additional cost to expand help in Cleveland (million)	Estimated additional older people receiving all needed help
Housework	10.0	4,300
Shopping	1.3	1,600
Physical tasks	14.6	1,500
Using telephone or taking medicine	0.2	700
Handling money	0.1	1,500
Preparing meals	0.2	600
Getting places out of walking distance	0.1	700
Total	26.5	10,900

METHODOLOGY

The information contained in this brief is based on our study of the personal conditions of older people in Cleveland, Ohio. Following are the details of the data gathering and analytical methodology used in the study.

WELL-BEING STATUS AND SERVICES DATA BASES

We took a sample from over 80,000 people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. We insured that our sample was demographically representative by comparing the characteristics of our sample to statistics for the city of Cleveland.

In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, 1,311 of these older people were reinterviewed.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center, in collaboration with the Administration on Aging, former Social and Rehabilitation Service, and Health Resources Administration. The questionnaire contains questions about an older person's well-being status in five areas of functioning--social, economic, mental, physical, and activities of daily living.

To identify factors that could affect the well-being of older people, we

--developed specific definitions of services being provided to older people and dimensions for quantifying the services;

--identified the providers of the services--families and friends, health care providers, and over 100 social service agencies;

--obtained information about the services provided to each person in our sample and the source and intensity of these services; and

--developed an average unit cost for each of the 28 services.

In defining and quantifying the services, we used a format developed by the Duke University Center to define 28 different services. These services are defined in appendix V of our prior report. 1/ Services are defined according to four elements: purpose, activity, relevant personnel, and unit of measure. For example, meal preparation was defined as follows:

Purpose: To regularly prepare meals for an individual.

Activity: Meal planning, food preparation, and cooking.

Relevant personnel: Cook, homemaker, family member.

Unit of measure: Meals.

Examples: Meals provided under 42 U.S.C. 3045 (supp. V, 1975), the Older Americans Act, and meals-on-wheels programs.

To quantify the service, we used the unit of measure along with the duration, or number of months, during which the service was received.

We also developed an average unit cost for each service based on the experience of 27 Federal, State, local, and private agencies in Cleveland between October 1976 and March 1977. We compared these costs to similar costs in Chicago, Illinois, and Durham, North Carolina. As discussed in our prior report, the family and friends are al important sources of services. In their absence, any services received would have to be from an agency. Therefore, we assigned the same cost to family and friend services that we found for agencies.

Each piece of data was collected so that it could be related to an individual in our sample. This included the questionnaire data, data on the 28 services provided by social service agencies, and data on the services

1/"The Well-Being of Older People in Cleveland, Ohio," April 19, 1977, HRD-77-70.

provided by health care providers. By relating these data to the individual, we were able to do comparative analyses of sampled older people for over 500 different variables.

Services or help provided is intended to either remedy a specific problem or help the older person cope with it. For example, an older person who has very little social contact quite often feels lonely. The condition is that the person feels lonely. The problem is a lack of social contact. The help--social-recreational services--would provide opportunities for more social contacts, thereby decreasing feelings of loneliness. In other instances, older people are unable to perform the normal activities of daily living and need help in coping with their disabilities. This kind of help--called compensatory help--is designed to perform activities that older people cannot do for themselves, as shown below:

Tasks of daily living

Can you use the telephone - without help, including looking up numbers and dialing--if not, then compensatory help could be any one of - checking, continuous supervision, personal care, nursing care.

Can you take your own medicine - without help (in the right doses at the right time)--if not, then compensatory help could be any one of - checking, continuous supervision, personal care, nursing care.

Can you get to places out of walking distance - without help (can travel alone on buses, taxis, or drive your own car)--if not, then compensatory help could be any one of - escort, transportation.

Can you go shopping for groceries or clothes (assuming person has transportation) - without help (taking care of all shopping needs yourself, assuming you had transportation)--if not, then compensatory help could be any one of - escort, food - groceries, shopping.

Can you prepare your own meals - without help (plan and cook full meals yourself)--if not, then compensatory help could be any one of - meal preparation.

Can you do your housework - without help (can scrub floors, etc.)--if not, then compensatory help could be any one of - homemaker

Can you handle your own money - without help (write checks, pay bills, etc.)--if not, then compensatory help could be any one of - administrative or legal.

Physical tasks of daily living

Can you eat - without help (able to feed yourself completely)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you dress and undress yourself - without help (able to pick out clothes, dress and undress yourself)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you take care of your own appearance, for example combing your hair and (for men) shaving - without help--if not, then compensatory help could be any one of - personal care, nursing care.

Can you walk - without help (except from a cane)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you get in and out of bed - without any help or aids--if not, then compensatory help could be any one of - personal care, nursing care.

Can you take a bath or shower - without help--if not, then compensatory help could be any one of - personal care, nursing care.

The six physical tasks of daily living shown above can be compensated for by one of the same two relevant compensatory helps. For this analysis, we combined the six and considered if a person could not do any one of six they needed one of two helps--personal care or nursing care.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #17

SUBJECT: Mental health of older people

SOURCE: Data Base on Well-Being of Older People in Cleveland, Ohio - 1975 and 1976, United States General Accounting Office

MENTAL HEALTH OF OLDER PEOPLE

To more specifically identify the mental health problems of an older population (65 years old and older), we analyzed our data collected on the conditions, problems and helps of a random sample of 1,609 older people in Cleveland, Ohio in 1975 and 1976 (See Appendix I). Although our analysis is based on data obtained on older people in Cleveland, we believe that by knowing about older people in Cleveland, a mental image of older people nationally can be formed--their problems and services needed. Our analysis was designed to answer the following questions:

--How many older people have some mental problems and to what extent does it limit activities of daily living?

--What activities of daily living are most likely to be limited when an older person has severe mental problems?

--To what extent are older people with severe mental problems receiving help?

--What is the estimated cost of compensatory services and treatment for older people with severe mental problems?

--Because some older people with severe mental problems do not receive <u>all</u> the help they need, what is the estimated first year cost of providing all help needed?

METHODOLOGY

The Duke University Center for Aging and Human Development included questions in its interview instrument relative to mental problems. Using these questions, we developed two categories of mental problems as follows.

--Memory problem

Older people giving 4 or less incorrect responses to 10 memory questions were categorized as having no memory problems, 5 through 7 incorrect responses as having some memory problems, and 8 or more incorrect responses as having severe memory problems. (See Appendix II).

--Mental health functioning problem

We categorized older people as having no, some, or severe mental health functioning problems by combining (1) their answers to 15 questions relating to their mental health function; (2) their self-rating of their mental health function; and (3) the interviewer's assessment of their mental health functio". (See Appendix III).

QUESTIONS AND ANSWERS

1. Question: How many older people have some mental problems and to what extent does it limit activities of daily living?

   Answer: A majority of older people do not have mental problems. About one-third of the older people in 1976 having severe mental problems (memory and/or mental health functioning problems)cannot perform activities of daily living such as eating, bathing, and getting in and out of bed.

A majority of older people do not have mental problems (memory and/or mental health functioning problems). However, 13 percent or 8,000 older people in Cleveland in 1976 had severe memory and/or mental health functioning problems, as shown in the following table.

Category	Percent in sample	Estimated number of older people in Cleveland
None	55	35,000
Some memory and/or mental health functioning problems	32	20,000
Severe memory and/or mental health functioning problems	13	8,000
Total	100	63,000 [a]

[a] Total does not include all older people in Cleveland (over 80,000 people) because the projections are based on only those who responded during interviews.

About one-third of the older people in 1976 having severe mental problems (memory and/or mental health functioning problems) cannot perform activities of daily living even with help. The following table shows the interrelationship among mental problems and/or illnesses with abilities to do activities of daily living. Activities of daily living include eating, bathing, and getting in and out of bed.

Category	Ability to perform activities of daily living: Can do: Without help	Can do: With some help	Cannot do even with help	Persons in sample: Number	Persons in sample: Percent
	(percent)				
No severe mental problems and/or illnesses	76	19	5	806	61
Severe mental problems and no severe illnesses	46	32	22	50	4
Severe illnesses and no severe mental problems	33	38	29	341	26
Severe mental problems and severe illnesses	22	41	37	114	9
Total				1,311	100

2. Question: What activities of daily living are most likely to be limited when an older person has severe mental problems?

Answer: The four most frequent activities of daily living that some older people are not able to perform when they have severe mental problems are (1) shopping, (2) doing housework, (3) preparing meals, and (4) handling money.

A greater percentage of older persons in 1976 had severe mental health functioning problems than had severe memory problems. As shown in the following table, 12 percent had severe mental health functioning problems compared to 2 percent with severe memory problems.

Category	Percent of sample with: Mental health functioning problem	Memory problem	Estimated number of people in Cleveland with: Mental health functioning problem	Memory problem
None	56	94	35,000	60,000
Some	32	4	20,000	2,000
Severe	12	2	8,000	1,000
Total	100	100	63,000	63,000

Some older people with severe mental problems are not able to perform some activities of daily living even if helped. The four most frequent activities are (1) shopping, (2) doing housework, (3) preparing meals, and (4) handling money as shown in the following table marked with boxes.

	Percent of people in sample with severe mental problems			
	Activities performed with some help when having a severe:		Activities unable to perform even with some help when having a severe:	
Activities of daily living	Mental health functioning problem	Memory problem	Mental health functioning problem	Memory problem
Going places	(41)	(67)	6	6
Taking medicine	(39)	(16)	6	10
Doing housework	(38)	(39)	18	50
Shopping	(29)	(28)	22	50
Bathing	(14)	(39)	7	11
Handling money	(16)	(33)	10	39
Walking	14	28	4	0
Using phone	10	28	5	33
Preparing meals	12	22	13	44
Taking care of personal appearance	5	17	3	11
Dressing	3	11	5	11
Eating	3	6	1	6
Getting in and out of bed	6	6	3	6

Other people with severe mental problems are able to do activities of daily living with some help. The six most common activities are (1) going places, (2) bathing, (3) taking medicine, (4) doing housework, (5) handling money, and (6) shopping, as shown in the previous table marked in parentheses.

3. Question: To what extent are older people with severe mental problems receiving help?

Answer: Older people with severe mental health functioning problems were more likely to receive help than people with severe memory problems.

As shown previously, 13 percent of the older people had severe mental problems(severe mental health functioning problem and/or severe memory problem). Older people with severe mental health functioning problems were more likely to receive help than people with severe memory problems. As shown in the following table, 55 percent of those people with severe mental health functioning problem received help compared to 36 percent with severe memory problems. We considered two kinds of help appropriate for treating these problems--mental health service and/or psychotropic drugs (See Appendix IV).

