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Statement of  
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Human Resources Division  
Before the  
Special Committee on Aging  
United States Senate

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[Comments on Proposed GAO Report Entitled  
"Conditions of Older People:  
National Information System Needed"]

Mr. Chairman and Members of the Committee, I am pleased to be here today as your deliberations focus on planning for the future of home care services for older Americans. My comments are based on our proposed report to the Congress on the conditions of older people and the need for a national information system for long term planning for the delivery of services to older people.

To design and plan for the delivery of services to older persons, society, the Congress, and the Executive Branch need information on (1) their well-being, (2) what factors make a difference in their lives, and (3) the impact of services on the well-being of older people. Currently this information <sup>collected</sup> is spread piecemeal throughout Federal, State, local, and private agencies. As a consequence, Federal agencies have not evaluated the combined effect of these services; and, in the



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absence of such information, it is difficult to assess the impact of various programs on the lives of older people.

Based on our study of the well-being of older people in Cleveland, Ohio, we believe it is possible to collect, measure, and evaluate information on the personal conditions of and services to older people.

We also believe that a national information system should be established for older people. Our study shows that information from such a system can be used in multiprogram evaluations which can

- measure the current conditions of older people,
- identify the current cost of helping older people,
- demonstrate the effects of help on improving the problems and conditions of older people, and
- estimate future costs of helping all older people in need and costs of alternative kinds of help.

Before covering each of these points, I will give you some background information on our Cleveland study.

#### WELL-BEING STATUS AND SERVICES DATA BASES

We sampled people from over 80,000 older people in Cleveland, Ohio, who were 65 years old and older and were not in institutions, such as nursing homes. We assured ourselves that our sample was demographically representative by comparing the characteristics of our sample to the population in Cleveland.

In our study, 1,609 older people were interviewed by Case Western Reserve University personnel from June through November 1975. A year later, they reinterviewed 1,325 of these older people.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center on Aging and Human Development in collaboration with the Administration on Aging, the former Social and Rehabilitation Service, and the Health Resources Administration of HEW. 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 those factors that could affect the well-being of older people, we

- developed specific definitions of 28 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; and
- obtained information about the services provided to each person in our sample and the source and intensity of these services.

We also developed an average unit cost for each service based on the cost 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. 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,

the data on the 28 services provided by social service agencies, and the services provided by health care providers. By relating these data to the individual, we were able to make comparative analyses of sampled older people for over 500 different variables.

#### CURRENT CONDITIONS OF OLDER PEOPLE

Measurements of conditions of older people are important in an information system. Our study shows these conditions can be measured. Further, the conditions of older people do change and they can improve.

In 1975, we measured the personal conditions--health, security, loneliness, outlook on life--of older people in Cleveland. Over half of the sample were in the best health, security, and loneliness conditions. The definitions of these conditions are shown in appendix I. However, only 24 percent of the sample were in the best condition in outlook on life.

We also combined these conditions into an overall condition. About a third of the sample were in the best overall condition. At the other end of the spectrum, more than one-fifth (21 percent) were in the worst condition.

In determining the conditions of older people, an information system should contain data on illnesses and the degree these illnesses lead to many older people having trouble doing routine daily tasks. As older people become more and more impaired in their ability to do daily tasks, their probability of being institutionalized increases.

Nearly all of the people in our sample had one or more illnesses. However, for many the illnesses did not greatly interfere with their

activities. For our analyses, we focused on those illnesses which interfered a great deal with a person's activities. One of every three older people in our sample had such illnesses in 1975.

The most common illnesses that greatly interfered with activities were mental impairment, arthritis, circulation trouble, heart trouble, and high blood pressure. Mental impairments and arthritis each interfered a great deal with the activities of 14 percent of our sample; circulation trouble did so for 8 percent; heart trouble did for 6 percent; and high blood pressure for 5 percent.

