BY THE COMPTROLLER GENERAL ───────── 114767

Report To The Congress
OF THE UNITED STATES   110399

Conditions Of Older People: National Information System Needed

This report is about older people- their conditions, the changes in those conditions, and the differences help can make in their lives GAO was able to measure and project what happens to older people by gathering information from them and by using an analytical framework to measure change in conditions, problems that affect these conditions, and help that is aimed at alleviating the problems

HEW should establish a comprehensive national information system that determines the personal conditions of, problems of, and help available to older people Information from this system should be useful to society, the Congress, and the executive branch in designing and planning for the delivery of services to older persons

110399

HRD-79 95
SEPTEMBER 20, 1979

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To the President of the Senate and the
Speaker of the House of Representatives

    This report, the second of two on the well-being
of older people in Cleveland, Ohio, describes the
personal conditions, the changes in those conditions,
and the differences help can make in the lives of
older people. It demonstrates that information can
be collected and used to measure the personal condi-
tions of older people and evaluate the services pro-
vided to them. Therefore, we are recommending that
a national information system be established for older
people.

    We are sending copies of this report to the
Director, Office of Management and Budget; the
Secretaries of Agriculture, Labor, Transportation,
Housing and Urban Development, and Health, Educa-
tion, and Welfare; the Administrator of the Com-
munity Services Administration; and the Director
of ACTION.

Comptroller General
of the United States

D I G E S T

This report describes personal conditions,
changes in those conditions, and differ-
ences 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 serv-
  ices 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 trans-
> portation, 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 trans-
portation 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 dis-
grace but a cause for a national
celebration. * * *"

To design and plan for the delivery of serv-
ices 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 informa-
tion 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 illus-
trate 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 an-
other important part of any information
system. (See p. 15.)

/The future costs of expanded help to all
older people can also be estimated./ Expand-
ing 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 compensa-
tory help (in the same proportion as they did
in 1975), public costs would have to be in-
creased 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 opera-
tional 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 valu-
able 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 ex-
panded 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 dif-
ferences 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 us-
ing 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 depend-
ing 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 Adminis-
tration on Aging, GAO has agreed to provide
technical assistance in using its model,
concepts, and techniques and to transfer
its data base.

C o n t e n t s

APPENDIX

ABBREVIATIONS

GAO   General Accounting Office

HEW   Department of Health, Education, and Welfare

CHAPTER 1

INTRODUCTION

The ever-increasing complexity of today's society and
the Government's ever-expanding involvement in that society
have made the congressional role of setting national policy
and legislative objectives extremely difficult. Faced with
the increasing demand for more Federal spending, the Congress
enacted the Congressional Budget and Impoundment Control Act
of 1974 (31 U.S.C. 1301) in an attempt to control spending,
set appropriate levels for revenues and expenditures, and
establish national budget priorities. This law also requires
us to (1) develop and recommend to the Congress methods for
evaluating Government programs and (2) help committees develop
statements of legislative objectives and methods for assess-
ing and reporting program performance toward achieving such
objectives.

Information about the impact Federal programs have on
the people they are trying to help is scattered throughout
many Federal, State, local, and private agencies. As a con-
sequence, Federal agencies have not evaluated the combined
effect of the many Federal programs. This report makes such
an evaluation--an evaluation of the impact on older people
of the various services provided to them.

In 1975 we started an evaluation of how Federal programs
and other factors affect people 65 years old and older in
Cleveland, Ohio. This effort, designed to develop analyt-
ical techniques for multiprogram evaluations, resulted in a
report 1/ that described the services designed to help older
people and discussed the type of help they received from
others.

This report shows how the combined impact of these various
services can be defined, measured, and evaluated. It demon-
strates that multiprogram evaluations can (1) define and
measure the current condition of the older people, (2) identify
the current cost of providing specific kinds of help to them,
(3) evaluate the help provided by agencies to all such people
who need help, (4) demonstrate the effects of help on improving
the conditions and problems of older people, and (5) estimate
future costs of helping all such people in need.

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

WHY STUDY OLDER PEOPLE?

The following statement summarizes the problems of older people and how efforts to help them could benefit all of society.

> "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 de-
> sign 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 * * *." 1/

The older population 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 per-cent of the total population).

This increase in the population of older people will magnify the problems they face now. While modern science has enabled a greater number of people to live to 65 and

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1/From an April 1974 speech by Dr. Eric Pfeiffer at Case Western Reserve University. Dr. Pfeiffer is a Professor of Psychiatry at the University of South Florida Medical Center, Tampa, Florida.

beyond, it has not yet found ways to eliminate many of the
problems that accompany the aging process. As people get
older, illness sets in. Illness, along with the "wearing
out" process of aging, can prevent them from getting around
and doing the routine tasks of daily living. This, coupled
with lower income and fewer friends or relatives to help
out, leads to feelings of insecurity, decreased social con-
tacts, and loneliness. Some older people begin to doubt
their self-worth and develop a sense of uselessness and a
negative outlook on life.

To alleviate many of these problems, the Congress has
enacted numerous laws to establish programs providing help to
the growing numbers of older people. These laws and programs
include Social Security, Medicare, public housing for the
elderly, Supplemental Security Income, and the Older Americans
Act, which provides general social services and nutrition
programs. Additional help is provided through families and
friends; State, local, and private efforts; and general Fed-
eral programs, such as Medicaid, food stamps, and general
social services under title XX of the Social Security Act.

Through these laws, the Congress tried to achieve many
objectives related to such conditions as health, security,
loneliness, and outlook on life. In 1965, the Congress in
the Older Americans Act (42 U.S.C. 3001) declared that the
United States has a duty to secure certain benefits of life
for older people. These benefits are related to certain
conditions of life, as shown below.

--Health condition: (1) Retirement in health, honor,
and dignity, (2) the best possible physical and
mental health which science can make available, and
(3) immediate benefit from proven research knowledge,
which can sustain and improve health and happiness.

--Security condition: (1) An adequate retirement
income in accordance with the American standard of
living and (2) suitable housing available at costs
older people can afford.

--Loneliness condition--Efficient community services
that provide social assistance.

--Outlook on life condition: (1) Opportunity for
employment, (2) pursuit of meaningful activity, and
(3) freedom, independence, and the free exercise of
individuals' initiative in planning and managing their
own lives.

3

PURPOSE AND SCOPE OF STUDY

This report is intended to assist the Congress and the executive branch in planning and dealing with various issues affecting older people by demonstrating what can be learned by assessing the well-being of older people and how these people are affected by the many services designed to help them. This report has two themes. The first (ch. 2) is that certain factors can be defined and measured. Namely: (1) personal conditions of older people, (2) services they received, (3) unmet needs for services, and (4) cost of expanding help. The second (ch. 3) is that these measurements can be used in an information system to provide insights into (1) the ways that expanding help to older people in need can affect their conditions and problems and (2) the cost and benefits of providing alternative services.

Cleveland was selected for the study because of the community's willingness to participate. Over 100 agencies provided us with service information on older people. The Cleveland Foundation was particularly helpful to us in arranging for interviews and acting as a catalyst in obtaining the support of local agencies.

We took a sample from over 80,000 older people in the city who were 65 years old and older and who 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 statistics for Cleveland.

In our study, 1,609 people were interviewed for us by Case Western Reserve University personnel from June through November 1975. A year later, 1,311 of these people were reinterviewed.

In interviewing, we used a questionnaire containing 101 questions developed by a multidisciplinary team at the Duke University Center for the Study of Aging and Human Development, in collaboration with the Administration on Aging, the former Social and Rehabilitation Service, and the Health Resources Administration of the Department of Health, Education, and Welfare (HEW). The questionnaire contains questions about an older person's well-being 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 used data available from the questionnaire and provided by various service agencies to design an analytical framework to identify personal conditions, problems affecting those conditions, and help aimed at alleviating the problems.

To identify helps we:

--developed specific definitions of 28 services being provided to older people and a technique 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.

