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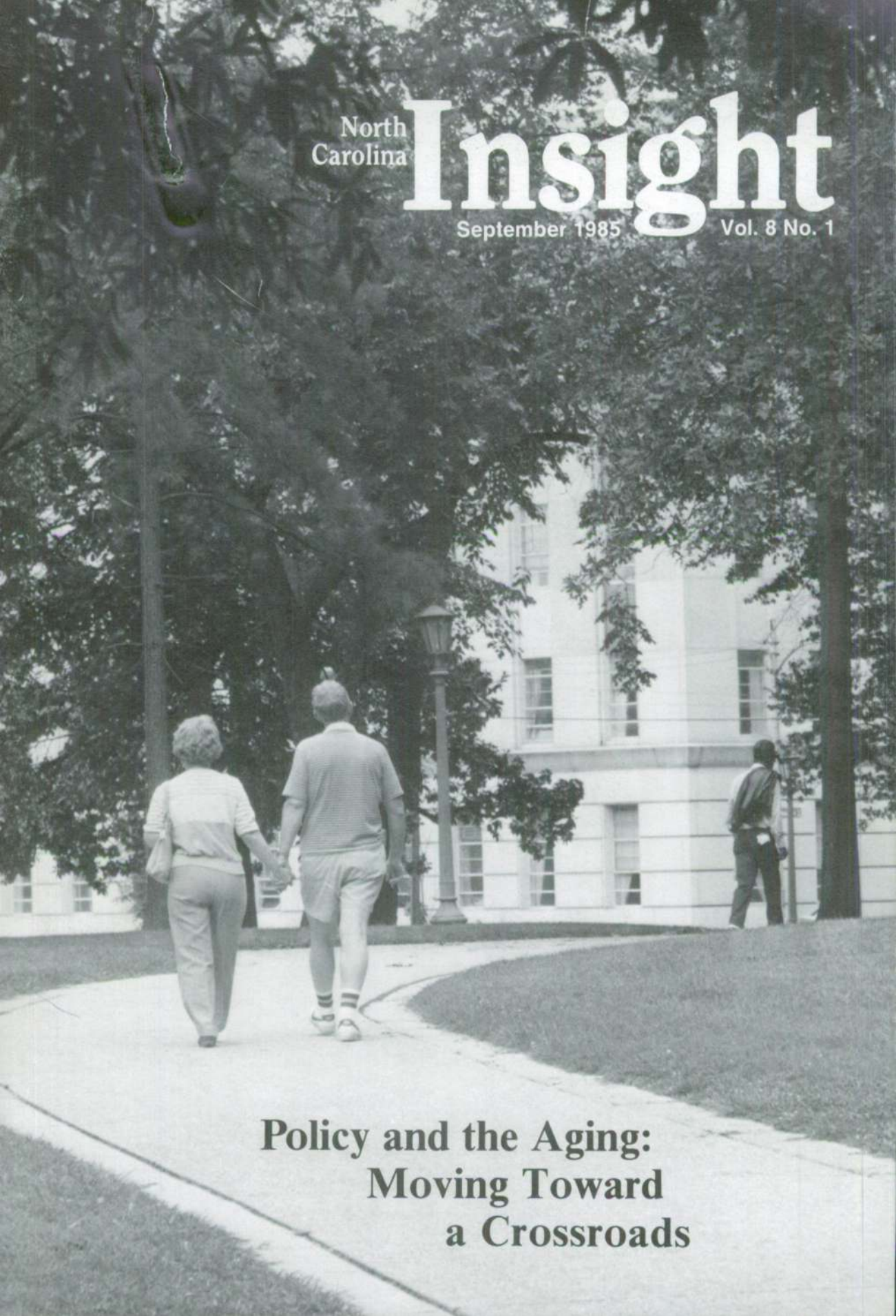

Policy and the Aging: Moving Toward a Crossroads

N.C. Center for Public Policy Research

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North Carolina **Insight**

Vol. 8, No. 1

Conflict or Consensus? Essays on Future Policy Directions

DEPARTMENTS

Of Grandmothers and Crossroads: An Introduction

When she was 99 years old, Mary Atkinson Monie Betts was still as alert as most folks half her age. She received visitors in much the same way as a queen held court—she picked their minds for nuggets of useful information. That summer of 1975, when I came back from Washington to visit her after covering Watergate for two years, she wanted to know precisely what it was that had led to Richard Nixon's downfall.

"Was it," she asked, her eyes gleaming, "the laws they said he broke, or was it the lies he told?" A perceptive question, I thought, but then my grandmother had always been sharp.