	Percent of people with:			
Kind of treatment received	Severe memory problem		Severe mental health functioning problem	
None	64		45	
Mental health service	5	36	4	55
Psychotropic drugs	26		45	
Mental health service and psychotropic drugs	5		6	
Total	100		100	

We estimate that Cleveland had as many as 3,000 older people not receiving treatment for severe mental health functioning problems and 600 older people not receiving treatment for severe memory problems.

4. Question: What is the estimated cost of compensatory services and treatment for older people with severe mental problems?

Answer: An older person with severe mental problems and no severe illnesses receives about $2,935 annually in compensatory services and treatments.

We computed the average 1976 annual cost of compensatory services received by older people in our sample who were in the severe mental problem categories shown on page 5. Compensatory services are those services provided to people with difficulty in performing activities of daily living. We rounded the annual costs to the nearest multiple of $5.

The annual cost for each older person for compensatory services is greater for people having severe illnesses and no severe mental problems than it is for people with severe mental problems and no severe illnesses--$3,560 compared to $2,180. People having both severe mental problems and severe illnesses received the most compensatory services--$4,275 annually, as shown in the following table.

Kind of compensatory service	Average 1976 annual cost of compensatory services for each person: No severe mental problems and/or illnesses	Severe mental problems and no severe illnesses	Severe illnesses and no severe mental problems	Severe mental problems and severe illnesses
Transportation	$ 240	$ 115	$ 210	$ 195
Personal care	330	905	1,430	1,750
Nursing care	380	655	955	1,140
Continuous supervision	5	5	20	40
Checking	5	5	5	5
Homemaker	205	365	795	940
Meals	35	55	85	125
Food/groceries	30	65	50	65
Administrative/ legal	5	10	10	15
Total	$1,235	$2,180	$3,560	$4,275

We determined the cost of receiving both compensatory services and treatment for mental problems. The average 1976 annual cost per person for psychotropic drugs was about $65 and for mental health services about $690. Combining these costs with compensatory services, we estimate that a person with severe mental problems and no severe illnesses receives about $2,935 annually in services.

5. Question: Because some older people with severe mental problems do not receive all the help they need, what is the estimated first year cost of providing all help needed?

Answer: About $4.3 million in compensatory services and treatments would be needed annually to provide the additional help required by people with severe mental problems and no severe illnesses.

As shown on page 4, 4 percent of our sample had severe mental problems and no severe illnesses and 9 percent had severe mental problems and severe illnesses. Some received all compensatory services and some did not. We computed the 1976 total annual cost for providing compensatory services used by these people and the additional cost to provide compensatory services to those people who did not receive them. As shown in the following table, about $20.9 million of services were provided and an additional $1.4 million would have been needed or about 7 percent increase would have been needed to provide all compensatory services required.

Category	Total 1976 Annual Cost of Compensatory Services		
	Provided	Additional needed	Total
Severe mental problems and no severe illnesses	$ 2,808,000	$ 60,000	$ 2,868,000
Severe mental problems and severe illnesses	18,101,000	1,355,000	19,456,000
Total	$20,909,000	$1,415,000	$22,324,000
Percent Increase		7%	

In addition to compensatory services, treatments for mental health problems were considered. Older people received $650,000 in treatments and others could have used an additional $2.9 million, annually.

In summary, about $21.6 million in compensatory services and treatments were provided in 1976 ($20,909,000 plus $650,000). An additional $4.3 million in these services could have been provided to people with these problems ($1.4 million compensatory services plus $2.9 million in treatments for mental health problems.)

METHODOLOGY

The information contained in this brief is based on our study of the personal conditions of older people in Cleveland, Ohio. Following are the details of the data gathering and analytical methodology used in the study.

WELL-BEING STATUS AND SERVICES DATA BASES

We took a sample from over 80,000 people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. We assured that our sample was demographically representative by comparing the characteristics of our sample to statistics for the city of Cleveland.

In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, 1,311 of these older people were reinterviewed.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center for Aging and Human Development in collaboration with Administration on Aging, former Social and Rehabilitation Service, and Health Resources Administration. The questionnaire contains questions about an older person's well-being status in five areas of functioning--social, economic, mental, physical, and activities of daily living.

To identify factors that could affect the well-being of older people, we

--developed specific definitions of services being provided to older people and dimensions for quantifying the services;

--identified the providers of the services--families and friends, health care providers, and over 100 social service agencies;

--obtained information about the services provided to each person in our sample and the source and intensity of these services; and

--developed an average unit cost for each of the 28 services.

In defining and quantifying the services, we used a format developed by the Duke University Center to define 28 different service. These services are defined in appendix V of our prior report.[1/] Services are defined according to four elements: purpose, activity, relevant personnel, and unit of measure. For example, meal preparation was defined as follows:

Purpose:	To regularly prepare meals for an individual.
Activity:	Meal planning, food preparation, and cooking.
Relevant personnel:	Cook, homemaker, family member.
Unit of measure:	Meals.
Examples:	Meals provided under 42 U.S.C. 3045 (supp. V, 1975), the Older Americans Act, and meals-on-wheels programs.

To quantify the service, we used the unit of measure along with the duration, or number of months, during which the service was received.

We also developed an average unit cost for each service based on the experience of 27 Federal, State, local, and private agencies in Cleveland between October 1976 and March 1977. We compared these costs to similar costs in Chicago, Illinois, and Durham, North Carolina. As discussed in our prior report, the family and friends are also important sources of services. In their absence, any services received

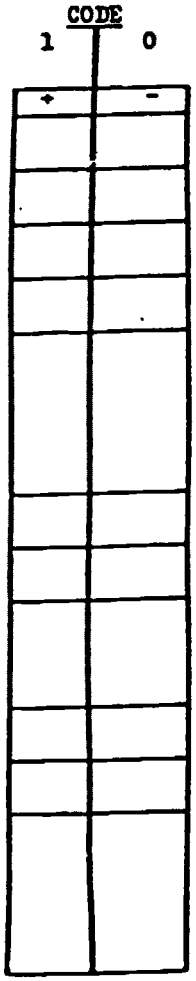
[1/] "The Well-Being of Older People in Cleveland, Ohio," April 19, 1977, HRD-77-70.

would have to be from an agency. Therefore, we assigned the same cost to family and friend services that we found for agencies.

Each piece of data was collected so that it could be related to an individual in our sample. This included the questionnaire data, data on the 28 services provided by social service agencies, and data on the services provided by health care providers. By relating these data to the individual, we were able to do comparative analyses of sampled older people for over 500 different variables.

QUESTIONS FOR DETERMINING MEMORY ABILITY

PRELIMINARY QUESTIONNAIRE
[ASK QUESTIONS 1-10 AND RECORD ALL ANSWERS. (ASK QUESTION 4a. ONLY IF SUBJECT HAS NO TELEPHONE.) CHECK CORRECT (+) OR INCORRECT (-) FOR EACH AND RECORD TOTAL NUMBER OF ERRORS BASED ON TEN QUESTIONS.]



1. What is the date today? _____
   Month Day Year
2. What day of the week is it? _____
3. What is the name of this place? _____
4. What is your telephone number? _____
   a. [ASK ONLY IF SUBJECT DOES NOT HAVE A PHONE.] What is your street address?
   _____
5. How old are you? _____
6. When were you born? _____
   Month Day Year
7. Who is the president of the U.S. now? _____
8. Who was the president just before him? _____
9. What was your mother's maiden name? _____
10. Subtract 3 from 20 and keep subtracting 3 from each new number you get, all the way down.

[CORRECT ANSWER IS: 17, 14, 11, 8, 5, 2]

_____ Total number of errors.

SOURCE: "Multidimensional Functional Assessment: The OARS Methodology", Duke University Center for the Study of Aging and Human Development, Second Edition

QUESTIONS RELATING TO MENTAL HEALTH FUNCTION

34. Please answer the following question "Yes" or "No" as they apply to you now. There are no right or wrong answers, only what best applies to you. Occasionally a question may not seem to apply to you, but please answer either "Yes" or "No", whichever is more nearly correct for you.

[CIRCLE "YES" OR "NO" FOR EACH.]

(CODE ALL CAPITAL RESPONSES "1" AND LOWER CASE ANSWERS "0".)	0	1
(1) Do you wake up fresh and rested most mornings?.....	yes	NO
	0	1
(2) Is your daily life full of things that keep you interested?...	yes	NO
	1	0
(3) Have you, at times, very much wanted to leave home?.....	YES	no
	1	0
(4) Does it seem that no one understands you?.....	YES	no
(5) Have you had periods of days, weeks, or months when you couldn't take care of things because you couldn't "get going"?.....	1	0
	YES	no
	1	0
(6) Is your sleep fitful and disturbed?.....	YES	no
	0	1
(7) Are you happy most of the time?.....	yes	NO
	1	0
(8) Are you being plotted against?.....	YES	no
	1	0
(9) Do you certainly feel useless at times?.....	YES	no
(10) During the past few years, have you been well most of the time?.....	0	1
	yes	NO
	1	0
(11) Do you feel weak all over much of the time?.....	YES	no
	1	0
(12) Are you troubled by headaches?.....	YES	no
(13) Have you had difficulty in keeping your balance in walking?.....	1	0
	YES	no
(14) Are you troubled by your heart pounding and by a shortness of breath?.....	1	0
	YES	no
(15) Even when you are with people, do you feel lonely much of the time?.....	1	0
	YES	no

Sum of Responses in Capital letters _____

SOURCE: "Mulitidmensional Functional Assessment: The OARS Methodology", Duke University Center for the Studying of Aging and Human Development, Second Edition.

TREATMENT DESCRIPTIONS

MENTAL HEALTH

Purpose:	To identify and evaluate mental impairments which relate to both intra- and interpersonal relationships, including individual, marital, familial, and environmentally related problems; to provide counseling and/or therapy in order to aid the individual to resolve these problems or to cope with them.
Activity:	Mental health evaluation, diagnosis and treatment.
Relevant Personnel:	Psychiatrist, social worker, psychologist, nurse; educational, rehabilitation, and pastoral counselors.
Unit of Measure:	Sessions.
Examples:	Psychotherapy (individual or group), counseling, crisis intervention, evaluation of need for psychiatric hospitalization.