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

We discussed our methodology and our review results with a panel of experts at Duke University, researchers from the Gerontological Society, and academicians at Cleveland State University. During our review, we used consultants in statistics, operations research, and gerontology. We also discussed the contents of this report with officials of the Administration on Aging and the Office of the Secretary of HEW, and their comments were considered in finalizing the report.

CHAPTER 2

OLDER PEOPLE: THEIR CONDITIONS, PROBLEMS,

SERVICES, AND UNMET NEEDS

The personal conditions and problems of older people, the services they receive, and their unmet needs are measurable.

--The personal conditions of older people are measurable and dynamic. Using our measures, about one-third of the older people in our sample were in the best overall condition in 1975. Dynamic: Over the next year, the personal conditions of 18 percent of these people improved and the personal conditions of 18 percent worsened.

--Older people do receive help. In Cleveland, an estimated $6,617 in help is provided to each older person annually. About 70 percent of this amount is provided through Federal, State, and local agencies.

--Older people have unmet needs. Overall, 65 percent of the older people in our sample needed one or more of the kinds of help we measured. Only 8 percent received all the help needed; the other 57 percent needed additional help.

--To expand help to all older people we identified as being in need would cost an estimated $1,601 per older person annually. This would mean a 24-percent increase in the current cost of help for older people.

PERSONAL CONDITIONS

In 1975, we defined and measured selected personal conditions--health, security, loneliness, and outlook on life--of older people in Cleveland. About a third of the sample were in the best overall condition, based on the definitions shown on page 40. At the other end of the spectrum, more than a fifth were in the worst condition, as shown in the following table.

Conditions	Level of conditions			
(note a)	Best	Marginal	Worst	Total
	------------(percent of sample)----------			
Health	51	27	22	100
Security	51	25	24	100
Loneliness	60	28	12	100
Outlook on life	25	50	25	100
Overall	32	47	21	100

a/For a description of conditions and level of conditions, see app. I.

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 illnesses that interfered greatly with a person's activities. One of every three older people in our sample had such illnesses in 1975, as shown in the following table.

Number of illnesses greatly affecting activities	Percent of sample
None	67
1	18
2 or more	15
Total	100

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, for 6 percent; and high blood pressure, for 5 percent.

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

In 1976 (a year after our first interview), we reinterviewed 82 percent of our original sample. The overall personal condition improved for 18 percent and declined for 18 percent. The outlook on life condition and the security condition changed the most. The loneliness and health conditions changed the least. The following table shows the changes that occurred between 1975 and 1976.

Conditions	Change over 1 year (note a)			
	Improved	No change	Worsened	Total
	----------(percent of sample)----------			
Health	13	67	20	100
Security	21	62	17	100
Loneliness	16	68	16	100
Outlook on life	21	59	20	100
Overall	18	64	18	100

a/These data are based on those who survived the year outside an institution. About 5 percent of our 1975 sample died over the year, about 1 percent entered nursing homes, and the other 12 percent either moved out of the Cleveland area or refused to respond to the second interview.

As a result of these changes, in 1976 the personal conditions of the older population who survived the year outside an institution looked like this:

Conditions	Level of conditions			
	Best	Marginal	Worst	Total
	------(percent of sample)------			
Health	48	27	25	100
Security	53	25	22	100
Loneliness	59	29	12	100
Outlook on life	25	51	24	100
Overall	32	47	21	100

As we discuss in chapter 3, the ability to measure change over time is an important tool for measuring the impact of existing and proposed services on older people. In that chapter we relate changes in conditions and problems to services received by older people.

PROBLEMS

The conditions of older people decline over time because of various problems. We measured as many of these problems as possible because it is by treating these problems that service providers try to improve or maintain the personal conditions of older people. Using the data available to us, we were able to define four problems as relating to the health, security, and loneliness conditions. We did not have sufficient data to define other problems that could affect conditions, but believe that more data on other problems could be added when establishing a national information system.

Relative to health, we considered illnesses as a problem that led to older people having trouble doing daily tasks. More than 75 percent of the older people who had no illness greatly affecting their activities had no trouble doing daily tasks, compared to only 37.6 percent of those with one such illness and only 20 percent of those with two or more such illnesses. The following table shows the relationship between illness and trouble with daily tasks.

Problem: Number of Illnesses Greatly Affecting Activities

Condition: ability to do daily tasks	None	1	2 or more
	(percent)		
Can do all 13 without help	75.5	37.6	20.2
Can do all 13 but only with help with 1 or more	19.2	40.9	48.2
Cannot do 1 or more even with help	5.3	21.5	31.6
Total	100.0	100.0	100.0

The two problems we defined as leading to a decline in the security condition were (1) older people's feelings that their money was not sufficient to meet their needs and (2) their concerns that no one would be available to care for them if they became sick or disabled. The following table shows the relationship between one problem—feelings about the adequacy

of money—and the security condition. It shows that 37.6 percent of those older people who felt their money did a poor job of meeting their needs were in the worst security condition, compared to 23.5 percent of those who felt their money met their needs fairly well and only 15.6 percent of those who felt their money met their needs very well.

Security conditions	Problem: money meets needs		
	Very well	Fairly well	Poorly
	(percent)		
Best	65.1	49.3	35.9
Marginal	19.3	27.2	26.5
Worst	15.6	23.5	37.6
Total	100.0	100.0	100.0

There was also a relationship between the other problem—concern that no one would care for the older person—and the security condition. Only 22 percent of those people who felt they had someone to help them indefinitely (or for a short time) were in the worst security condition, compared to 31 percent of those with no help available (or help available only now and then).

The fourth problem we defined was the lack of social contacts that leads to decline in the loneliness condition. Sixty-six percent of the older people who had the highest frequency of social contacts were in the best loneliness condition, compared to only 56 percent of those who had less contact. (For a description of social contact, see app. I.)

SERVICES RECEIVED BY OLDER PEOPLE

There is much concern at all levels of government—Federal, State, and local—for the conditions of older people. Help from the Federal Government comes through numerous programs, many of which fund projects administered at the State and local levels. In addition, State and local governments as well as private agencies fund many projects targeted to meet needs of the elderly.

We could not obtain national estimates of the cost of help provided to older people from all sources. The results of our work are not statistically projectable to the entire

country. However, to illustrate the information that could
be obtained from a national information system about the
extent of such help, we 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, which are made for illustrative pur-
poses only, show that $139 billion in help is provided
annually to the 21 million people in this country who are
65 years old and older and live outside institutions. About
70 percent of this amount is provided through Federal,
State, local, and private agencies. Most of this amount is
federally funded.

As discussed previously, the 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 de-
creasing 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 per-
form activities that older people cannot do for themselves,
as shown on the following page.

Many such problems and inabilities afflict older people,
and more than one kind of help may be appropriate for each
problem. Further, persons commonly have many problems that
must be addressed simultaneously. To illustrate, the diagram
on page 13 depicts the whole person--conditions, related prob-
lems, and kinds of help being provided. It shows that we
defined six kinds of help that older people could receive:

1. Treatment for illnesses.

2. Compensatory help to compensate for an inability to
   do daily tasks (e.g., meal preparation, homemaker,
   etc.).

3. Financial help for money problems.

4. Social-recreational help for persons with little or
   no social contact.

5. Caregiving help when the person feels there is no
   one to provide care if he or she becomes sick or
   disabled.

11

Relevant Compensatory Help

Activities of daily living	Supportive devices	Checking	Continuous supervision	Personal care	Nursing care	Administrative/legal	Meal preparation	Homemaker	Escort	Transportation	Shopping-food and groceries
Use the telephone		X	X	X	X						
Get to places out of walking distance									X	X	
Go shopping for groceries or clothes									X		X
Prepare meals							X				
Do housework								X			
Take medicine		X	X	X	X						
Handle money						X					
Eat				X	X						
Dress and undress				X	X						
Take care of appearance (shave, comb)				X	X						
Walk	X			X	X						
Get in and out of bed	X			X	X						
Take a bath or shower	X			X	X						