These illnesses, along with the "wearing out" process of aging, lead to many older people--39 percent--having trouble doing routine daily tasks. In addition, 27 percent needed help in performing one or more tasks and 12 percent could not do any tasks even if helped. They had the most trouble doing housework (29 percent), getting to places not within walking distance (22 percent), and going shopping (21 percent).

An information system should also have the capability of measuring change in conditions over time. In 1976, 1 year after our first interview, we reinterviewed most of our original sample. The overall personal condition of older people improved for 18 percent and declined for 18 percent. The most change was in the outlook on life condition followed by security. The least change was in loneliness and health.

#### CURRENT COSTS OF HELPING OLDER PEOPLE

Helps provided by family and friends and Federal, State, local, and private agencies are significant. The ability to identify the kinds and costs of these helps is crucial and, consequently, another important element of an information system.

The helps provided are intended to either remedy a specific problem or to help the older person cope with it. Many such 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, appendix II contains a diagram which 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.

In Cleveland, the annual cost of providing these kinds of help averaged \$6,617 a person. Various agencies provided \$4,616 worth of help, and family and friends provided the remaining \$2,001. The greatest portion (47 percent) of help is financial. The next greatest is compensatory help with daily tasks (36 percent) and then medical

(15 percent). Social-recreational help accounts for only 2 percent and caregiving and developmental help accounts for less than 1 percent.

Comparing sources of help, the families and friends of older people provide 76 percent (\$1,821 of \$2,399) of the compensatory help by performing daily tasks for them, and only about 6 percent of the financial help (\$172 of \$3,118). The other kinds are provided mostly by public and private agencies funded under Federal programs. From the agency standpoint, 64 percent of their cost was in financial help (\$2,946 of \$4,616) and 21 percent in treatment of illnesses (\$954 of \$4,616).

The results of our work are not statistically projectible to the entire country. However, to illustrate the information that could be obtained from a national information system, we have made national estimates for the 21 million noninstitutionalized older people 65 years old and older in 1975 in the nation. I want to make it very clear that the estimates I will be presenting were not made on a statistical basis but were done for illustrative purposes only.

Thus, using the results of our Cleveland work, the magnitude of the national picture could look like this--\$139 billion in help is provided annually to the 21 million people who are 65 years old and older and live outside institutions. Seventy percent of the 139 billion would be provided through Federal, State, local, and private agencies. Most of this amount is federally funded.

EFFECTS OF HELP ON  
CONDITIONS OF  
OLDER PEOPLE

The ability to determine from an information system the effects of expanded help on conditions of older people would aid considerably in formulating and reviewing proposed legislation. We measured the changes in the conditions and problems of older people between 1975 and 1976 and related services to these changes. Using this analysis, we determined that the effects of services on older people can be measured.

To again illustrate what a national information system could show if it were designed similar to our study, we projected the results found in Cleveland to the 21 million non-institutionalized older people 65 years old and older. These projections demonstrate the role that a national information system on older people can play in major policy decisions.

A sizable portion of the older population would benefit from expanded help. The most benefit would be realized in their illness situation--about 9.2 percent of our sample (1.9 million people nationwide) would have been in a better situation in 1976 if they had been treated for all their illnesses that interfered a great deal with their activities. The second most benefit would be realized in dealing with the security problems, with 5.6 percent of the sample (1.2 million people nationwide) being in a better situation. Also about 4.9 percent of the sample (1.0 million people nationwide) would have a better outlook on life with developmental help.

FUTURE COSTS OF  
HELPING OLDER PEOPLE

Better decisions can be made if costs of services can be projected. An information system should have this potential.

Projections of future costs of expanded help to benefit older people are possible. To demonstrate the effects of help over 20 years, we projected the conditions and problems of the 65 to 69 year old age group for the next 20 years. For example, our projections show 11 percent more of the 65 to 69 age group would be experiencing a better illness situation in 1980 if they had received expanded help. Fourteen percent more would be experiencing a better condition in 1985, 14 percent more in 1990, and 12 percent more in 1995.