PSYCHOTROPIC DRUGS

Purpose:	To improve the mood and/or psychological function of an individual who is symptomatic, manifesting anxiety, depression, thought disturbances, or physical symptoms with psychological overlay.
Activity:	Evaluation of need for psychotropic drugs; prescribing and/or dispensing of psychotropic drugs.
Relevant Personnel:	Any physician.
Unit of Measure:	Quantity and type.

Examples: Valium, Librium, Thorazine, Mellaril, Stelazine, Elavil, Triavil, Tofranil, Miltown, Equanil, Haldol.

SOURCE: "Multidimensional Functional Assessment: The OARS Methodology", Duke University Center for the Study of Aging and Human Development, Second Edition

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #18

SUBJECT: Housing of older people

Attached is information extracted from an analysis of long-term care by the Congressional Budget Office As shown in the analysis, there is a large unmet demand for sheltered living arrangements and congregate housing. In 1976, 1.5 to 1.9 million people needed this kind of housing, but the estimated supply was 300,000 to 800,000.

SOURCE OF DATA: "Long-term Care for the Elderly and Disabled", Congressional Budget Office, Congress of the United States Washington, D. C., February 1977.

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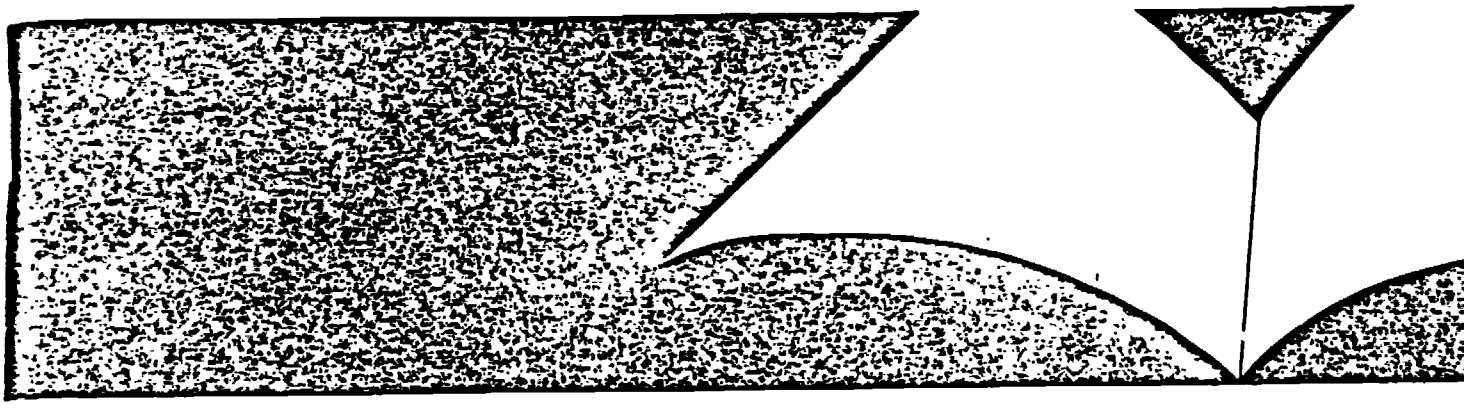

Long-Term Care for the Elderly and Disabled

February
1977

(Reprinted August 1977)

Congressional Budget Office
Congress of the United States
Washington, D.C.

SUMMARY

Long-term care refers to health and social services provided to chronically disabled, usually elderly, persons. Federal, state, and local governments spent $5.7 to $5.8 billion on long-term care in 1975. Of this, $3.1 billion or 56 percent was federal spending. Private expenditures for long-term care totaled $5.9 to $7.7 billion. These costs will continue to grow as a result of the aging of the population, increased utilization of services, and inflation. This combination of factors is expected to increase total long-term care spending from $11.7 to $13.4 billion in 1975 to $25.8 to $31.0 billion in 1980. Federal spending under existing programs would be $7.2 to $7.6 billion in 1980.

The presence of a chronic condition such as arthritis or diabetes is one indicator of a potential long-term care patient, but it is not a sole or sufficient determinant of need. Functional impairment or the need for assistance in activities of daily living such as eating and bathing is a better gauge. Despite a wide variation in estimates of the functionally disabled from several national studies, the relatively high rate of functional disability among the elderly is clear. While 1.2 to 3.9 percent of the population aged 18-64 is estimated to be functionally disabled, between 11.8 and 16.8 percent of the elderly population is estimated to be functionally disabled. Given the incidence of functional disability, the total potential demand for long-term care is estimated to increase from 5.5 to 9.9 million persons in 1975 to 6.3 to 11.1 million in 1980 and to 7.4 to 12.5 million in 1985.

Long-term care services needed range from frequently required highly skilled nursing and therapy that must be provided in a nursing home to occasional visits by a homemaker/home health aide or social worker. Of the 5.5 to 9.9 million persons functionally disabled in 1975, only 1.9 to 2.7 million received long-term care under government programs. Medicaid, the federal-state health program for the poor, is the principal source (77 percent) of government financing of long-term care. To a lesser degree,

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long-term care services are financed under medicare, the Veterans Administration, the Supplemental Security Income program, and Title XX social services. Perhaps 3 to 6.7 million persons receive basic long-term care services from their families but nothing is known about its quality or adequacy. An estimated 800,000 to 1.4 million disabled may receive no form of long-term care.

Public programs disproportionately support nursing home care. Less than 10 percent of public funds are for home-based services. This has certain consequences. While many disabled receive no long-term care, there is evidence that 20 to 40 percent of the nursing home population could be cared for at less intensive levels were adequate community-based care available. If all services were readily available, the distribution of the disabled and elderly among levels of care would be quite different from its present distribution. As seen in the following table, there is a large unmet demand for sheltered living arrangements, congregate housing, and home health care.

LONG-TERM CARE ESTIMATED SUPPLY AND POTENTIAL NEED, For Calendar Year 1976, Adults in Millions

Type of Treatment		Estimated Potential Need	Estimated Supply
Nursing Home Care:	Skilled Care	0.7	0.9
	Intermediate Care	0.6	0.4
Personal Care Homes, Sheltered Living Arrangements, and Congregate Housing		1.5 - 1.9	0.3 - 0.8
Home Health Care and Day Care		1.7 - 2.7	0.3 - 0.5
Informal Family Care Only or No Care		1.0 - 4.0	3.6 - 7.2

SOURCE: CBO estimates.

GAPS IN COVERAGE

There is evidence that many of the 5 to 10 million adults who might have needed some form of long-term care in 1975 were not receiving it.

An annual average of 1.6 million people were receiving care in institutions in calendar year 1976. Medicaid financed home health care for 150,000 people. Under medicare, home health bills were approved for an estimated 431,000 persons--not necessarily different individuals from those in the medicaid program. 1/ Given medicare regulations, these home health expenses are more properly considered acute care than chronic care. VA funded or provided care for 30,550 veterans in domiciliaries and provided home health services to 1500 veterans. Supplemental state SSI payments were made to 107,000 people in domiciliaries or other supervised living arrangements. 2/ Based upon the number of domiciliary and foster home residents receiving supplemental SSI payments, it is estimated that perhaps a total of 75,000 to 635,000 people are in sheltered living arrangements or in congregate housing. 3/ Under the social services programs, an estimated 36,000 disabled adults received day care; that is, rehabilitation and social services at a center during the day.

1/ Social Security Administration. Based on a 40 percent sample of 1974 bills.

2/ Unpublished data from the Office of Research and Statistics, Social Security Administration.

3/ Long-Term Care: Actuarial Cost Estimates, Congressional Budget Office, February 1977.

Since the recipients of noninstitutional care under federal programs may receive services under more than one program and the degree of overlap is unknown, a range of individuals estimated to be served is shown in Table 6.

Table 6. LONG-TERM CARE ESTIMATED SUPPLY AND POTENTIAL DEMAND, FOR CALENDAR YEAR 1976, Adults in Millions

Source	Estimated Potential Demand	Estimated Number Served
Potential Demand	5.5-9.9	
Estimated Supply		
Chronic hospitals and facilities for the deaf, blind, and disabled		0.1
Nursing home care (ICF & SNF)		1.3
Personal care or domiciliary care		0.2
Sheltered living arrangements		0.1-0.6
Home care and day care		0.3-0.5 a/
Estimated Total Number Served Under Government Programs		1.9-2.7 a/
Estimated Informal Care by Families		3.0-6.7 b/
Estimated Number Receiving No Care		0.8-1.4 c/

SOURCE: CBO estimates.

a/ Function of range of overlap of persons receiving possible duplicate treatment under medicare and medicaid.

b/ Estimates of the disabled population living with others in private residences, congregate housing, or sheltered living arrangements. These persons may also receive home care under public programs.

c/ Estimated disabled living alone less number receiving home care if home care is assumed to be evenly divided between those living alone and those living with others.

Informal basic care is provided to a large degree by the families and friends of the disabled. According to the NCHS survey of the disabled cited earlier, 88 percent of the functionally disabled between 18 and 64 and 70 percent of the elderly disabled live with others. Presumably these other individuals provide whatever assistance is required by the disabled in the way of shopping, cooking, or personal care, although they cannot provide specialized health care. The remaining 30 percent of the elderly disabled and 12 percent of the disabled age 18-64 live alone. If they are not among those receiving home-based services funded under a public program or do not have relatives nearby to provide assistance, they probably receive no care.

In summary, of the 5.5 to 9.9 million functionally disabled, only 1.9 to 2.7 million persons can be identified as receiving assistance under formal programs. Of these, 1.6 million are in institutions and 75,000 to 635,000 are in other sheltered living arrangements. Home health agencies serve up to 500,000 people under medicare and medicaid, but some of these people are probably also receiving help from relatives and not all can be considered to be receiving long-term care. In order to estimate the total number of persons receiving services, it is assumed that the noninstitutionalized disabled living with others are receiving basic services from their families. Under this assumption, an estimated 3 to 6.7 million disabled are receiving some form of informal care. This group may also be receiving home care or may reside in congregate housing so that it is impossible to estimate how many are receiving only informal family care. Moreover, nothing is known about the quality or adequacy of such family services. Similarly, it is assumed that those living alone receive no family care but receive half the home health care under medicare and medicaid (a simplistic and possibly optimistic assumption). Under this assumption, an estimated 800,000 to 1.4 million disabled may receive no form of long-term care.

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This uncertainty, combined with the strong possibility that even with a generous noninstitutional service program the elderly might ultimately have to be institutionalized, reinforces the conservative inclinations of the states.