12

CAREGIVING HELP
NO CAREGIVER

LITTLE SOCIAL CONTACT
SOCIAL – RECREATIONAL

FINANCIAL HELP
MONEY PROBLEMS

SECURITY

LONELINESS

TREATMENT
ILLNESSES

HEALTH

COMPENSATORY HELP
CAN'T DO DAILY TASKS

OUTLOOK ON LIFE

NO INTEREST IN LIFE
DEVELOPMENTAL HELP
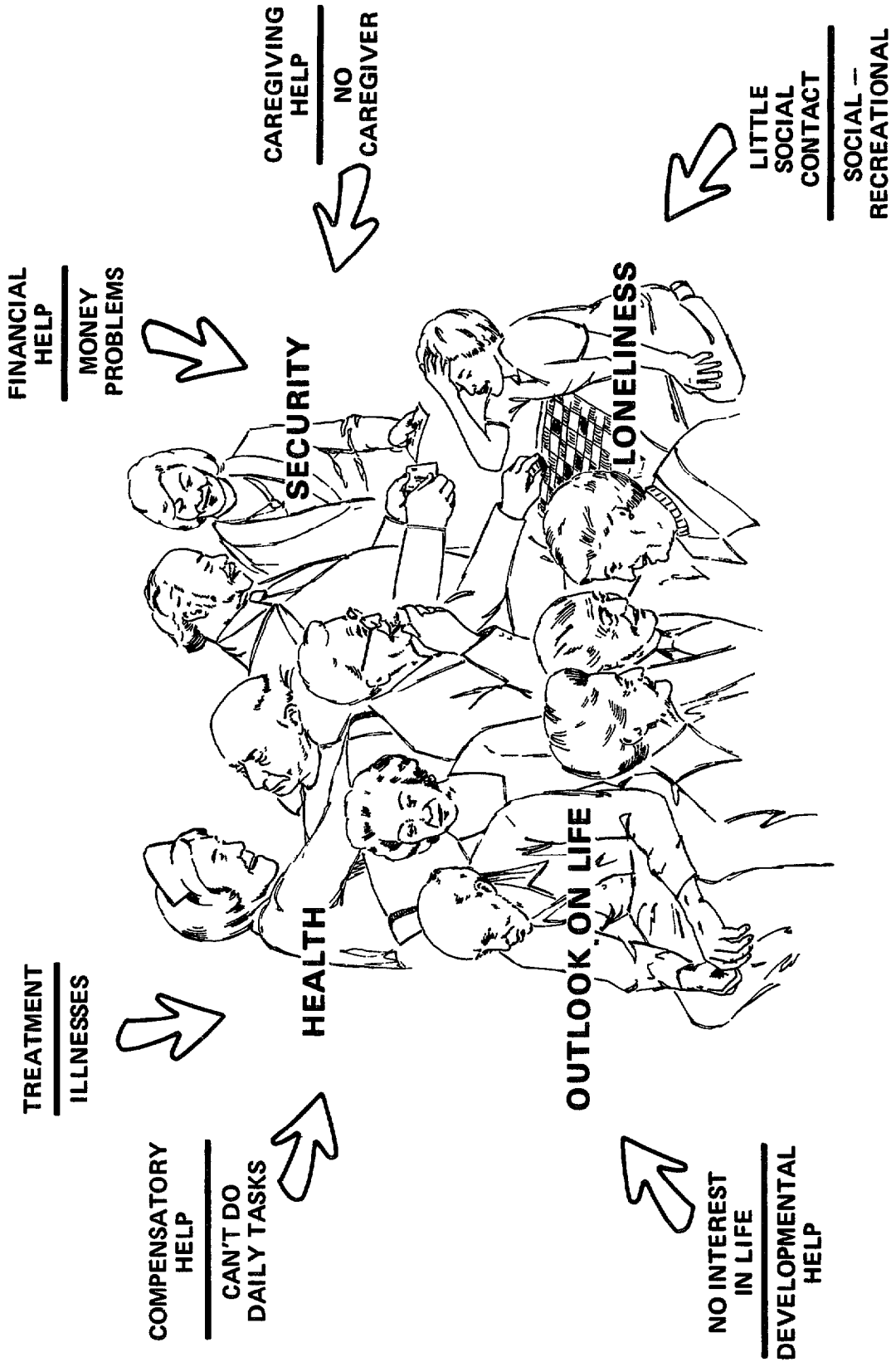
6. _Developmental help_ (e.g., educational and employment services) for people with few interests, which can lead to a negative outlook on life.

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, as shown in the following table.

Average Cost of Help for Each Older Person in Cleveland

Kind of help	From family and friends	From agencies	Total Amount	Total Percent	Our projected national estimate (note a) (billions)
Medical treatment	$ 6	$ 954	$ 960	14.51	$ 20.2
Compensatory	1,821	578	2,399	36.26	50.4
Financial	172	2,946	3,118	47.12	65.5
Social-recreational (note b)	-	134	134	2.03	2.8
Caregiving	2	3	5	.07	.1
Developmental (note b)	-	1	1	.01	.02
Total	$2,001	$4,616	$6,617	100.00	$139.02
Percent	30	70	100		

a/Includes the cost of help paid directly to the agency by family and friends or by the older person. See page 10 for a description of how we made our projections.

b/As defined in our review, such help can be provided only by agencies.

As shown, the greatest portion (47 percent) of help is financial, followed by compensatory help with daily tasks (36 percent) and medical help (15 percent). The three other kinds of help account for only small percentages of the total.

Comparing sources of help, the families and friends of older people provide 76 percent ($1,821 of $2,399) of the compensatory help but only about 6 percent of the financial

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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).

UNMET NEEDS

We defined unmet need for help by matching a specific problem with a specific help, using the data available to us. For example, we determined if people who had arthritis were receiving arthritis medication, if those who couldn't prepare their own meals were having their meals prepared for them, or if those who had little social contact were receiving social-recreational help. In defining unmet needs for medical treatment, we considered 28 different illnesses. For compensatory help, we considered 13 different daily tasks as shown on page 12.

As shown in the following table, the kinds of help that were reaching the lowest proportion of those in need were financial, social-recreational, and developmental help. Overall, 65 percent of our sample needed some kind of help--only 8 percent received all the help needed and 57 percent needed additional help. In contrast, compensatory help was reaching the highest proportion of those in need. As mentioned earlier, this kind of help is primarily (76 percent) furnished by family and friends.

Kind of help	Definition of need	Percent of sample not in need	Percent of sample		
			In need	Receiving all the help needed	Not receiving all the help needed
Medical treatment	Have illness that interferes a great deal with activities	67	33	14	19
Compensatory	Cannot do daily task without help	60	40	24	16
Financial	Inadequacy in amount of money	84	16	-	16
Social-recreational	Infrequent social contacts	82	18	3	15
Caregiving	No one available to help if become sick or disabled or help available only now and then	87	13	4	9
Developmental	Negative outlook on life	76	24	2	22
Overall	One or more of the above	35	65	8	57

The most common illnesses not being treated were mental impairment, arthritis, and circulation trouble. Based on their questionnaire responses, 7 percent of the sample had mental impairments and were not receiving mental health services, 6 percent were not receiving treatment for arthritis that interfered a great deal with their activities, and 5 percent were not receiving treatment for circulation trouble. The most unmet needs for compensatory help were meal preparation, homemaker services, and administrative and legal help. Two percent of our sample could not prepare meals without help and were not receiving meal preparation services. These people were either improperly preparing meals or periodically not eating balanced meals. Nine percent of the sample could not do housework without help and were not receiving homemaker services, and 2 percent could not handle their money matters and were not receiving administrative and legal services.

In estimating need for financial help, we defined only those who indicated their money met their needs <u>poorly</u>. As shown in the table on the previous page, 16 percent of our sample in 1976 were in this category. We based our estimates of the level of financial help needed to improve feelings about the adequacy of their income on the total income of older people who felt their money met their needs fairly well in 1976. On this basis, (1) the average married older couple who needs more financial help would receive another $1,975 a year, bringing their average income up to $7,036, and (2) the average unmarried older person would receive another $980 a year, bringing his or her average income up to $4,057. The table below shows those average incomes.

| | Average income of people whose money meets needs | | Difference (additional help needed) |
	Fairly well	Poorly	
Total sample	$5,197	$3,739	$1,458
Not married	4,057	3,077	980
Married	7,036	5,061	1,975

Variations in the need for additional financial help were due to differences in <u>personal</u> incomes and not to financial help received from the Federal Government and others. Those whose money met their needs poorly were receiving about the same amount of financial help as the fairly well group; however, they had an average $1,397 per year less personal income.