Her age seemed to have impaired her not at all. Only when she turned 102 did she really begin to get old, and today perhaps I still judge the so-called elderly in terms of her. My father, 40 years my senior, is still a young man to me, vigorous now as ever, refusing to bow to the usual constraints of age.

For many of us in our middle years, deciding who is "elderly" or "old"—or to use the current euphemism, a "senior citizen"—has become increasingly difficult. We struggle with the ambiguity of language. Words cast about in print (like "the elderly") seem incongruous next to our vigorous parents. But what about the older person who has turned frail?

Does sensitivity propel us in our choice of terms, just as we proceeded from "crippled" to "handicapped" to "physically impaired"? Are we searching for the right term to describe a class of people without insult? Yes, certainly pejorative connotations are to be avoided, but there is more.

The dilemma of language reflects the dilemma of policy. The elderly—the sweeping term for *all* persons 65 or over—are as diverse as the country in which they live. Yet policies, and the words to describe these policies, insist for the most part on lumping all older persons together. Consequently, we feel compelled to find the correct word to call our oldest citizens.

Ironically, all these terms—old, elder, elderly, senior—have the same basic meanings and stem from several common roots. The terms elder, elderly, and old, for example, evolved from the Old English word "eldra"—itself a derivative of the Old Teutonic word, "eald." But the grandfather of labels for the 65 plus crowd is the Latin word "senex." From senex came the Romans' word "senatus" and eventually our word "senate"—meaning a council of elders. Senex also, by the way, serves as the root of the words "senior" and "senile." But don't bandy that about lightly down at the N.C. General Assembly.

In 19th century Japan, retired statesmen who had served their country well were accorded a special status. Because of their long experience, sound judgment, and proven ability, they were especially sought by the imperial court as a class of senior advisers. Their status led to coining of the term "elder statesmen."

Many of us have fond attachments for the honored elderly like my grandmother. But we have also seen the pain and suffering of older persons who have turned dependent. Many have paid an enormous financial and emotional toll in trying to provide for those who lack the means, and the mental and physical capacity, to care for themselves.

For 50 years, the government has gradually poured more resources into caring and providing for the elderly population. Today, one of every nine persons in the U.S. qualifies as "elderly." By the year 2000, the number of elderly in North Carolina alone will swell to nearly a million persons. Can government programs for elders continue to expand in the face of such numbers? A crossroads is fast approaching when federal and state policymakers may have to say "no."

This issue of *North Carolina Insight* attempts to chart the crossroads that lies ahead. The first four articles are designed to serve as a primer—on demographics, on the array of state programs that exist, on the new director of the N.C. Division of Aging and her priorities, and on the political dynamics among the elderly. The next section highlights three policy debates among policymakers, analysts, and older persons themselves. Is there conflict or consensus on encouraging work versus retirement? On using age or financial need to determine government benefits? On using tax breaks to attract retirees to a state? Finally, we tackle perhaps the most difficult of all issues—long-term health needs and the system of care that is supposed to be meeting those needs.

Few of us can expect to become centenarians like my grandmother, nor can we expect to remain as alert for as long as she did. But as life expectancies continue to lengthen, we can all reasonably expect to become old. Perhaps it's high time, then, that we found out what we're getting into.

Jack Betts
Associate Editor

"Everyone aged 65 and over is classified as elderly, yet the elderly are the most diverse group within the population. Their differences have been accumulated over a lifetime, and a full range of situations exists within the elderly population. . . ."

—Southern Growth Policies Board

Who Are the Elderly?

by Jack Betts

More than 100 years ago the German head of state, Count Otto von Bismarck, unknowingly defined who the elderly are in the 20th Century. Bismarck declared that henceforth all workers who achieved the age of 65 would be rewarded with retirement and entitled to an old-age pension. It wasn't so much that Bismarck was instituting an altruistic social program; in Germany in 1876, the life expectancy of the average worker was only 40. Designating retirement age as 65 was a brilliant, if cynical, political ploy by Bismarck. He could get credit for setting up a retirement system for his people, but because few of them would live long enough to benefit from it, the system wouldn't cost his government very much money.[1]

Today, the life expectancy of males in both Germany and the United States is well over 70 years. But the general benchmark for retirement has remained at 65. That magic number remains the standard for determining who is elderly and who is not, regardless of more substantive indications such as physical and mental health, personal circumstances, and economic security.

When Congress enacted the Social Security law in 1935, that same age 65 standard was adopted as the appropriate age for retirement, with little debate on why that number was best. The only major change came in 1978 when Congress raised the *mandatory* retirement age in the public and private sectors from 65 to 70, yet retirement—and thus the designation "elderly"—revolves somewhere around Bismarck's magic number.