Unexploited Potential of Housing Programs

Congregate housing is a concept that can provide an alternative residence and semi-independent lifestyle for older people. It has been defined as

> "a residential environment which includes services such as meals, housekeeping, health, personal hygiene, and transportation, which are required to assist impaired, but not ill, elderly tenants to maintain or return to a semi-independent lifestyle and avoid institutionalization as they grow older." 8/

The Department of Housing and Urban Development (HUD) operates several programs that provide assistance for congregate housing. These include: (1) Section 202 financing for construction or rehabilitation of housing for the elderly and handicapped; (2) Section 231 mortgage insurance for rental housing for the elderly; and (3) specific authority for congregate housing in the 1970 Housing and Urban Development Act. Nevertheless, HUD can identify only 22,560 units of congregate housing funded under these authorities. 9/

CBO estimates that a total of 75,000 to 635,000 units of congregate housing or rooms in foster homes exist, whereas an estimated 1.3 to 1.7 million persons could conceivably benefit from such living arrangements. 10/ Reasons for the limited number of units may include disinterest on the part of private developers and absence of guarantees by state and local service agencies to provide meals and other services.

8/ U.S. Senate Special Committee on Aging, Congregate Housing for Older Adults, Senate Report 94-478, 94th Congress, 1st Session, Washington, GPO, November 1975. Quoted in The Impact of Federal Housing Programs on the Elderly by Susan Dovell, Congressional Research Service, HD 7106D, 76-156E, August 19, 1976.

9/ "Federally-Assisted Congregate Housing Developments for the Elderly," HUD, mimeo, January 1976.

10/ Long-Term Care: Actuarial Cost Estimates, Congressional Budget Office, February 1977.

WHITE HOUSE CONFERENCE ON AGING

INFROMATION BRIEF #19

SUBJECT: Home care services

Attached is information extracted from an analysis of long-term care by the Congressional Budget Office. Concerning home care services, the analysis estimates that ambulatory and home care services is expected to rise to $4 to $10 billion by fiscal year 1985, a level up to seven times that in fiscal year 1976.

SOURCE OF DATA: "Long-term Care: Actuarial Cost Estimates" Congressional Budget Office , Congress of the United States, Washington, D. C.; August 1977.

LONG-TERM CARE:

ACTUARIAL COST ESTIMATES

A CBO Technical Analysis Paper

August 1977

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C.

CHAPTER II. SPENDING UNDER PRESENT LAW FOR LONG-TERM CARE SERVICES

ESTIMATED SOURCES AND USES OF FUNDS IN FISCAL YEAR 1976

Spending for long-term medical services in fiscal 1976 is summarized in Table 1, according to sources and uses of funds. 1/ The estimate of total national spending for these services is between $18 and $20 billion; of this, roughly 45 percent or $8 to $10 billion was raised by private sources. Consumers directly paid $7 to $9 billion; the remainder was paid by private insurance policies or philanthropic organizations.

Government programs paid an estimated $10.5 billion for long-term care services; of this, $5 billion was paid by the federal government and $5.5 billion by state and local governments. Over half of all public expenditures ($5.7 billion) was paid through the federal/state medicaid programs. State and local governments are estimated to have spent another $2.9 billion for direct payments to providers.

An estimated $17 to $19 billion was spent for institutional care; of this, $14 to $16 billion or three-fourths, was for care in nursing homes or sheltered living facilities, and $3 billion was for hospital care. Only an estimated $1.1 to $1.4 billion paid for ambulatory or home health services.

ESTIMATED SPENDING DURING FISCAL YEARS 1977-1985

Table 2 shows an estimate of the average number of residents of long-term care institutions in 1976. Projections of the average number of residents of each type of long-term care institution through 1985 are also given. The average resident total of these facilities is estimated to have been between 1.9 and 2.5 million in 1976. These numbers will grow substantially during the next decade, to 3.3 to 4.2 million by 1985.

1/ All figures in this chapter include custodial psychiatric care, which was excluded from the earlier budget issue paper.

TABLE 1. SOURCES AND USES OF FUNDS FOR LONG-TERM CARE SERVICES, FISCAL YEAR 1976 a/: DOLLARS IN BILLIONS

	Total	Private			
		Total	Out-of Pocket b/	Insurance	Other
All Services	18.1 to 20.4	7.7 to 9.9	6.9 to 8.9	0.5	0.4 to 0.6
Institutional Care	17.0 to 18.9	7.5 to 9.3	6.7 to 8.4	0.4	0.4 to 0.6
Long-term hospitals d/	0.8	0.2	0.2	0	*
Psychiatric hospitals d/	2.5	0.5	0.4	0	*
Skilled nursing facilities e/	8.7	4.2	3.7	0.4	0.1
Intermediate care facilities	1.9	0.6	0.6	0	*
Personal care homes	1.5	1.3	1.2	0	0.2
Homes for physically handicapped	*	*	*	0	*
Homes for the blind and deaf	0.1	*	*	0	*
Drug and alcoholism facilities	0.2	0.1	*	0.1	*
Homes for mentally disturbed	0.3	0.1	0.1	0	*
Homes for mentally retarded	0.9	0.2	0.2	0	*
Other sheltered living f/	0.3 to 2.2	0.2 to 2.1	0.2 to 1.9	0	* to 0.2
Ambulatory and Home Care	1.1 to 1.4	0.2 to 0.6	0.2 to 0.5	*	*
Home health agencies	0.7 to 0.9	0.1 to 0.3	0.1 to 0.3	*	*
Rehabilitation agencies	0.3	*	*	*	*
Private practitioners g/	0.1 to 0.2	0.1 to 0.2	0.1 to 0.2	0	*

* Less than $50 million.

a/ Excludes administrative cost of insurance or government programs and social services, assistance with routine chores, food preparation, etc.

b/ Includes payments by all income maintenance programs, including supplemental security income, social security, and any state supplements.

c/ Includes premiums paid by individuals for Part B.

TABLE 1. (continued)

Total – Public	Federal Outlays					State and Local Outlays		
	Total	Medicare c/	Medicaid	VA	Other	Total	Medicaid	Other
10.4 to 10.5	5.0	0.6	3.2	1.0	0.2	5.5	2.5	2.9
9.6	4.5	0.3	3.1	1.0	0.1	5.1	2.5	2.6
0.6	0.3	0	0	0.3	*	0.2	0	0.2
2.0	0.4	0	0	0.4	0.1	1.6	0	1.6
4.5	2.6	0.3	2.1	0.1	*	1.9	1.7	0.2
1.3	0.7	0	0.7	0.1	*	0.6	0.5	0.1
0.2	0.1	0	0	0.1	*	0.1	0	0.1
*	*	0	0	*	*	*	0	*
0.1	*	0	0	*	*	0.1	0	0.1
0.1	0.1	0	*	*	0.1	*	*	*
0.2	*	0	0	*	*	0.2	0	0.2
0.7	0.3	0	0.3	0	*	0.4	0.3	0.1
0.1	0	0	0	0	*	0.1	0	0.1
0.9	0.5	0.3	0.1	*	0.1	0.3	0.1	0.3
0.6	0.4	0.3	0.1	*	*	0.2	0.1	0.2
0.3	0.1	0	0	*	0.1	0.1	0	0.1
*	*	0	0	*	*	0	0	0

d/ Includes custodial services only — i.e., those not receiving active treatment to diagnose or cure an illness.

e/ Includes all patients in facilities certified as skilled nursing facilities, regardless of actual level of care received.

f/ Includes only residents not able to live independently in normal housing.

g/ Excludes services of physicians, dentists, and other practitioners who normally treat acute illness.

By far the largest number of long-term care patients reside in nursing homes. In 1976, the estimated average number of residents was 1.5 million; by 1985, this number is expected to reach 2.9 million. The lack of information on sheltered living facilities prevents the estimation of the number of residents with much precision or confidence. Between 75,000 and 635,000 persons resided in these facilities during 1976. The average number of residents in 1985 is projected at between 114,000 and 980,000.

Table 3 shows the estimated spending, under present law, for long-term care medical services during fiscal years 1977-1985. Total estimated spending for these services is expected to grow very rapidly, to $64 to $75 billion by fiscal year 1985. In 1985, the largest part of this spending would be for institutional services ($59 to $65 billion). Projected spending for custodial care in long-term and psychiatric hospitals is expected to increase to approximately $2 billion and $5 billion respectively by fiscal year 1985, by virtue of a projected higher treatment cost per patient. A decline in the number of patients is projected. Nursing home expenditures, on the other hand, are projected to quadruple by 1985 to $48.6 billion, resulting from an increase in both the number of residents and the cost of care.

Although much smaller in size, estimated spending for ambulatory and home care services is expected to rise at a more rapid rate than that for institutional care. Outlays for these services are projected to be $4 to $10 billion by fiscal year 1985, a level up to seven times that in fiscal year 1976.

Table 4 summarizes the projected sources and uses of funds for long-term care services in fiscal year 1980. Total estimated spending for long-term care medical services is $32 to $36 billion. Private spending is estimated at $15 to $18 billion, of which $13 to $16 billion would be paid for directly out-of-pocket. Total public expenditures for long-term care are estimated to be $17 to $18 billion, of which $8.9 to $9.3 billion would be paid by the federal government and $8.4 to $8.9 billion by state and local governments.

Table 5 summarizes the estimated spending in federal programs that would occur under current law. Total outlays under federal programs are expected to triple from $7 billion in fiscal 1977 to $24 to $26 billion in fiscal 1985. Estimates for 1977 medicare outlays for long-term care are $700 to $800 million; they are expected to reach $2.2 to $3.2 billion by 1985. By 1985, under the low projection, outlays would be divided about equally between skilled

TABLE 2. ESTIMATED AVERAGE NUMBER OF RESIDENTS IN LONG-TERM CARE INSTITUTIONS, CALENDAR YEARS 1976-1985: IN THOUSANDS

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
All Institutions	2061 to 2621	2186 to 2772	2316 to 2934	2452 to 3106	2602 to 3292	2762 to 3483	2929 to 3685	3110 to 3901	3309 to 4135	3517 to 4383
Long-Term Hospitals a/	35	35	35	35	35	35	35	35	35	35
Psychiatric Hospitals a/	140	135	130	125	120	120	120	120	120	120
Skilled Nursing Facilities	935	1015	1095	1175	1260	1360	1460	1570	1690	1815
Intermediate Care Facilities	365	390	420	450	490	525	565	605	650	700
Personal Care Facilities	200	215	230	250	270	290	310	335	360	385
Homes for Physically Handicapped	4	4	5	5	5	5	5	5	5	5
Homes for the Blind and Deaf	21	22	22	22	23	23	23	23	24	24
Drug Addiction and Alcoholism Facilities	33	35	38	41	44	47	50	53	56	59
Homes for Mentally Disturbed	65	70	75	80	85	85	85	85	85	85
Homes for Mentally Retarded	188	186	184	183	180	178	177	175	175	175
Other Sheltered Living b/	75 to 635	79 to 665	82 to 700	86 to 740	90 to 780	94 to 815	99 to 855	104 to 895	109 to 935	114 to 980

a/ Includes only those not receiving active treatment to diagnose or cure an illness.

b/ Includes only residents not able to live independently in normal housing.

skilled nursing facilities and home health agencies; under the high projection, outlays for home health agencies would grow to almost twice the level of spending for skilled nursing facilities. 2/

In fiscal 1977, medicaid program outlays are estimated at $6 billion and are anticipated at $20.5 to $21.6 billion by fiscal 1985. About nine-tenths of these outlays are projected to be spent to support nursing home residents. Estimated outlays for home health agency services are expected to grow from less than $200 million in 1977 to between $0.6 and $1.6 billion by 1985.