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The overall conditions of older people need to be assessed. Otherwise, some of these conditions are responded to and others are not. Few social service agencies in Cleveland (only 13 percent) conducted overall evaluations to assess the multiple needs of older people. However, more than one in every four older people (27 percent) in our sample were defined as needing more than one kind of help. Without overall evaluations, older people would more than likely not receive all the help they need from any one agency.

We were not able to determine why older people with unmet needs did not get help. It might be because they are reluctant to accept help from others or it might be because no family members are available to help or no social service agencies are nearby. It might also be because older people do not recognize the value and potential benefits of help. Further research is needed to determine why older people do not receive or accept the help they need.

COST OF EXPANDED HELP

We estimate that expanding the six kinds of help to all older people we defined as being in need would initially cost about $34 billion a year. However, in the long run, these annual costs would be reduced considerably due to earlier improvement in conditions of older people who would require less help in the future. (See ch. 3.) These national projections are based on our Cleveland sample, which is not statistically projectable to the entire country; they are presented solely to demonstrate the usefulness of a national information system.

Expansion of all six kinds of help to those we defined as in need would increase total costs by 24 percent. More than half ($19.5 billion) of the additional cost would be for financial help, and nearly a third ($10.5 billion) would be needed for compensatory 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 inflation or to the predicted future increase in the older population.

	Average cost per person without expand- ing help	Additional cost to expand help		
Kind of help		Average per person	National total estimate	Percent of total addi- tional cost
		(millions)		
Medical treatment	$ 960	$ 109	$ 2,289	6.8
Compensatory	2,399	498	10,458	31.1
Financial	3,118	a/930	19,530	58.1
Social- recrea- tional	134	56	1,176	3.5
Caregiving	5	2	42	.1
Develop- mental	1	6	126	.4
Total	$6,617	$1,601	$33,621	100.0

a/As shown on page 16, we identified those people in our
   sample who felt their money met their needs poorly as
   needing more financial help and suggested increasing
   their incomes to a minimum $4,057 for individuals and
   $7,036 for married couples. However, administering such
   an increase would require increasing the income of all
   older people to those minimums, not just those who felt
   their money met their needs poorly. Thus, the additional
   cost to expand help is based on our estimates of the cost
   to raise the income of all older people in our sample
   to those minimums.

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 a 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, based
on our Cleveland data which are not statistically projectable
to the Nation, that $8 billion less public money would be
required to expand help if family and friends could provide
this additional help. Further research is needed to deter-
mine ways to encourage family and friends to provide such
help.

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Also, the total cost of expanding help would be reduced considerably if the minimum income levels used to expand financial help were set lower. If minimum income levels were set at $3,000 for individuals and $5,000 for married couples, the total cost to expand help would be reduced by about $11 billion nationally. However, the effects of expanded help would also be nearly cut in half.

CHAPTER 3

NATIONAL INFORMATION SYSTEM:

POTENTIAL FOR DETERMINING EFFECTS

AND LONG-RUN COSTS OF SERVICES

Ultimately, the objectives set out in the Older Americans Act of 1965 relate to alleviating the conditions and problems of older people. Thus, an important question is "If help is expanded, how many older people would benefit?" That is, how many would experience improvement in their personal conditions and alleviation of their problems? An additional consideration is "How much will it cost in the long run?" The answers to these questions can be obtained using evaluation and analytical techniques similar to those we used in Cleveland.

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

To ensure that analytical framework and methodology were sound, we discussed our methodology with numerous experts in the fields of mathematics, systems analysis, operations research, and gerontology. We conducted several seminars and a national symposium with researchers, methodologists, statisticians, and HEW officials in the field of aging. Our own consultants in the areas of statistics, operations research, and gerontology reviewed our methodology in minute detail. The consensus of all involved was that our framework and methodology were sound. In addition, at the request of the Administration on Aging, we plan to give it details of our methodology and our data base for distribution to researchers, planners, and administrators in the field of aging.

EFFECTS OF EXPANDED HELP

Before describing our findings, we believe it is important to mention the limitations of the methods we used to establish the effects of help. Because our model was designed

to estimate the effects of help provided in an operational environment, it involved statistical analysis of data collected in uncontrolled circumstances. Also, our data base lends itself more to measurement of the effects of some kinds of help than to others, and our estimate of effects is based on changes observed in a limited sample of older people in Cleveland, over only a 1-year period. The analysis was limited by the data available to us and, as a result, has a heavy emphasis on health conditions and problems.

However, we believe our methods demonstrate that the effects of help on older people can be measured and represent a major step toward providing information on the effects of help on older people. These methods should be developed further in the future on larger data bases with more information, placing particular emphasis on gathering more data and developing a better understanding of the security, loneliness, and outlook on life conditions; the problems that affect these conditions; and the helps that affect those problems.

To estimate the effects of expanded help, we compared how different subgroups changed over the year. Basically we compared those who were receiving all the help they need in our second year with those who were not receiving all they needed in that year. (For our definition of need, see p. 15.) We then controlled for the help received initially by dividing these two groups based on whether they were receiving all the help they needed in the first year. Thus, we had four comparison groups as shown below:

1976

1975	Receiving all needed help	Not receiving all needed help
Receiving all needed help	GROUP A	GROUP B
Not receiving all needed help	GROUP C	GROUP D

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We then compared how the problem situations of group A changed to how group B changed. Similarly we compared how groups C and D changed.

To illustrate, at the health level, 175 people were in comparison group A (all their illnesses 1/ were being treated in both 1975 and 1976), 179 people were in group B, 132 people were in group C, and 123 were in group D. 2/ When comparing how the illness situation of these groups changed over the year, we found that those who were receiving all the medical help needed in the second year (groups A and C) fared much better over the year than those who were not (groups B and D). The following table shows those comparisons. It shows that only 45.7 percent of group A worsened over the year, compared to 77.7 percent of group B. Similarly, only 3.8 percent of group C worsened, compared to 18.7 percent of group D:

Change in illness situation
over 1 year (note a)

| | Group | | | |
	A	B	C	D
	——————(percent)——————			
Improved	28.0	1.1	73.5	8.9
No change	26.3	21.2	22.7	72.4
Worsened	45.7	77.7	3.8	18.7
Total	100.0	100.0	100.0	100.0

a/Statistically significant differences at 99-percent confidence level.

1/In this chapter we use the term "illness" to mean an illness that interfered a great deal with the older person's activities.

2/The analysis did not include the 702 people who had no illnesses in 1975 and 1976. Also, some older people changed their need for treatment because they lost an illness and thus no longer needed the help. Others changed because they had a need (an illness) and began receiving the help (treatment) over the year. In placing people in groups we considered either possibility as an improvement in the person's treatment situation. This procedure tends to increase our estimates of the effects of help. We performed an alternative procedure, which tends to decrease the estimates, and arrived at results that were closed to those of the procedure used.

Then, to determine the number of people who would be affected by expanding help to all older people in our sample, we applied the change rates for those who received all the help they needed in the second year to those who did not, but would if help were expanded. We applied the change rates for group A to group B and then applied the rates for group C to group D (controlling for their problem situation in 1975). 1/

On this basis, we estimated that 120 of the people who would receive expanded help would have been in a better situation if they had been treated for all their illnesses. These 120 people represent 9.2 percent of the total sample. The following table shows our estimates for expanded medical treatment.

| Category | Number of people in sample | | | Estimate of people in a better illness situation | |
	1976 status without change in help	1976 status with change in help	Differences	Number of people	Percent of sample
Best	817	906	+89	120	9.2
Marginal	256	287	+31		
Worst	238	118	-120		
	1,311	1,311	-		

Finally, we applied the same analytical techniques to the remaining security, loneliness, and outlook on life conditions and problems as we had defined them. We then estimated the number of people nationwide who would have been in a better situation in 1976 if the help needed had been expanded to all in need.