Whatever the threshold number, the fact is that the elderly represent the fastest-growing segment of the population—a segment that is about to explode.[2] The current cliche is to call it "The Graying of America," and that is an accurate if tired expression. Consider the numbers: At the turn of the century, one person in 25 was 65 or older; today the ratio is one in nine; by the year 2030, one person in five will be at least 65. Even more important, the ratio of retired to working people will be about 3 to 1.

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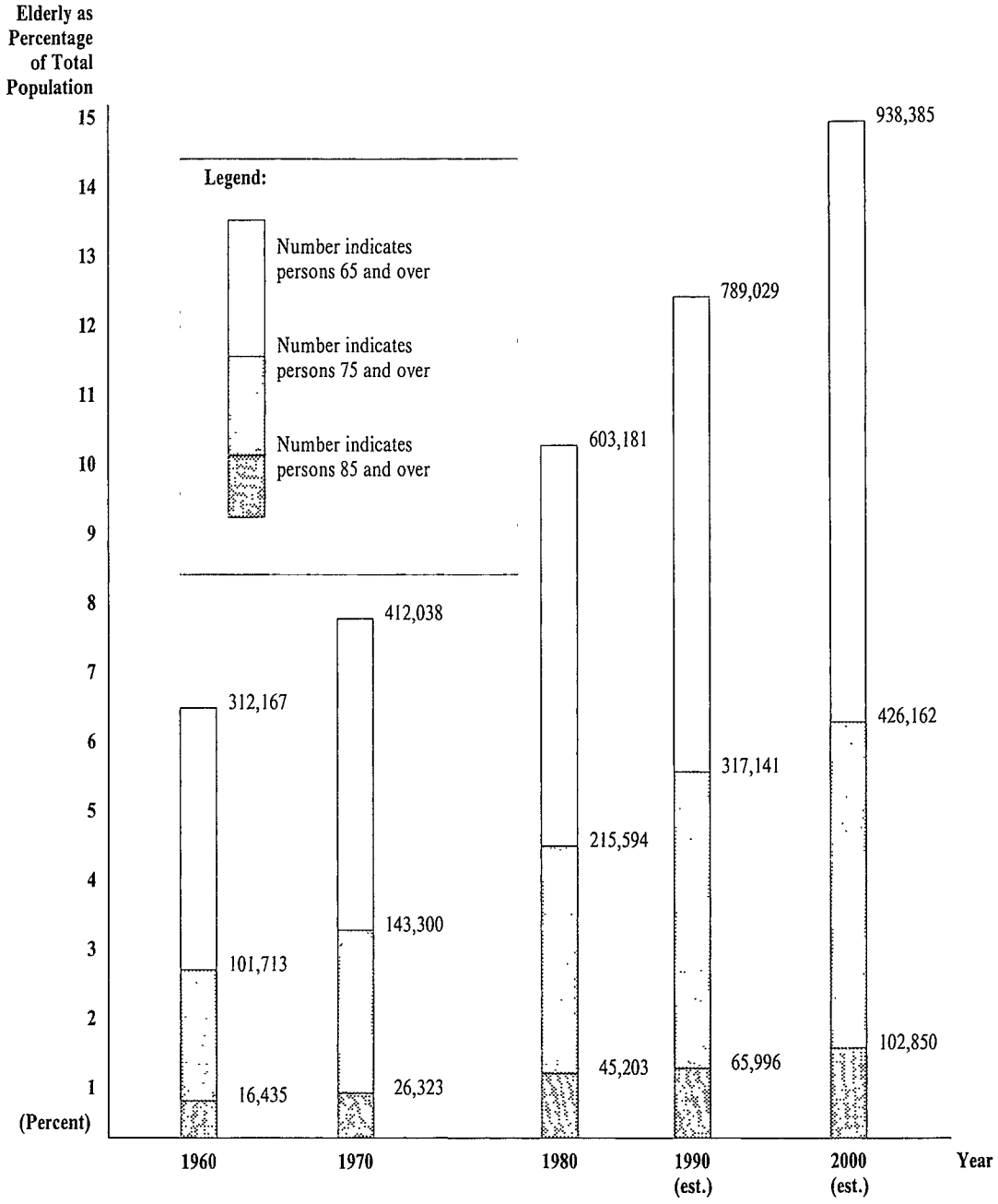
Figure 1. Elderly as Percentage of Total Population, By Age Group (1960-2000)



Source: N.C. Office of Budget and Management and Division of Aging.