Total federal outlays are estimated to be $4.5 billion in 1977 and to reach $14.7 to $16.9 billion by 1985.

2/ For interpretation of the low and high projections of spending for home health agency services, see Chapter IV and Appendix B.

TABLE 3. TOTAL ESTIMATED SPENDING UNDER PRESENT LAW FOR LONG-TERM CARE SERVICES, FISCAL YEARS 1977-1985 a/: DOLLARS IN BILLIONS

	1977	1978	1979	1980	1981	1982	1983	1984	1985
All Services	21.3-24.1	24.5-27.7	28.0-31.7	32.0-36.3	36.7-42.0	42.1-48.4	48.3-55.8	55.6-64.7	63.7-74.5
Institutional Care	20.0-22.1	22.9-25.3	26.0-28.9	29.9-32.9	34.2-37.7	39.3-43.1	45.0-49.4	51.8-56.7	59.4-64.8
Long-Term Hospitals b/	0.8	0.9	1.0	1.1	1.1	1.3	1.4	1.5	1.6
Psychiatric Hospitals b/	2.7	2.9	3.0	3.2	3.5	3.8	4.1	4.5	4.9
Skilled Nursing Facilities	10.5	12.2	14.2	16.5	19.2	22.3	25.8	30.1	34.9
Intermediate Care Facilities	2.3	2.7	3.1	3.6	4.2	4.8	5.6	6.5	7.5
Personal Care Homes	1.8	2.1	2.5	2.9	3.4	3.9	4.6	5.4	6.2
Homes for Physically Handicapped	*	*	*	*	*	*	*	*	*
Homes for Blind and Deaf	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Drug and Alcoholism Facilities	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.5	0.5
Homes for Mentally Disturbed	0.4	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1
Homes for Mentally Retarded	0.9	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7
Other Sheltered Living c/	0.3-2.5	0.3-2.8	0.4-3.1	0.4-3.5	0.5-4.0	0.5-4.4	0.6-4.9	0.7-5.5	0.7-6.2
Ambulatory and Home Care	1.4-1.9	1.6-2.3	1.9-2.9	2.2-3.5	2.5-4.3	2.9-5.3	3.3-6.5	3.7-8.0	4.3-9.8
Home Health Agencies	0.9-1.3	1.1-1.7	1.4-2.2	1.6-2.7	1.8-3.4	2.0-4.3	2.4-5.4	2.8-6.8	3.2-8.6
Rehabilitation Agencies	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.7	0.8
Private Practitioners d/	0.1-0.2	0.1-0.3	0.1-0.3	0.2-0.3	0.2-0.3	0.2-0.4	0.2-0.4	0.2-0.4	0.2-0.5

* Less than $50 million.

a/ Excludes administrative cost of insurance or public programs and social services, assistance with routine chores, food preparation, etc.

b/ Includes only those not receiving active treatment to diagnose or cure an illness.

c/ Includes only those not capable of independent living.

d/ Excludes services of physicians and dentists.

TABLE 4. TOTAL ESTIMATED SPENDING FOR LONG-TERM HEALTH CARE SERVICES, FISCAL YEAR 1980 UNDER PRESENT LAW a/: DOLLARS IN BILLIONS

	Total	Private				Total Public
		Total	Out-of Pocket b/	Insurance	Other	
All Services	32.0 to 36.4	14.7 to 18.3	13.1 to 16.2	0.9 to 1.0	0.8 to 1.3	17.4 to 18.2
Institutional Care	29.8 to 32.9	14.0 to 17.0	12.5 to 15.5	0.8	0.7 to 1.1	15.8 to 15.9
Long-Term Hospitals d/	1.0	0.3	0.3	0	*	0.8
Psychiatric Hospitals d/	3.2	0.7	0.7	0	*	2.5
Skilled Nursing Facilities e/	16.5	8.4	7.5	0.8	0.1	8.1
Intermediate Care Facilities	3.6	1.1	1.0	0	0.1	2.5
Personal Care Homes	2.9	2.7	2.3	0	0.4	0.2
Homes for Physically Handicapped	*	*	*	0	*	*
Homes for the Blind	0.1	*	*	0	*	0.1
Drug and Alcoholism Facilities	0.3	0.1	0.1	*	*	0.2
Mentally Disturbed	0.6	0.1	0.1	*	*	0.4
Mentally Retarded	1.2	0.3	0.3	*	*	0.9
Other Sheltered Living f/	0.4 to 3.5	0.4 to 3.4	0.3 to 2.9	0	0.1 to 0.5	0.1 to 0.2
Ambulatory and Home Care	2.2 to 3.5	0.7 to 1.3	0.6 to 1.1	0.1	0.1	1.5 to 2.4
Home Health Agencies	1.6 to 2.7	0.4 to 0.9	0.3 to 0.7	0.1	* to 0.1	1.1 to 1.9
Rehabilitation Agencies	0.5	0.1	0.1	*	*	0.4
Private Practitioners g/	0.2 to 0.3	0.2 to 0.3	0.2 to 0.3	*	*	*

* Less than $50 million.

a/ Excludes administrative cost of insurance or government programs and social services, assistance with routine chores, food preparation, etc.

b/ Includes payments by all income maintenance programs, including supplemental security income, social security, and any state supplements.

c/ Includes premiums paid by individuals.

TABLE 4. (continued)

Federal Outlays					State and Local Outlays		
Total	Medicare c/	Medicaid	VA	Other	Total	Medicaid	Other
8.9 to 9.3	1.1 to 1.4	5.8 to 5.9	1.6	0.4	8.4 to 8.9	4.6 to 4.6	3.9 to 4.3
8.0	0.6	5.7	1.6	0.2	7.8 to 7.9	4.5	3.3 to 3.5
0.5	0	0	0.5	*	0.3	0	0.3
0.7	0		0.6	0.1	1.9	0	1.9
4.7	0.6	4.0	0.1	*	3.4	3.1	0.3
1.5	0	1.2	0.3	*	1.0	1.0	0.1
0.1	0	0	0.1	*	0.1	0	0.1
*	0	0	*	*	*	0	*
*	0	0	*	*	0.1	0	0.1
0.1	0	*	*	0.1	0.1	0	0.1
*	0	0	*	*	0.4	0	0.4
0.5	0	0.5	0	*	0.5	0.4	0.1
0	0	0	0	0	0.1 to 0.2	0	0.1 to 0.2
1.0 to 1.3	0.6 to 0.8	0.1 to 0.2	*	0.2	0.6 to 1.0	0.1	0.5 to 0.8
0.7 to 1.0	0.6 to 0.8	0.1 to 0.2	*	*	0.4 to 0.8	0.1 to 0.2	0.3 to 0.6
0.2	0	0	*	0.2	0.2	0	0.2
*	0	0	*	*	*	0	*

d/ Includes custodial services only — i.e., those not receiving active treatment to diagnose or cure an illness.

e/ Includes all patients in facilities certified as skilled nursing facilities, regardless of actual level of care received.

f/ Includes only residents not able to live independently in normal housing.

g/ Excludes services of physicians, dentists, and other practitioners who normally treat acute illness.

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TABLE 5. ESTIMATED SPENDING UNDER PRESENT FEDERAL PROGRAMS FOR SELECTED LONG-TERM CARE SERVICES, FISCAL YEARS 1977-1985: DOLLARS IN BILLIONS

	1977	1978	1979	1980	1981	1982	1983	1984	1985
Program Outlays	7.1-7.3	8.4-8.5	9.7-10.0	11.3-11.8	13.2-13.8	15.3-16.2	17.7-19.0	20.6-22.3	23.9-26.1
Medicare	0.7-0.8	0.9	1.0-1.2	1.1-1.5	1.3-1.7	1.5-2.0	1.6-2.4	1.9-2.8	2.2-3.2
Skilled Nursing Facilities	0.4	0.4	0.5	0.6	0.6	0.7	0.8	0.9	1.0
Home Health Services	0.4	0.4-0.5	0.5-0.7	0.7-1.0	0.701.2	0.7-1.2	0.8-1.5	1.0-1.8	1.1-2.1
Administrative Expenses	*	*	*	* - 0.1	* - 0.1	* - 0.1	* - 0.1	0.1-0.1	0.1-0.1
Medicaid	6.0-6.1	7.1-7.2	8.3-8.4	9.6-9.8	11.2-11.5	13.0-13.4	15.2-15.7	17.7-18.5	20.5-21.6
Skilled Nursing Facilities	4.5	5.3	6.1	7.1	8.2	9.6	11.1	13.0	15.1
Intermediate Care Facilities	1.4	1.6	1.9	2.2	2.5	3.0	3.4	4.0	4.6
Home Health Services	0.1-0.2	0.2	0.2-0.3	0.2-0.4	0.3-0.5	0.3-0.7	0.4-0.9	0.5-1.2	0.6-1.6
Administrative Expenses	0.1	0.1	0.1	0.2	0.2	0.2	0.2-0.3	0.3	0.3-0.4
Other Civilian Programs	0.3	0.4	0.4-0.5	0.5	0.6	0.7-0.8	0.9	1.0-1.1	1.2
Skilled Nursing Facilities	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3
Intermediate Care Facilities	0.2	0.2	0.2	0.3	0.3	0.4	0.5	0.6	0.7
Personal Care Facilities	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Home Health Services	*	*	*	*	*	*	*	*	*
Federal Outlays	4.5-4.6	5.3-5.4	6.1-6.4	7.2-7.6	8.3-8.9	9.6-10.4	11.0-12.2	12.9-14.3	14.7-16.9
Medicare	0.7-0.8	0.9-1.0	1.0-1.2	1.2-1.5	1.3-1.7	1.5-2.0	1.6-2.4	1.9-2.8	2.2-3.2
Medicaid	3.4	4.0-4.1	4.7	5.5-5.6	6.3-6.5	7.3-7.5	8.5-8.8	9.9-10.4	11.5-12.2
Other Civilian Programs	0.3	0.4	0.4-0.5	0.5	0.6	0.7-0.8	0.9	1.0-1.1	1.0-1.2

* Less Than $50 million.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #20

SUBJECT: Income and employment of older people.