1/We did not control for other factors—such as age, sex, or race—which might have an effect on the change in their problems between 1975 and 1976. To the extent that such factors affect the change rate, our estimates of the number of older people benefiting from expanding help could be overstated or understated.

A sizable portion of the older people would benefit from expanded help. The greatest benefit would be realized in their illness situation--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 greatest 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.

The table on the following page shows our projections, based on our Cleveland sample, of the number of older people nationwide who would have been in a better situation in 1976 if the help needed had been expanded to and received by all those in need. (For details, see app. II.)

In presenting our national projections on this basis, we are not recommending that help be expanded but rather estimating the potential effects of such expansion. HEW should evaluate alternative policies to determine their potential effects on the older population.

Previously, we have discussed the effects of expanding help for 1 year. 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 than if they had not received expanded help. Fourteen percent more would be experiencing a better situation in 1985, 14 percent more in 1990, and 12 percent more in 1995. The table on page 26 shows our projections of the potential effects over the next 20 years for the 65 to 69 age group if help were expanded. (For national projections, see app. III.)

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Estimated Effect Over 1 Year of Changes in Help

Condition or problem (note a)	Kind of help	Effect of increased help	Percent of sample benefiting	Our national estimate of people benefiting (notes b and c)
				(000 omitted)
Health problem	Medical treatment	Better illness situation	9 2	1,923
Health condition	Medical treatment	Better ability to perform activities of daily living	6	129
Security condition	Medical treatment	Better security condition	7	137
Security problem	Financial	Better feeling about adequacy of money (notes d and e)	5 6	1,169
Loneliness problem	Social-recreational	More social contact	3.3	693
Outlook on life condition	Developmental	Better outlook on life	4.9	1,035

a/For a definition of conditions and problems, see appendix I

b/People may be included in more than one category

c/These estimates were made for illustrative purposes only and are point estimates. We did not set confidence limits around these esitmates because to do so would require making too many assumptions which could not be tested about the complex interdependent distributions of the variables involved

d/The estimate for financial help was calculated by comparing (1) the change in feelings about adequacy of money experienced by those people whose income rose above, or fell below, a set income level (see p. 16) and (2) the changes in feelings experienced by those people whose income did not rise above or fall below that income level Those who rose above the set level increased their income by an average of $4,562 Tnose who fell below decreased theirs by an average of $3,037

e/Because our data were based on relating changes in income to changes in the feelings about adequacy of money over only 1 year, some changes in income may be only temporary (e g , proceeds from life insurance policy) which may not have as much of an effect on feelings about money as permanent changes. As a result, our estimates may understate the effects of permanent changes in income on feelings about money

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Condition or problem	Kind of help	Effect of expanded help	Average percent of 65 to 69 age group in a better condition (note a)			
			In 5th year	In 10th year	In 15th year	In 20th year
Health problem	Medical treatment	Better illness situation	11	14	14	12
Security problem	Financial help	Better feeling about adequacy of money	11	12	14	15
Loneliness problem	Social-recreational	More social contact	2	4	3	3
Outlook on life condition	Develop-mental	Better outlook on life	4	4	5	4

a/These estimates were made using a Markoff change process
  which applies the same rate of change that was observed
  in the first year (between 1975 and 1976) for the 65-69
  age group over the next 19 years, thus arriving at a
  20-year estimate. This process was applied twice--
  first using the observed rates of change between 1975
  and 1976 and then using the rates of change based on
  our estimates of the effects of expanded help. The
  results of the two applications were then compared to
  arrive at the estimates shown in the table.

    We were not able to estimate the effects of increases
in all kinds of help. In some cases, this was because the
help was not designed to improve a person's condition, but
rather to compensate for an already deteriorated condition.
In others, it may have been because the help was not effec-
tive in improving or maintaining an older person's condition.
If similar data are collected on a larger national sample in
the future, progress could be made in estimating the effects
of increases in all kinds of help.

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LONG-RUN COSTS

Our projected first-year costs to provide expanded help would be reduced considerably in the long run because expanded help leads to better conditions and less need for future help. Our projections 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 decrease slightly. Also, the cost of compensatory help would be reduced significantly because of the effects of expanded medical treatment.

The following table shows our national projections of the decrease in the average annual medical and compensatory costs that could be achieved from expanded medical treatment--for those in the 65 to 69 age group in 1975--over the next 20 years. It shows a total reduction of about $1.4 billion--$1.2 billion in compensatory help and $0.2 billion in medical treatment--due to preventive medical treatment earlier in life. (These data are based on our Cleveland estimates that are not statistically projectable to the Nation and are presented here for illustrative purposes only.)

Estimated Annual Costs Nationwide of 65 to 69 Age Group Over 20 Years

	Cost of medical help	Cost of expanded compensatory help	Cost of medical and compensatory help
With no change in medical treatment (billions)	$4.5	$12.6	$17.1
With expanded medical treatment (billions)	4.3	11.4	15.7
Decreases due to expanded medical treatment (billions)	$ .2	$1.2	$ 1.4
Percent decrease	4.4	9.5	8.2

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If the same cost reduction holds true for the population presently 65 years old and older, during the next 20 years the national total cost of help after expansion would be reduced by $9 billion. This would mean that total cost to expand help would be reduced from about $34 billion (see p. 18) to $25 billion a year.

ALTERNATIVE KINDS OF HELP

The Congress needs alternatives to choose from. A national information system could estimate what percentage of older people receiving various kinds of help are benefiting. Estimates could also be made of the cost/benefit ratios for these 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, whereas only 1 of every 4.5 who receive expanded developmental help would have a better outlook on life, as shown in the following table:

	National projection of number of older people that (note a)		
	(col. 1) Receive expanded help	(col. 2) Benefit from expanded help	(col. 1 ÷ col. 2) Receive expanded help to one person benefiting
Kind of help			
	(000 omitted)		
Medical treatment	3,990	1,922	2.1
Social- recreational	3,150	693	4.5
Developmental	4,620	1,035	4.5

a/We did not make a comparable analysis for financial help because our methodology was not sufficiently sensitive to identify the effects of changed financial help on the feelings about the adequacy of money for a portion of those older people who would receive expanded financial help.

A cost to have one person benefit can be derived from this comparison of older people benefiting from help to those receiving help. The average cost per person receiving help is $574 for medical treatment and $27 for developmental help. For one person to be in a better illness situation because of expanded medical help, however, about two people have to

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receive this help--a cost of $1,191 per person benefiting.
For 1 person to show improvement in his or her outlook on
life, about 4.5 people have to receive more developmental
help--a cost of $122 per person benefiting. The following
table shows the cost per person benefiting from expanding
different kinds of help:

Kind of help	Effect of help	Number of people receiving expanded help to one person benefiting	Average cost per person receiving expanded help	Total cost per person benefiting
Medical treatment	Better illness situation	2.1	$574	$1,191
Social-recreational	More social contact	4.5	373	1,697
Developmental	Better outlook on life	4.5	27	122

    The above analysis should not be used as the sole means
for comparing alternative kinds of help. Our analysis did
not take into account the relative value of better health
compared to less loneliness, or a better outlook on life.

    Also, our analysis was designed to identify large changes
in conditions and problems over 1 year; different analyses
would have to be used to detect smaller changes or those that
take more than 1 year. If similar data were collected on a
larger sample over a longer time, smaller changes or changes
that take more than 1 year could be detected.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND

AGENCY COMMENTS AND OUR EVALUATION

CONCLUSIONS

To design and plan for the delivery of services to older persons, information about their well-being and the factors that make a difference in their lives is needed by society, the Congress, and the executive branch. We believe that it is now possible to develop a national information system on older people.

We have demonstrated that:

--The conditions of older people as we defined them do change, they can be improved, and they are measurable. Such measurements are important in an information system.

--Help provided by family and friends and Federal, State, local, and private agencies is significant. The ability to measure the impact of these sources of help is another important element of an information system.