In North Carolina, the numbers are equally dramatic. In 1970, 8.1 percent of the 5.1 million North Carolinians—412,000—were 65 or over. By 1980, the portion had grown to 10.2 percent (603,000). Projections for the future indicate a continued increase—to 12.2 percent in 1990 and 15 percent in the year 2000 (see Figure 1).[3] The *percentage increase* in the number of persons over age 65 is even more startling: a jump of 56 percent from 1980 to 2000 (603,000 to 938,000), compared to the percentage increase in the overall population of 19 percent. The steepest growth will occur among the *very old*, those 85 and over. In 1980, there were 45,203 North Carolinians 85 or over. By the year 2000, that number will have grown to 102,850—*an increase of 128 percent* (see Figure 1).

In 1980, North Carolina ranked only 35th among the 50 states in the percentage of its population 65 or over. But the rate of growth in the number of elderly persons in the state was high. From 1970 to 1980, the number of persons 65 or over in the state increased by 45.7 percent, ranking North Carolina eighth nationwide (see Table 1). Some analysts believe this increase is due largely to an in-migration of retired persons (for more on this, see article on page 55).

Within this general "graying" trend, many subtle distinctions are emerging. "The elderly are a heterogeneous group economically, socially, and in terms of health status, need for services, and use of available resources," report Carol Hollenshead and Jeanne E. Miller in the quarterly magazine *Frontiers of Health Services Management*.[4] "But the media's need for brevity and impact is fed by the desire of politicians, gerontologists, and special interest groups of older people to effectively market the particular programs, services, or ideologies they wish to sell." Such marketing efforts have produced a stereotype of the elderly as a homogeneous population group—poor, inactive, taking from society, in ill health, and dependent upon others.

In 1984, a Southern Growth Policies Board report took note of these beliefs. "Everyone aged 65 and over is classified as elderly, yet the elderly are the most diverse group within the population. Their differences have been accumulated over a lifetime, and a full range of situations exists within the elderly population—rich to poor, healthy to invalid, totally independent to totally dependent, scholars to illiterates." [5]

Financial Status of the Elderly

One popular notion about the elderly is that they are poor and must resort to eating dog food to survive. In some cases that may in fact be true. But the economic data available on the elderly paint a far different picture. In the latest Economic Report of the President, researchers found that the elderly, by and large, are better off economically today then ever before.

Table 1. Top 10 States, by Percentage of Population Over 65 (1980)

State	% of Population Over 65
1. Florida	17.3
2. Arkansas	13.7
3. Rhode Island	13.4
4. Iowa	13.3
5. Missouri	13.2
6. South Dakota	13.2
7. Nebraska	13.1
8. Kansas	13.0
9. Pennsylvania	12.9
10. Massachusetts	12.7
35. North Carolina	10.2

Top 10 States, by Percentage Increase of Population Over 65 (1970-80)

State	% Increase (1970-80)
1. Nevada	112.3
2. Arizona	90.4
3. Hawaii	72.4
4. Florida	70.6
5. Alaska	67.7
6. New Mexico	64.2
7. South Carolina	50.5
8. North Carolina	45.7
9. Utah	40.8
10. Georgia	40.6

Source: Aging America, Trends and Projections, published by the U.S. Senate Special Committee on Aging and the American Association of Retired Persons, 1984, p. 15.

"Thirty years ago the elderly were a relatively disadvantaged group in the population. That is no longer the case. The median real income of the elderly has more than doubled since 1950, and the income of the elderly has increased faster over the past two decades than the income of the non-elderly population . . . . Poverty rates among the elderly have declined so dramatically that in 1983 poverty rates for the elderly were lower than poverty rates for the rest of the population." [6]

That's not the case for everyone, of course. Many elderly live alone and those who do—particularly women, the elderly black, and the very old—have limited financial resources. Hollenshead and Miller found that more than 3 percent of older families had incomes exceeding $50,000 in 1980, but 17 percent of the families headed by the elderly had incomes below the poverty level. The remainder of the elderly population live on income between these two extremes.[7]

Table 2. Income of the Elderly By Sex and Race (65 and Over in North Carolina, 1980)

	All Races		Whites		Blacks	
	Males	Females	Males	Females	Males	Females
No Income	5,822	26,256	3,879	21,462	1,853	4,601
Total with Income	229,162	340,591	184,581	274,305	42,898	63,837
$0-1,999	18,809	75,030	11,981	56,113	6,553	18,137
$2,000-3,999	68,541	145,100	48,679	110,972	19,127	32,962
$4,000-5,999	43,783	47,447	35,550	40,731	7,955	6,455
$6,000-7,999	27,541	25,757	22,992	22,937	4,419	2,739
$8,000-9,999	18,971	15,836	16,856	14,306	2,012	1,470
$10,000-14,999	24,389	18,438	22,526	16,984	1,786	1,401
$15,000-24,999	16,077	9,193	15,259	8,638	792	521
$25,000-49,999	8,196	3,000	8,000	2,887	156	105
$50,000 & Over	2,855	790	2,738	737	98	47

Source: 1980 U.S. Census. Data for "all races" includes other minorities not shown on table.