Attached is information extracted from an analysis of employment and income of older people living in rural and urban locations. The analysis, completed by the U.S. General Accounting Office, determined that:

--family incomes were lower in Kentucky than in the two other locations sampled (Cleveland and Lane County, Oregon), and

--only a small percentage of the older people were employed full time in any of the locations.

SOURCE OF DATA: "Comparison of Data on Older People in Three Rural and Urban Locations" (HRD-80-83). U.S. General Accounting Office, Washington, D.C., May 23, 1980.

QUESTIONS AND ANSWERS ABOUT PEOPLE 65 YEARS OLD AND OLDER IN THREE LOCATIONS

DESCRIPTION OF DATA BASES

The data for our comparative analyses come from three separate studies that included information about people 65 years old and older not residing in institutions. The older people in the samples lived in Cleveland, Ohio; Lane County, Oregon; and the Gateway Health District, northeastern Kentucky. Using Bureau of Census definitions of rural and urban, we classified the data from Cleveland as urban, the data from Lane County as rural and urban, and the data from northeastern Kentucky as rural.

Cleveland, Ohio

We took a statistical sample of people from over 80,000 people in Cleveland who were 65 years old and older and were not in institutions, such as nursing homes. In our study, 1,609 older people were interviewed by Case Western University in 1975 and 1,311 were reinterviewed a year later. Our analysis used data on the 1,311 older people interviewed in 1976. We refer to these people in the analyses as urban Cleveland.

Lane County, Oregon

The Lane County study was made by the University of Oregon and the Lane County Community Health and Social Services Department . The study was initiated to develop a comprehensive data base for planning programs for persons 60 years old and older living in the county. The county, located in west-central Oregon, contains two adjacent cities, Eugene and Springfield, which had a 1976 combined population of about 132,000 (54 percent of the county's population). The county also contains four other incorporated areas, each with a population over 2,500.

The selection process for the Oregon study involved a statistical sample of 1,197 people from six subareas of the county. The people sampled were interviewed in 1978. Data from the study are to be used for planning and evaluation with a capability to study rural and urban differences.

We segregated data on 868 persons 65 years old and older from the Lane County sample. We divided the data into three groups, which we refer to as rural Lane County, Oregon; urban Lane County, Oregon; and Lane County, Oregon (town). They are described as follows:

--Rural Lane County, Oregon--426 older persons who live in unincorporated areas consisting of farms, timberland, or open space or in incorporated areas with populations of fewer than 2,500 people.

--Urban Lane County, Oregon--318 older persons who live within the corporation limits of Eugene and Springfield, Oregon. Over 60 percent of Lane County's residents who are 65 years old and older live in these two cities.

--Lane County, Oregon (town)--124 older persons who live in three small towns--Florence, Cottage Grove, and Oakridge. These towns have populations of 3,050, 6,900, and 3,930, respectively.

Gateway Health District, Kentucky

The Gateway Health District studied the demographic characteristics and needs of people 60 years old and older living in the district. This district consists of five counties in northeastern Kentucky (Bath, Menifee, Montgomery, Morgan, and Rowan) within the Cumberland Plateau. The district is a severely economically depressed rural area consisting of small communities and homes dispersed over a large area of mountainous terrain in Appalachia. In 1970, this area had a population of 55,678.

A statistical sample of people 60 years old and older living in the five-county area was selected for interviews. This sample included people from rural and urban areas, and people in institutions. People not in institutions were interviewed in 1977. Data on 128 people 65 years old and older, not in institutions and living in unincorporated or incorporated areas of fewer than 2,500 people, were segregated by us from this sample and used in our comparative analyses. We refer to these 128 people as rural northeastern Kentucky.

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All three studies used the Older Americans Resources and Service Questionnaire developed by a multidisciplinary team headed by Dr. George Maddox and Dr. Eric Pfeiffer at the Duke University Center for the Study of Aging and Human Development. During a personal interview, the older people in the three studies replied to 101 questions about their well-being in five areas of functioning--social, economic, mental, physical, and activities of daily living. Data from these interviews were used to answer the following questions.

Income

1. Question: Did family income vary among the three locations?

Answer: Family incomes were lower in northeastern Kentucky than in the other locations. Over 52 percent of the older people in northeastern Kentucky had incomes of less than $3,000, compared to 32 percent in Cleveland and 15 percent or less in Lane County. (See enc. II.)

Because married people often have higher incomes than single people and because the percentage of married people varies at each location, we analyzed income by location and marital status. As shown in the following table (even when marital status is considered), older people in northeastern Kentucky have lower incomes than those in other locations. For example, 80 percent of the married people in northeastern Kentucky have an income of less than $5,000. In urban Lane County only 11 percent of the married people had an income under $5,000.

		Urban			Rural	
Income range	Marital status	Cleveland	Lane County, Oregon	Lane County, Oregon (town)	Lane County, Oregon	Northeastern Kentucky
		(percent)				
Less than $3,000	Married	6	1	3	3	39
	Not married	48	29	32	37	73
		35	11	15	29	80
$3,000 to $3,999	Married	10	3	7	12	23
	Not married	23	26	25	24	10
$4,000 to $4,999	Married	19	7	5	14	18
	Not married	11	14	11	9	0
$5,000 or over	Married	65	89	85	71	20
	Not married	18	31	32	30	17

2. Question: Were there differences in sources of income among the three locations?

Answer: Similarities: Most older people at the three locations had income from social security--ranging from 88 percent in northeastern Kentucky to 96 percent in urban Lane County. Differences: Fewer people in northeastern Kentucky (14 percent) had retirement pensions than elsewhere (ranging from 33 percent in rural Lane County to 43 percent in urban Lane County). Also, more older people in northeastern Kentucky had income from Supplemental Security Income payments (18 percent) compared to the other locations--3 percent in rural Lane County, 5 percent in Cleveland, and 1 percent in urban Lane County. This information is shown in the following table.

Income sources	Urban			Rural	
	Cleveland	Lane County, Oregon	Lane County, Oregon (town)	Lane County, Oregon	Northeastern Kentucky
	(percent)				
Wage, salary, business income	8	18	10	12	13
Rental, interest, investments	23	45	36	27	19
Retirement pension	34	43	36	33	14
Veterans' benefits	5	7	11	5	9
Social Security	92	96	94	93	88
Supplemental Security Income	5	1	1	3	18

Employment

1. Question: What was the employment status of the older people in the three locations?

Answer: Only a small percentage of the older people were employed full time in any of the locations--1 percent in northeastern Kentucky to 3 percent in urban Lane County. About 5 to 11 percent were employed part time, as shown in the following table.

Employment status	Urban			Rural	
	Cleveland	Lane County, Oregon	Lane County, Oregon (town)	Lane County, Oregon	Northeastern Kentucky
	(percent)				
Full time	2	3	1	1	1
Part time	6	11	9	5	5
Not employed	92	86	90	94	94
Total	100	100	100	100	100

2. Question: Were older people seeking employment?

Answer: Most older people were not seeking employment. Three percent or less of the older people in all of the locations were seeking employment, as shown in the following table.

Not employed but seeking work	Urban		Lane County, Oregon (town)	Rural	
	Cleveland	Lane County, Oregon		Lane County, Oregon	Northeastern Kentucky
	(percent)				
Yes	3	2	1	0	1
No	97	98	99	100	99
Total	100	100	100	100	100

DEMOGRAPHIC CHARACTERISTICS OF SAMPLES

Characteristics	Urban			Rural	
	Cleveland	Lane County, Oregon	Lane County, Oregon (town)	Lane County, Oregon	Northeastern Kentucky
	(percent)				
Sex:					
Male	38	43	40	50	30
Female	62	57	60	50	70
Age:					
65-74	54	65	59	64	60
75 and older	46	35	41	36	40
Education:					
Less than 12 years	75	53	56	62	87
12 years or more	25	47	44	38	13
Race:					
White	72	99	100	98	98
Black	28	1	0	2	2
Marital status:					
Married	38	59	55	67	61
Widowed	48	32	40	25	37
Single	14	9	5	8	2
Income:					
Less than $3,000	32	13	15	14	52
$3,000 to $6,999	50	44	50	51	40
More than $7,000	18	43	35	35	8
Number in sample	1,311	318	124	426	128

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #21

SUBJECT: Services in the home for older people

SOURCE OF DATA: Special analysis of the General Accounting Office Data Base on the Well Being of Older People in Cleveland, Ohio

HOME HELP SERVICES

In our report entitled "Conditions of Older People: National Information System Needed" (HRD-79-95, dated September 20, 1979), we estimated that more than a third of all the help provided to people 65 years old and older was in the form of help in performing activities of daily living, such as meal preparation or housework. An average $2,400 of this kind of help was provided each older person in our sample population in Cleveland in 1975.

To more specifically identify the kind and nature of home help needed by the older population, we analyzed our data collected on the conditions, problems, and helps of a random sample from the over 80,000 older people in Cleveland, Ohio in 1975 and 1976. Our analysis was designed to answer the following questions:

--How many older people have a need for home help and what specific kinds of home help do they need?

--What portion of the need for home help is being met? By whom is it being met--family and friends or public agencies?

--What is the cost of existing home help and who is bearing the cost?

--What would it cost to expand home help to all older people in need?

--How many older people would get all their needs met by expanding the different kinds of home help?

Although our analysis is based on data obtained on older people in Cleveland, we believe that by knowing about older people in Cleveland, a person can form a mental image of older people--their problems and services needed.

Home help for our purposes is defined as compensatory help, that is, help designed to compensate for an older person's inability to do daily tasks such as housework or meal preparation. (See page 10 for a description of how we matched helps and daily tasks.)

How many older people need home help?

Overall 40 percent of our Cleveland sample could not do one or more of 13 daily tasks. Of the 40 percent, more than half were receiving help, mostly from families and friends. The remaining people needed more compensatory help to do daily tasks. More people needed help with housework than any other daily task. The next most needed was help with shopping, then help getting places out of walking distance. The following shows the percent of people in our sample who needed help by daily task.