--Problems that lead to the decline of older people's personal conditions can be identified and measured. More needs to be done to further identify other problems that lead to decline in personal conditions.

--The unmet needs of older people for the kinds of help we used can be determined. Overall, 65 percent of the older people in our sample needed some kind of help. Only 8 percent received all the help needed, while 57 percent needed additional help. Few social services agencies assess the multiple needs of older people; consequently, some needs are not responded to. In other instances, we were not able to determine why their needs were unmet. Research should be done in these areas. Showing what portion of our society is not helped by services is an important part of an information system.

--Many older people would benefit from expanded help. We estimate, based on our Cleveland sample, that about 9.2 percent of the older people in our sample would have been in a better situation in 1976 if they had

been treated for all their illnesses between 1975 and 1976. Being able to project from an information system what portion of society would benefit from expanded help would aid considerably in formulating and reviewing proposed legislation.

--Analytical techniques will enable projections to be made of the costs of expanded help to older people over a number of years. Based on the Cleveland sample, we estimated the first year costs of expanding help to all older people and showed that, in the long run, these costs could be reduced due to earlier improvements in conditions of older people who would require less future help. If family and friends could be encouraged to provide more help, even less public money would be required. Research is needed to determine ways to encourage family and friends to provide such help. Better decisions can be made if costs of services can be projected. An information system should have this potential.

--Methods for estimating the number of older people who must receive expanded help to have one person benefit have been developed and shown to yield some interesting results. Only 1 in 4 older persons in our Cleveland sample would benefit from social-recreational help, compared to 1 in 2 who would benefit from medical help. The Congress needs this type of analysis so that it has alternatives to choose from in making legislative decisions. An information system should contain data to provide insights into these alternatives.

This report is about older people--their conditions, changes in those conditions, and the differences help can make in their lives. We were able to measure and project what happens to them. To design and plan for the delivery of services to older people, information similar to that developed in this report is needed. A national information system is the best way to provide such information.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Office of Human Development Services to establish a comprehensive national information system with characteristics similar to those discussed in this report. Information collected for this system should be available to the Congress for analyses. The system should be expanded over time to include that information necessary to study (1) why older people do not receive the help they need and (2) how family and friends can be encouraged to provide such help.

Information system
implementation considerations

This information system should be able to assess the many aspects of an older person's well-being. The Duke University instrument was used in our methodology. However, we expect that, over time, a more refined instrument would evolve that would include additional data elements in the dimensions of security and outlook on life and the many problems that affect these and other dimensions. It should gather data:

--On the many factors that could affect a person's well-being, including the kinds and related cost of services by public agencies and families and friends.

--At specified points in time (at least every 5 years) to allow analysis of change.

--On a national sample of older people stratified on a basis that would permit estimates to be used for planning by State and area agencies on aging.

The cost of this information system would vary depending on its structure. Such factors as how large the national sample is, how the sample is stratified to include various subgroups (urban and rural people, for example), and how frequently the data are collected would determine the costs of the system.

The Bureau of the Census gave us insights into how much a national system might cost. A recent study of Medicare involved interviews with a national sample of 15,000 people. The Bureau's average cost per person sampled, based on a number of studies similar to ours, is $50. Thus, use of a similar sample size for a national information system would cost about $750,000. This cost does not include the costs of analyzing the data or gathering data from agencies on the services provided to older people and the related costs on a selected basis. However, the cost of a national information system would be relatively small compared to the benefits that can be derived from better planning and resource allocation of billions of dollars of help for older people.

AGENCY COMMENTS AND OUR EVALUATION

In a May 18, 1979, letter (see app. VII.), HEW said that the research done for this report has made a major contribution to the understanding of the problems of older people and the impact of various types of help that they

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receive. HEW hoped that the report would receive wide distri-
bution. However, HEW preferred not to implement the recom-
mendation to establish a comprehensive national information
system. HEW raised certain issues which warrant further em-
phasis and discussion.

HEW data bases and
information mechanisms

     HEW commented that our report (1) overlooks considerable
bodies of data and analysis that are available, currently
being collected, or being planned for and (2) omits any dis-
cussion of alternative information-gathering mechanisms
for collecting such data.

     During the feasibility phase of our study (see app. I),
we researched existing bibliographies on studies and data
bases in the field of aging to determine if any of them could
meet our needs. The data bases and mechanisms cited by
HEW were among those we considered. Further, we had exten-
sive discussions with officials of the Bureau of the Census
and HEW agencies, researchers, academicians, and service
providers on existing models or methodologies that we might
use. None had all the essential elements needed for our
study; namely,

     --a functional measure of the whole person;

     --the capability of discerning change over time in the
       functional well-being of a person;

     --the ability to define, quantify, and match services
       to specific people; and

     --the technical methodology to develop transition
       matrices and predict future outcomes.

Although some segments of what we needed were available
piecemeal throughout some studies and mechanisms, methods
were not available to modify or pull together these segments
so that they could be useful to us. Also, the existing HEW
data bases and mechanisms lack a crucial element--the process
of change in the life conditions and well-being of older
people. This change process is a major component of our
methodology.

Further, HEW in its comments did not indicate that it had a plan to integrate its data bases and mechanisms into a model for a national information system similar to ours. Without such a plan, these studies, data bases, and mechanisms remain segmented and serve different purposes.

The thrust of HEW's comments is that it would prefer to wait until its studies, data bases, and mechanisms are more advanced. We believe that the capability to report on the conditions, problems, and help available to older people, and the differences such help can make, exists as demonstrated in this report. We believe HEW should wait no longer, but should begin building a national information system. It can begin by building on our methodology and experiences. Further, by modifying and using its existing mechanisms and data bases wherever possible, HEW can enhance our model and develop it into a national information system. Our experience has shown the best way to enhance a methodology is through widespread use with provision for refinement. Only by moving in this direction can HEW meaningfully respond to its own planning and policymaking needs as well as those of the Congress. We believe HEW should begin, not wait.

Cost of a national information system

HEW commented that the report understates the cost of a national information system. As the report indicates, our estimate is only a benchmark on the cost of interviews. Our estimate does not include the total costs of analyzing the data and obtaining it from agencies on the services provided to older people and the related costs. We did not estimate all of these costs because they depend on the level of analysis performed and the specific techniques used in obtaining and handling the data. However, we believe these costs would be minimized because we have already developed the methods for quantifying services and computerizing the analytical techniques. At any rate, the total cost would be relatively small compared to the benefits derived from better planning and resource allocation of billions of dollars of help for older people.

What is the alternative to a national information system? Each planning area would perform its own functional assessment of the well-being of older people. Considering the number of planning areas, including States, counties, cities, and towns—or over 560 area agencies on aging—we believe that the total costs of these assessments would far exceed the cost of a national system. Also, if each planning area uses a different assessment technique, the results would not be comparable. Such assessments could not be used for national policymaking and planning.

HEW can benefit from our experience, thereby minimizing costs in implementing a national information system. Over time HEW could gradually refine our model, concepts, and techniques, and incorporate existing HEW data collection systems for services into the national system. This gradual evolution, we believe, would not be prohibitively costly and would be cost effective.

Recognizing the cost effectiveness of using an existing methodology and an available data base, the Administration on Aging has requested our technical assistance and our data base. We have agreed to provide technical assistance in understanding and using our model, concepts, and techniques, and we will also transfer our data base.

Interview instrument

HEW commented that our interview instrument emphasizes mental and physical health facts more than other dimensions of a person's well-being. After extensive discussions with Administration on Aging officials, researchers, academicians, and service providers, we determined that this interview instrument was the most comprehensive available at the time of our study. Its uniqueness lies in its ability to gather data on the whole person--a prerequisite for our study.

HEW also recognized the need to define as much of the whole person as possible. Three HEW agencies jointly funded the research to develop this multidimensional interview instrument. (See p. 4.) We have used this valuable research in our study. Other instruments with similar characteristics may be under development or may evolve in the future. As these instruments are developed, we expect that HEW would incorporate their features in the longitudinal national information system. Just as we built on HEW-funded research, so too could HEW build on our methodology.