Our projected costs to provide expanded help would be reduced considerably in the long run because expanded help leads to better conditions and less need for help in the future. Our illustrative projections nationwide for the 65 to 69 age group over the next 20 years show that if medical treatment were expanded to all in need, total medical costs over the 20 years would be slightly decreased from \$4.5 billion to \$4.3 billion. Also, the cost of compensatory help would be reduced significantly due to the effects of expanded medical treatment from \$12.6 billion to \$11.4 billion. In total, a reduction of about \$1.4 billion results--\$1.2 billion in compensatory help and \$.2 billion in medical treatment--from the impact of preventative medical treatment earlier in life.

The Congress needs alternatives to choose from. A national information system could provide projections of the number of older people benefiting from various kinds of help out of the total number of

people receiving these helps. Additionally, estimates could be made of the costs of alternative kinds of help.

For example, older people have a better chance of benefiting from some kinds of help than others. One of every two people receiving expanded medical treatment would be in a better illness situation and 1 of every 12 who received expanded financial help would have better feelings about the adequacy of their money.

A cost to have one person benefit can be derived from comparing the number of older people who would be in a measurably better condition or situation because of help to the number receiving expanded help. The average cost per person receiving help is \$574 for medical treatment and \$1,442 for financial help. For one person to be in a better illness situation because of expanded medical help, however, about two people have to receive this help or a cost of \$1,191 per person benefiting.

#### RELEASE OF OUR DATA BASE

Considerable interest exists in our study. We discussed our methodology with numerous experts in the field of mathematics, systems analysis, operations research, and gerontology. We conducted several seminars and a national symposium with a variety of researchers, methodologists, statisticians, and HEW officials in the field of aging. Our own consultants in the areas of statistics, operations research, and gerontology advised us and reviewed our methodology in minute detail. The consensus of all involved was that we developed a sound methodology.

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In addition, the staff of the Subcommittee on Human Services, House Select Committee on Aging, has expressed interest in using data from our study for their human service model which is under development. Further, at the request of the Administration on Aging, we plan to provide it with the details of our methodology along with our data base, for distribution to researchers, planners, and administrators in the field of aging.

We believe that the information contained in our data base will be useful to researchers, planners, service providers, and policy-makers. However, this data base will have to be expanded and updated to be useful in the future for long term planning. Therefore, we are recommending to the Administration on Aging that a national information system be developed based on our methodology and data base. Information for this system should be gathered periodically on a national sample of older people stratified to permit estimates for planning at the State and area agency on aging level.

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Our draft report on our Cleveland study is in final processing and we expect to issue our report in June 1979.

Mr. Chairman, that concludes our statement. We will be happy to answer any questions that you or the other Committee members may have.

CONDITIONS

<u>Level of condition</u>	<u>Health (note a)</u>			<u>Security</u>	<u>Loneliness</u>	<u>Outlook on life</u>	<u>Overall personal condition</u>
	<u>Illness</u>	<u>Ability to do daily tasks</u>	<u>Overall (note b)</u>				
Best	No illness that interferes a great deal with activities	Can do all 13 daily tasks without help	In best category for <u>both</u> 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 <u>or</u> ability to do daily tasks <u>and</u> marginal in other or (2) in marginal category for <u>both</u>	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 <u>either</u> 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 in our prior report on pages 57 - 60 of appendix IV.

b/ To be more descriptive in chapter 3, we showed separately the effects of expanded help on illnesses and ability to do daily tasks.

TREATMENT  
ILLNESSES

FINANCIAL  
HELP  
MONEY  
PROBLEMS

COMPENSATORY  
HELP

CAN'T DO  
DAILY TASKS

CAREGIVING  
HELP

NO  
CAREGIVER

HEALTH

SECURITY

OUTLOOK ON LIFE

LONELINESS

NO INTEREST  
IN LIFE

DEVELOPMENTAL  
HELP

LITTLE  
SOCIAL  
CONTACT

SOCIAL -  
RECREATIONAL