Daily task	People needing help	
	percent	number
Housework	38	20,500
Shopping	26	16,400
Getting places out of walking distance	24	14,800
Using telephone or taking medicine	14	8,900
Preparing meals	12	7,800
Physical tasks (eating, dressing, taking care of appearance, walking, bathing, getting out of bed)	14	8,600
Handling money	12	7,200

Considering the need for help in combination, many people had a need for multiple kinds of help. Nearly one in every three older people (30 percent of our sample) needed help with more than one daily task as shown in the table below.

Number of daily tasks person needs help with	Percent of sample	Number of people in Cleveland
none	60	37,600
one	11	6,900
two	7	4,400
three	6	3,700
four	4	2,500
five	4	2,500
six	3	1,900
seven or more	5	3,100
	100	62,600 a/

a/Total does not include all older people in Cleveland because the projections are based on only those who responded during interviews and does not include those in institutions.

What portion of the need for home help is being met?

As stated previously, 18 percent of the sample (228 people) needed more compensatory help to do daily tasks. Three-fourths of the 228 people needed more help with only one daily task. Help with housework was the most unmet need as shown in the following table.

Number of daily tasks	Number of people with unmet need	Number of people in Cleveland
One daily task		
Housework	90	4,300
Physical tasks	22	1,000
Handling money	21	1,000
Shopping	18	900
Getting places out of walking distance	11	500
Using telephone or taking medicine	10	500
Subtotal	172	8,200
More than one daily task	56	2,700
Total	228	10,900

Home help is provided to older people by two primary sources. The first, and largest source are the families and friends of older people. The other major source is public agencies. To examine the relative importance of these two sources, we analyzed our Cleveland data to see which source was providing home help to the most older people. We found that most home help was coming from families and friends. Seventeen percent of the people in our sample were getting all their needs for home help met by family or friends.

Public agencies were playing an important but smaller role in providing home help to older people. When home help from public agencies was considered, another 5 percent of the sample had all their needs met. Thus, when considering help from both sources--families/friends and public agencies--22 percent of the sample had a need for home help and were receiving all the help they needed.

What is the cost of home help?

To estimate cost of home help, we gathered and quantified data on home help provided by 120 social service agencies and families and friends. We than developed an average unit cost for each kind of help based on 1976 Cleveland cost data and applied it to the units of help provided (see p. 9). We used these methods to estimate the cost of home help currently being provided to the older people in our sample and to estimate the cost of expanding help to all those in need.

We estimate that each older person in Cleveland received an average of $429 of home help in 1976. Families and friends provided more than four-fifths of the help with agencies providing the other fifth. We estimate the families and friends of older people provided an average $349 of home help for each older person and agencies provided another $80 per person.

To expand home help to all older people would nearly double the cost of existing home help--or cost an additional $423 for each older person in our sample. This expanded help when added to the $429 cost of existing help would average $852 for each older person each year.

The bulk of this additional cost--93 percent--would be to provide help to older people who cannot do one of the physical tasks or who cannot do housework. We estimate that to expand help to all older people who could not do one or more of the physical tasks without help would cost an additional $234 for each older person annually. Our comparable estimate for those who could not do housework without help was $160 for each older person annually.

How many older people would have all their needs met by expanding the different kinds of home help?

To identify the benefits of expanding the different kinds of home help, we considered how many people would have all their needs for home help met if each kind of help were expanded. We first identified the number of additional people who would have all their needs met if help with housework were expanded to all those in need. We chose housework first because help with housework was needed by more older people than any other kind of help. We then considered how many more people would have all their needs met if both help with housework and help with shopping were expanded. We then added the other kinds of help into the analysis until we had considered all seven kinds of help.

The following table shows the results of our analysis for the estimated 62,600 noninstitutionalized older people in Cleveland in 1976. To illustrate, if help with housework were expanded to all the older people in Cleveland who needed but were not getting such help an additional 4,300 older people would be receiving all the home help needed. Similarly, if help with shopping were

expanded (in addition to help with housework), another 1,600 older people would have all their needs met. The remainder of the table shows a comparable analysis for help with other daily tasks as expanded incrementally.

Kind of daily task helped	Estimated additional older people receiving all needed help
Housework	4,300
Shopping	1,600
Physical tasks	1,500
Using telephone or taking medicine	700
Handling money	1,500
Preparing meals	600
Getting places out of walking distance	700
Total	10,900

Using our Cleveland data we then estimated the cost to expand the different kinds of help and related it to the number of additional people who would have all their needs met if each kind were expanded incrementally. The following table shows that it would cost an estimated $10.0 million to provide help with housework to all the older people in Cleveland who needed such help and, as a result, an additional 4,300 older people would be receiving all help needed. Similarly, if help with shopping were expanded, in addition to help with housework, it would cost another $1.3 million and another 1,600 older people would have all their needs met. The remainder of the table shows a comparable analysis for help with other daily tasks as expanded incrementally.

Kind of daily task helped	Estimated additional cost to expand help in Cleveland -----(million)------	Estimated additional older people receiving all needed help
Housework	10.0	4,300
Shopping	1.3	1,600
Physical tasks	14.6	1,500
Using telephone or taking medicine	0.2	700
Handling money	0.1	1,500
Preparing meals	0.2	600
Getting places out of walking distance	0.1	700
Total	26.5	10,900

METHODOLOGY

The information contained in this brief is based on our study of the personal conditions of older people in Cleveland, Ohio. Following are the details of the data gathering and analytical methodology used in the study.

WELL-BEING STATUS AND SERVICES DATA BASES

We took a sample from over 80,000 people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. We insured that our sample was demographically representative by comparing the characteristics of our sample to statistics for the city of Cleveland.

In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, 1,311 of these older people were reinterviewed.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center, in collaboration with the Administration on Aging, former Social and Rehabilitation Service, and Health Resources Administration. The questionnaire contains questions about an older person's well-being status in five areas of functioning--social, economic, mental, physical, and activities of daily living.

To identify factors that could affect the well-being of older people, we

--developed specific definitions of services being provided to older people and dimensions for quantifying the services;

--identified the providers of the services--families and friends, health care providers, and over 100 social service agencies;

--obtained information about the services provided to each person in our sample and the source and intensity of these services; and

--developed an average unit cost for each of the 28 services.

In defining and quantifying the services, we used a format developed by the Duke University Center to define 28 different services. These services are defined in appendix V of our prior report. 1/ Services are defined according to four elements: purpose, activity, relevant personnel, and unit of measure. For example, meal preparation was defined as follows:

Purpose: To regularly prepare meals for an individual.

Activity: Meal planning, food preparation, and cooking.

Relevant personnel: Cook, homemaker, family member.

Unit of measure: Meals.

Examples: Meals provided under 42 U.S.C. 3045 (supp. V, 1975), the Older Americans Act, and meals-on-wheels programs.

To quantify the service, we used the unit of measure along with the duration, or number of months, during which the service was received.

We also developed an average unit cost for each service based on the experience of 27 Federal, State, local, and private agencies in Cleveland between October 1976 and March 1977. We compared these costs to similar costs in Chicago, Illinois, and Durham, North Carolina. As discussed in our prior report, the family and friends are al important sources of services. In their absence, any services received would have to be from an agency. Therefore, we assigned the same cost to family and friend services that we found for agencies.

Each piece of data was collected so that it could be related to an individual in our sample. This included the questionnaire data, data on the 28 services provided by social service agencies, and data on the services

1/"The Well-Being of Older People in Cleveland, Ohio," April 19, 1977, HRD-77-70.

provided by health care providers. By relating these data to the individual, we were able to do comparative analyses of sampled older people for over 500 different variables.

Services or help provided is intended to either remedy a specific problem or help the older person cope with it. For example, an older person who has very little social contact quite often feels lonely. The condition is that the person feels lonely. The problem is a lack of social contact. The help--social-recreational services--would provide opportunities for more social contacts, thereby decreasing feelings of loneliness. In other instances, older people are unable to perform the normal activities of daily living and need help in coping with their disabilities. This kind of help--called compensatory help--is designed to perform activities that older people cannot do for themselves, as shown below:

Tasks of daily living

Can you use the telephone - without help, including looking up numbers and dialing--if not, then compensatory help could be any one of - checking, continuous supervision, personal care, nursing care.

Can you take your own medicine - without help (in the right doses at the right time)--if not, then compensatory help could be any one of - checking, continuous supervision, personal care, nursing care.

Can you get to places out of walking distance - without help (can travel alone on buses, taxis, or drive your own car)--if not, then compensatory help could be any one of - escort, transportation.

Can you go shopping for groceries or clothes (assuming person has transportation) - without help (taking care of all shopping needs yourself, assuming you had transportation)--if not, then compensatory help could be any one of - escort, food - groceries, shopping.

Can you prepare your own meals - without help (plan and cook full meals yourself)--if not, then compensatory help could be any one of - meal preparation.

Can you do your housework - without help (can scrub floors, etc.)--if not, then compensatory help could be any one of - homemaker

Can you handle your own money - without help (write checks, pay bills, etc.)--if not, then compensatory help could be any one of - administrative or legal.

Physical tasks of daily living

Can you eat - without help (able to feed yourself completely)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you dress and undress yourself - without help (able to pick out clothes, dress and undress yourself)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you take care of your own appearance, for example combing your hair and (for men) shaving - without help--if not, then compensatory help could be any one of - personal care, nursing care.

Can you walk - without help (except from a cane)--if not, then compensatory help could be any one of - personal care, nursing care.

Can you get in and out of bed - without any help or aids--if not, then compensatory help could be any one of - personal care, nursing care.

Can you take a bath or shower - without help--if not, then compensatory help could be any one of - personal care, nursing care.

The six physical tasks of daily living shown above can be compensated for by one of the same two relevant compensatory helps. For this analysis, we combined the six and considered if a person could not do any one of six they needed one of two helps--personal care or nursing care.

WHITE HOUSE CONFERENCE ON AGING

INFORMATION BRIEF #21

SUBJECT: Disability of men

SOURCE: United States General Accounting Office analysis of data from the "National Longitudinal Surveys" created by the Ohio State University Center for Human Resource Research.

DISABILITY OF MEN

This brief provides some insight into disability of men. Specifically, the data presented is about men whose ages ranged from 45 to 59 in 1966 and follows them as they aged over a 10 year period--1966-1976. Our analysis was directed towards

--showing sources of disability payments and whether the sources changed over time, and

--describing what happens over time to men who were receiving a disability payment in 1966.