Sample size

HEW commented that the choices in targeting resources for services for older people are largely made at the State and sub-State levels. To provide data on older people at this level, HEW believed a prohibitively expensive large sample would be required.

We disagree. Statistical techniques are available that can provide samples at these levels at a reasonable cost. We have discussed with Administration on Aging officials

one method of accomplishing this sample. For example, a
stratified sample of area agencies on aging planning areas
could be taken, being careful to include urban and rural
areas, various racial groups, and different age groups. From
this sample, homogeneous areas could be determined. These
results could then be extrapolated by statistical methods to
areas not within the sample. The extrapolated data could
then be used to make decisions at the State and sub-State
levels. The data could also be used to adjust the formula
used to distribute funds to the States to more closely re-
flect each State's actual needs. The Bureau of the Census
could be quite helpful to HEW in developing this sampling
plan.

METHODOLOGY

Our overall approach involved the following steps:

1. Assessing the separate aspects of well-being of a sample of older people.

2. Gathering information on the many factors that could affect a person's well-being, including the kinds of help received from public agencies and family and friends.

3. Relating this information to individuals in the sample.

4. Repeating steps 1 through 3 to identify changes in a 1-year period and factors that may have influenced the change.

In reviewing other evaluations of major programs helping older people, we found none as comprehensive as we desired. Some included partial measures of well-being, some gathered information over time, and some included information on services provided. However, none of the evaluation methodologies involved gathering information on services provided by many sources, including all programs and the family and friends. Accordingly, we had to create our own data base to do this.

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 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.

1/See footnote, page 1.

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.

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.

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CONDITIONS

Level of condition	Health			Security	Loneliness	Outlook on life	Overall personal condition
	Illness	Ability to do daily tasks (note a)	Overall (note b)				
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 in our prior report on pages 57 to 59 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

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.

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:

--"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 infor-
mation combined to establish a loneliness problem variable
called social contacts.

How often a week talks on telephone	How often a week visits with someone			
	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
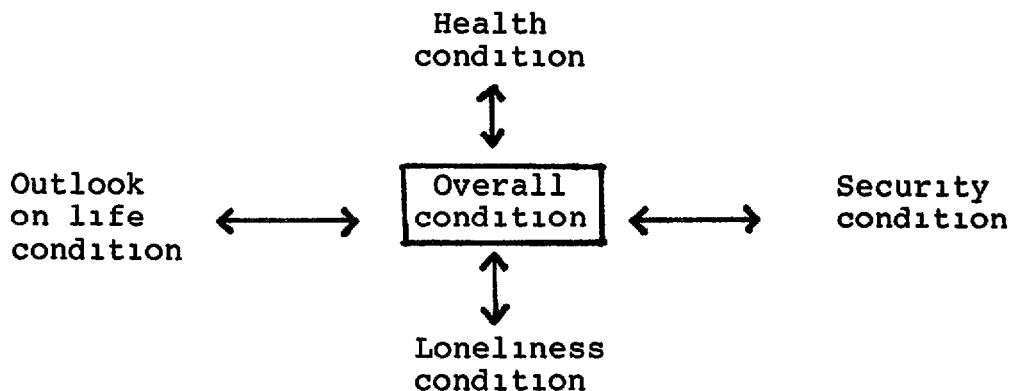condition.

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.

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

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.

RELEASE OF OUR DATA BASE

Because of the uniqueness and usefulness of the data
base, HEW officials have asked that it be made available to
researchers, planners, and academicians. We agreed to place
this data base in the HEW archives in mid-1979. The privacy
of individuals involved in our study will be protected because
information in the data base cannot be associated with the
identity of the individuals to whom it pertains. Along with
the tapes of the data base, we will also provide a documenta-
tion package for using the tapes and a detailed explanation
of our methodology.

PROJECTIONS OF THE NUMBER OF OLDER PEOPLE NATIONWIDE

WHO WOULD HAVE BEEN IN A BETTER SITUATION IN 1976

IF HELP HAD BEEN EXPANDED

Category	Kind of help changed	Number of people			Estimate of people in a better condition	
		1976 status without change in help	1976 status with change in help	Difference	Number of people	Percent of population
Illness situation	Medical					
Best		13,087,000	14,513,000	+1,426,000	1,923,000	9 2
Marginal		4,100,000	4,597,000	+497,000		
Worst		3,813,000	1,890,000	-1,923,000		
		21,000,000	21,000,000	-		
Ability to do daily tasks	Medical					
Best		12,366,000	12,495,000	+129,000	129,000	6
Marginal		5,558,000	5,510,000	-48,000		
Worst		3,076,000	2,995,000	-81,000		
		21,000,000	21,000,000	-		
Security	Medical					
Best		11,167,000	11,218,000	+51,000	137,000	.7
Marginal		5,181,000	5,267,000	+86,000		
Worst		4,652,000	4,515,000	-137,000		
		21,000,000	21,000,000	-		
Feelings about money	Financial					
Meets needs very well		4,831,000	6,000,000	+1,169,000	1,169,000	5 6
Meets needs fairly well		12,022,000	11,735,000	-287,000		
Meets needs poorly		4,147,000	3,265,000	-882,000		
		21,000,000	21,000,000	-		
Social contacts	Social- recrea- tional					
High		9,516,000	9,808,000	+292,000	693,000	3 3
Medium		8,312,000	8,713,000	+401,000		
Low		3,172,000	2,479,000	-693,000		
		21,000,000	21,000,000	-		
Outlook on life	Develop- mental					
Best		5,212,000	5,384,000	+172,000	1,035,000	4 9
Marginal		10,653,000	11,516,000	+863,000		
Worst		5,135,000	4,100,000	-1,035,000		
		21,000,000	21,000,000	-		

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PROJECTED EFFECT OF INCREASED TREATMENT OF ILLNESSES

OVER 20 YEARS FOR PEOPLE 65 TO 69 YEARS OLD NATIONWIDE

Year projected	Illnesses	Number with no changes in treatment	Number with increased treatment	Difference due to increased treatment	Older people in better condition	
					Number	Percent
1975	Not ill	5,787,000	-	-	-	-
	One illness	1,462,000	-	-		
	Two+ illnesses	751,000	-	-		
	Nursing home or deceased	-	-	-		
	Total	8,000,000	-	-		
1980	Not ill	4,467,000	5,157,000	690,000	690,000	10 6
	One illness	1,157,000	1,036,000	a/(122,000)		
	Two+ illnesses	772,000	305,000	(467,000)		
	Nursing home or deceased	1,604,000	1,502,000	a/(101,000)		
	Total	8,000,000	8,000,000	-		
1985	Not ill	3,695,000	4,487,000	792,000	792,000	14 0
	One illness	934,000	914,000	(20,000)		
	Two+ illnesses	650,000	244,000	(406,000)		
	Nursing home or deceased	2,721,000	2,355,000	(366,000)		
	Total	8,000,000	8,000,000	-		
1990	Not ill	2,497,000	3,046,000	a/548,000	548,000	14 1
	One illness	711,000	629,000	a/(81,000)		
	Two+ illnesses	487,000	203,000	(284,000)		
	Nursing home or deceased	4,305,000	4,122,000	(183,000)		
	Total	8,000,000	8,000,000	-		
1995	Not ill	1,441,000	1,706,000	a/264,000	264,000	12 1
	One illness	386,000	345,000	(41,000)		
	Two+ illnesses	244,000	122,000	(122,000)		
	Nursing home or deceased	5,929,000	5,827,000	a/(101,000)		
	Total	8,000,000	8,000,000	-		

a/ Difference due to rounding

PROJECTED EFFECT OF INCREASED FINANCIAL HELP

OVER 20 YEARS FOR PEOPLE 65 TO 69 YEARS OLD NATIONWIDE

(INCOME RAISED TO $4,057 FOR SINGLE AND $7,036 FOR MARRIED PEOPLE)