Because age is a primary factor in labor force participation and indirectly on eligibility for some disability payments, all the data is presented by age. This brief is divided into three sections: (1) background, (2) methodology, and (3) results of our analysis in question-and-answer form. Appendix I provides a description of the data base.

BACKGROUND

Disability in general terms describes any reduction of a person's activities resulting from an accute or chronic health condition. This includes changes in the amount of work or other activities pursued. Depending in part on the duration of the functional limitation, disability may be short-term, long-term, or permanent.

In 1976, about 2.1 million males between the ages of 45 and 54 had work-related disabilities. This represented 18 percent of the population in this age group. Approximately 860,000 were completely unable to work because of their disability.

In the age group 55 to 64, another 2.7 million had work-related disabilities. Approximately 1.2 million of those with work-related disabilities in this age group were not working.

Some monetary compensations are directly related to a type or cause of disability. For instance, Workmen's Compensation is the social insurance program that provides compensation to workers disabled on-the-job. Indemnity benefits are provided through (1) cash payments for total disability and death, replacing a portion of lost wages; (2) cash payments for partial disability, often as a scheduled payment for loss of specific body parts or functions; (3) medical care benefits; and (4) rehabilitation services. Benefits generally are paid weekly or, especially when determination of eligibility and the amount to be received is negotiated between employers and/or insurance companies on the one hand and workers and/or their union or lawyer representatives on the other, the payment may be a lump sum.

Another disability compensation program is the disability insurance part of the Old Age, Survivors, and Disability Insurance (OSADI) program. Workmen's

Compensation complements the OASDI program in offering income-maintenance and medical protection for short-term disability and for permanent partial disabilities.

A third disability compensation program is Supplemental Security Income (SSI) which in 1974 replaced categorical grants to the permanently blind and/or totally disabled. Workmen's Compensation and SSI payments are also complementary because disabled workers may turn to SSI for support when Workmen's Compensation benefits either end or furnish insufficient income replacement.

Another source of disability payments is the Veterans Administration for service-connected disability compensation. In 1976 there were approximately 2.2 million veterans receiving compensation (58 percent were World War II survivors).

METHODOLOGY

For this brief, disability is defined in terms of an actual cash receipt from one or more disability programs. These sources include Workmen's Compensation, Veterans Administration, the former categorical programs - aid to the permanently blind and disabled (now under SSI), Social Security Disability payments and private disability plans.

This definition may exclude some men who have severe limitations, have not yet qualified for program participation, or have limitations not severe enough to qualify them for a cash payment. Included within the definition are veterans who get service-related disability payments which may have little near-term affect on the economic earning power of the recipient. The analysis for this brief did not pursue or attempt to interrelate the needs or degree of disability of those getting cash payments to those not receiving payments.

The sample as taken in 1966 was divided into three age groups age 45-49, 50-54, and 55-59 based on their reported age in the first interview year (1966).

Over the time period between 1966 and 1976, information was collected in eight of these years. For our analysis, the data base yielded three snapshots in time--1966, 1970, and 1975--to look at the question of long-term changes in those receiving disability payments.

To aid the reader, the data that follows is in question-and-answer form. Appendix I provides a description of the data base.

QUESTIONS AND ANSWERS

1. Question: What percentage of the sample was receiving a disability payment in 1966?

Answer: Overall, 11.1 percent of the sampled men were receiving disability payments in 1966. While only 11 percent received a disability payment in 1966, another 20 percent of the sample reported health related problems who were not receiving any payments.

The percentage of those getting cash payment varied slightly by age group varying from 9.9 percent to 12.6 percent as shown in the following table.

Percent and number receiving disability payments in 1966 by age

Category	45 - 49	50 - 54	55 - 59	Total
Number in age group	1,835	1,724	1,461	5,020
Number receiving a disability payment	203	170	184	557
Percent receiving a disability payment	11.1	9.9	12.6	11.1

2. Question: For those receiving payments, what were the sources of payments and what were the differences in source of payments between age groups?

Answer: Overall, the Veterans Administration was the major source of disability payments. However, there were considerable differences between the age groups. The following table shows the percent coming from each source.

Age comparison of 1966 disability payment sources

	45 - 49	50 - 54	55 - 59
	(percent)		
Multiple sources (2 or more below)	9.3	9.4	10.9
Categorical aid (after 1974 SSI)	1.0	3.5	3.8
Private plans	8.9	18.8	13.0
Workmen's compensation	12.3	11.8	15.2
Social security disability	9.9	16.5	33.2
Veterans Administration disability	58.6	40.0	23.9
Total	100.0	100.0	100.0

As shown in the previous table, the Veterans Administration was the largest source for both the 45 to 49 and 50 to 54 age groups. These percentages (58.6 percent and 40.0 percent, respectively) reflect a high concentration of World War II veterans with service connected disabilities. The second highest source for the 45 to 49 age group is Workmen's Compensation.

The 55 to 59 age group received the largest portion of their payments from social security (33.2 percent).

3. Question: For those receiving disability payments in 1966, what portion were these payments of their total family income?

Answer: Without considering family size, duration of disability, or additional sources of income, about 17 percent of those in the 55 to 59 age group received their total family inocme from disability payments. As shown in the following table, the greater the age, the more likely a person will obtain a larger portion of his total family income from disability payments.

Percent ot total family income coming from disability payments in 1966 by age

Percent of family income from disability payments	45 - 49	50 - 54	55 - 59
	(percent)		
Less than 10	59	47	27
10 to 49	25	31	31
50 tc 99	9	14	25
	16	22	42
100	7	8	17
Total	100	100	100

4. Question: If a person receives a disability payment, is he out of the the labor force?

Answer: To the contrary, many persons receiving disability payments are full-time workers. While each of the five sources can not be exclusively categorized as payments to someone who is not able to work as opposed to someone who is able to work, generally, persons receiving social security disability payments were non-workers. In the case of payments from the Veterans Administration, in all age groups, at least 50 percent of those drawing just a Veterans Administration disability were working 48 weeks or more during 1966.

5. Question: For those men receiving a disability payment in 1966, what happened over time to these men?

Answer: Over time means a time span from 1966 to 1975--a 9-year period. Over this time span, we looked at two years, 1970 and 1975 to see if those getting disability payments in 1966 continued to receive them. If they had their disability payments discontinued, we tried to determine whether they returned to the labor force or retired.

The percent of men continuing to receive disability payments decreased over time from 51 percent in 1966 to 24 percent in 1975, as shown in the following table.

Percent of 1966 disability receivers continuing to receive disability payments from 1966 through 1975

Category	45 - 49	50 - 54	55 - 59
	(percent)		
Continue to receive payment(s)	51	46	24
Disability payment(s) discontinued	31	23	33
Deceased by 1976	18	31	43
	100	100	100
Number Receiving in 1966	203	170	184

Age plays a role in determining whether the man who received disability payments in 1966 but who subsequently had the payment(s) discontinued, returned to the labor force. Men in age grouping 45 to 49 who received workmen's compensation and/or aid from private disability plans, often returned to the labor force as full-time workers and continued working. For example, 44 percent of the men in

age grouping 45 to 49 whose disability payment had discontinued by 1975, also had it discontinued in 1970 and in 1966 had received payments from either workmen's compensation or private disability plans. Overall, 85 percent of those whose payments were discontinued after 1966 in the 45 to 49 age grouping were working 48 weeks or more in 1975. Thus, most men who lost a payment in the 45 to 49 age grouping, were in the labor force in 1975.

In contrast, men in the age grouping 55 to 59 who subsequent to 1966 had their disability payments discontinued, often reentered the labor force to drop-out again. By 1975, where most should have been retired (men are now ages 64 to 69), few were receiving retirement pensions and many were on the federally sponsored program--aid to the low income aged.

APPENDIX I

DESCRIPTION OF THE DATA BASE [1/]

The information contained in this brief is based on the National Longitudinal Surveys. Following is a description of the data gathering and methodology from the surveys.

The Sample

The analysis in this brief are based on data from the National Longitudinal Surveys. These surveys were designed by the Ohio State University Center for Human Resource Research under a contract with the Employment and Training Administration of the U.S. Department of Labor. The sample design, field work, and the initial stages of data processing were the responsibility of the U.S. Bureau of the Census under a separate contract with the Employment and Training Administration. In addition to the sample of middle-aged men between the ages of 45 and 59 on which the data of this brief are based, the National Longitudinal Surveys include three other age-sex cohorts: women between the ages of 30 and 44, young men between the ages of 14 and 24, and young women in the same age category. Each of the four age-sex cohorts is represented by a multi-stage probability sample located in 235 sample areas comprising 485 counties and independent cities representing every state and the District of Columbia.

The members of the sample who provided the information were selected to be representative of the approximately 15 million men in the U.S. civilian noninstitu-

1/This description is an abbreviated form of the published description of the data bases contained in "The Pre-Retirement Years: A Longitudinal Study of the Labor Market Experience of the Cohort of Men 45-59 Years of Age" by Herbert S. Parnes, B.M. Fleisher, R.C. Miljus, R.S. Spitz and Associates, October 1968

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tionalized population who in 1966 were between the ages of 45 and 59. However, one of the survey requirements was to provide separate reliable statistics for blacks, and in order to provide sufficient numbers of observations for reliable racial comparisons, the sampling ratio for black men was between three and four times as high as for whites. Thus, the sample of 5,020 men originally interviewed in 1966 included 3,518 white men, 1,420 black men, and 82 men of other races.

Of the 5,020 men interviewed in 1966, 3,487 remained in the sample as of 1976. Sampling weights have been adjusted to reflect the effects of attrition through death and nonresponse. Thus, for most of the analysis the sample may be regarded to represent those men in civilian population who in 1966 were between the ages of 55 and 69. The number of men interviewed in each age group were:

Age Group	Number of Men Interviewed
45 - 49	1,835
50 - 54	1,724
55 - 59	1,461
Total	5,020

The data for the sample were collected in a series of eight surveys of the members of the sample. Extended face-to-face interviews were conducted in 1966, 1967, 1969, 1971, and 1976. In 1968 there was a very brief mailed questionnaire, and in 1973 and 1975 short telephone interviews were conducted.

Because the survey studied the cohorts systematically for this 10-year period, the National Longitudinal Survey has two distinct advantages, characteristic of

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longitudinal population studies. First, it involves measurement or description of one or more characteristics of the same group of individuals at two or more points in time. Second, it involves analysis of relationships among the characteristics of these individuals at different times or of changes in one or more of their characteristics over time.