Year projected	Feelings about money	Number with no change in financial help	Number with increased financial help	Difference due to increased help	Older people in better condition	
					Number	Percent
1975	Very well	1,754,000	-	-	-	-
	Fairly well	4,784,000	-	-		
	Poorly	1,462,000	-	-		
	Nursing home or deceased	-	-	-		
	Total	8,000,000	-	-		
1980	Very well	1,170,000	1,861,000	691,000	691,000	11 4
	Fairly well	3,508,000	3,402,000	(106,000)		
	Poorly	1,382,000	797,000	(585,000)		
	Nursing home or deceased	1,940,000	1,940,000	-		
	Total	8,000,000	8,000,000	-		
1985	Very well	904,000	1,541,000	a/638,000	638,000	11 8
	Fairly well	2,684,000	2,552,000	a/(133,000)		
	Poorly	1,037,000	532,000	(505,000)		
	Nursing home or deceased	3,375,000	3,375,000	-		
	Total	8,000,000	8,000,000	-		
1990	Very well	558,000	930,000	372,000	372,000	13 5
	Fairly well	1,568,000	1,515,000	(53,000)		
	Poorly	638,000	319,000	(319,000)		
	Nursing home or deceased	5,236,000	5,236,000	-		
	Total	8,000,000	8,000,000	-		
1995	Very well	239,000	452,000	213,000	213,000	14 6
	Fairly well	877,000	797,000	(80,000)		
	Poorly	346,000	213,000	(133,000)		
	Nursing home or deceased	6,538,000	6,538,000	-		
	Total	8,000,000	8,000,000	-		

a/Difference due to rounding

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PROJECTED EFFECT OF INCREASED SOCIAL-RECREATIONAL HELP

OVER 20 YEARS FOR PEOPLE 65 TO 69 YEARS OLD NATIONWIDE

Year projected	Social contacts	Number with no change in social-recrea-tional help	Number with increased social-recrea-tional help	Difference due to increased help	Older people in better condition	
					Number	Percent
1975	High	3,624,000	–	–	–	–
	Medium	2,984,000	–	–		
	Low	1,392,000	–	–		
	Nursing home or deceased	–	–	–		
	Total	8,000,000	–	–		
1980	High	3,359,000	3,514,000	155,000	155,000	2 4
	Medium	2,541,000	2,519,000	(22,000)		
	Low	597,000	464,000	(133,000)		
	Nursing home or deceased	1,503,000	1,503,000	–		
	Total	8,000,000	8,000,000	–		
1985	High	2,829,000	3,050,000	221,000	221,000	4 0
	Medium	2,188,000	2,121,000	a/(66,000)		
	Low	530,000	376,000	a/(155,000)		
	Nursing home or deceased	2,453,000	2,453,000	–		
	Total	8,000,000	8,000,000	–		
1990	High	2,100,000	2,210,000	110,000	110,000	2 8
	Medium	1,547,000	1,525,000	(22,000)		
	Low	353,000	265,000	(88,000)		
	Nursing home or deceased	4,000,000	4,000,000	–		
	Total	8,000,000	8,000,000	–		
1995	High	1,370,000	1,436,000	66,000	66,000	2 5
	Medium	995,000	995,000	–		
	Low	243,000	177,000	(66,000)		
	Nursing home or deceased	5,392,000	5,392,000	–		
	Total	8,000,000	8,000,000	–		

a/Difference due to rounding

PROJECTED EFFECT OF INCREASED DEVELOPMENTAL HELP

OVER 20 YEARS FOR PEOPLE 65 TO 69 YEARS OLD NATIONWIDE

Year projected	Outlook on life	Number with no change in develop- mental help	Number with increased develop- mental help	Difference due to increased help	Older people in better condition	
					Number	Percent
1975	Good	2,225,000	-	-	-	-
	Fair	3,955,000	-	-		
	Poor	1,820,000	-	-		
	Nursing home or deceased	-	-	-		
	Total	8,000,000	-	-		
1980	Good	1,798,000	1,843,000	44,000	269,000	4 2
	Fair	3,168,000	3,393,000	225,000		
	Poor	1,416,000	1,146,000	(269,000)		
	Nursing home or deceased	1,618,000	1,618,000	-		
	Total	8,000,000	8,000,000	-		
1985	Good	1,438,000	1,438,000	-	202,000	3 9
	Fair	2,629,000	2,832,000	a/202,000		
	Poor	1,169,000	966,000	a/(202,000)		
	Nursing home or deceased	2,764,000	2,764,000	-		
	Total	8,000,000	8,000,000	-		
1990	Good	1,011,000	1,101,000	90,000	157,000	4 6
	Fair	1,685,000	1,753,000	a/67,000		
	Poor	742,000	584,000	a/(157,000)		
	Nursing home or deceased	4,562,000	4,562,000	-		
	Total	8,000,000	8,000,000	-		
1995	Good	562,000	607,000	45,000	90,000	4 4
	Fair	1,034,000	1,079,000	45,000		
	Poor	449,000	359,000	(90,000)		
	Nursing home or deceased	5,955,000	5,955,000	-		
	Total	8,000,000	8,000,000	-		

a/Difference due to rounding

DEPARTMENT OF HEALTH EDUCATION AND WELFARE
OFFICE OF THE SECRETARY
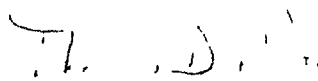WASHINGTON D C 20201

MAY 18 1979

Mr Gregory J. Ahart
Director, Human Resources
   Division
United States General
   Accounting Office
Washington, D C.   20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our
comments on your draft report entitled, "Conditions of Older
People National Information System Needed."   The enclosed
comments represent the tentative position of the Department
and are subject to reevaluation when the final version of
this report is received.

We appreciate the opportunity to comment on this draft
report before its publication.

                               Sincerely yours,

                               Thomas D Morris
                               Inspector General

Enclosure

Comments of the Department of Health, Education, and Welfare on the
General Accounting Office's Draft Report Entitled "Conditions of Older
People   National Information System Needed"

General Comment

The Department of Health, Education, and Welfare has reviewed with great
interest this GAO report on the conditions of older persons   We believe
that the research conducted under this project has made a major contribu-
tion to the understanding of the problems of older people and the impact
of the various types of help that they receive   However, the Department
has a number of serious reservations about the approach recommended in
this draft report for adoption by the Department

GAO Recommendation

The draft report recommends that DHEW/OHDS undertake the creation of a
national information system based on the OARS methodology to report on
the conditions, problems, and help available to older people

Departmental Comment

The Department believes that the approach advocated in the draft report
has the following major weaknesses

o   It overlooks considerable bodies of data and analysis that
        are available, or are currently being collected, or are
        currently being planned for, it omits any discussion of
        alternative mechanisms currently in place for collecting such
        data, and to the extent that existing mechanisms could not
        provide the kinds of data called for, the report does not
        consider what new alternative mechanisms might be developed to
        collect such data   In addition, the Administration on Aging
        is currently in the process of funding a project to examine
        alternatives to the survey interview approach to area-wide
        needs assessment   The Health Care Financing Administration is
        funding a project to evaluate the strengths and weaknesses of
        the major needs assessment instruments for individual client
        assessment   The Department would prefer to wait until these
        efforts are more advanced before proceeding with a commitment
        to a particular approach to needs assessments

o   Under most of the major Federally funded social services and
      health programs, funds are distributed to states on a formula
      basis   The choices in the targeting of resources are largely
      made at the state and sub-state levels. The type of study
      proposed in this report could not produce statistically valid
      data which would be immediately applicable at these levels
      (where needs assessment is needed most) unless the sample were
      increased to a prohibitively expensive size   The draft report
      also understates the costs and technical problems involved in
      implementing such an information system. For example, the
      OARS instrument used in this report has a number of major
      shortcomings which limit its usefulness   Because of its
      disproportionate emphasis on health and mental health, it
      falls short of the broad scope which would be required in a
      national information system   From a cost perspective, the
      report understates the true costs by including only the costs
      for a single sample survey   An operational information system
      would require a planning study to further develop the method-
      ology, at least a two wave survey of the sample of older
      persons as well as interviews with providers, and a substantial
      commitment of staff resources by the Department

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