The Economic Report of the President, however, emphasized the improving side of the picture. The report found that the mean family income for the elderly increased by 17 percent from 1970 to 1983, $18,260 to $21,420 (computed in 1983 dollars). For the non-elderly (age 25-64), the mean family income actually *fell,* from $31,050 in 1970 to $30,940 by 1983. In other words, the elderly as a whole are better off than they were, while the non-elderly are slightly worse off financially than they used to be. The financial gap is narrowing.

But if the overall financial gap between the elderly and the rest of the population is smaller, the distinctions among groups *within* the elderly population remain dramatic—by race, by sex, by region of the country, and by family status. Take *race*, for example. In 1980, the income of white families with elderly heads of households averaged $13,382; for blacks, it was more than a third less, $8,383.

Income also varies according to *family status.* That is, older Americans living alone have smaller incomes that those who live with members of their families. "In the elderly population," wrote Hollenshead and Miller, "single people are more likely to be poor than married people, women are more likely to be poor than men. The single most disadvantaged group is older minority women who live alone; an appalling 52 percent of these women have incomes below the poverty level."

The same general findings—that elderly men are better off than elderly women, that elderly whites are better off than elderly blacks—hold true for the South as a region and for North Carolina. Incomes of the elderly have risen in the region and in the state—though not as fast nor as high as the national average.

In North Carolina, the elderly population as a whole has generally improved regarding income. But, like the rest of the South, the increases have not been as great as the rest of the nation. Moreover, the gaps within the elderly population remain large.

Overall, elderly males have higher median incomes ($5,095) in North Carolina than do females ($3,099). Likewise, white elderly males have better median incomes ($7,114) than black elderly males ($3,425), white elderly females ($3,339), or black elderly females ($2,592). Similar patterns hold true for other elderly minorities in North Carolina, with males enjoying substantially higher incomes than females.

The Bureau of the Census figures for 1980 also show another startling statistic. Among those 65 and older in North Carolina, 5,822 males and 26,256 females have no income. In other words, 32,078 elderly North Carolinians—one of every 20 of the state's elderly population—have no income at all. Another 18,809 males and 75,030 females reported having income of less than $2,000 per year. Thus, one in five of the state's elderly have incomes of less than $2,000 annually.

The Institute of Southern Studies, in a recent issue of its bimonthly magazine *Southern Exposure,* found that while the rate of elderly households with income of less than $5,000 was about 7.4 percent for the rest of the nation, it was more than twice that high—15.6 percent—in the South.[8] For whites, that

rate in the South was 12.8 percent, but for blacks it was 30.6 percent. Similarly, the median income of elderly households in the South was $10,968, compared with $13,066 for the rest of the country. Median income for southern elderly whites was $11,691, while for blacks the level was much lower—$7,393.

At the other end of the scale, there is relative affluence. More than 11,000 elderly citizens had incomes of between $25,000 and $49,999, and more than 3,600 other elderly North Carolinians had incomes exceeding $50,000 per year. Again, most of those affluent elderly were white males, with 2,738 of them reporting incomes exceeding $50,000, while 737 white females over 65 had incomes of that size. Yet among blacks, only 98 elderly males reported incomes over $50,000, while 47 elderly females had similar incomes. For further information see Table 2.

Health of the Elderly

One popular notion about the elderly is that most of them are in ill health and must live in institutions. But like other myths about the elderly, the facts paint a somewhat different picture. It is true that the vast majority of nursing home patients are elderly. But the current research indicates that only about 5 percent of the elderly live in nursing and rest homes, while most of the elderly—95 percent, according to Hollenshead and Miller—remain in the community. In addition, nearly three-fourths of the elderly own their own homes.

In this area, too, men are better off than are women. "Of those older people who do live in institutions, a disproportionate number (more than 70 percent) are women, generally those who are widowed or unmarried," wrote Hollenshead and Miller. "This statistic reflects not only the greater life expectancy of women, but also the fact that older women are often without family support, living alone rather than in family households."[9]

Advances in medicine and the standard of living have led to longer life expectancies. In recent decades, the death rate of older citizens has declined about 20 percent for women and 30 percent for men, which means that the number of very old has increased substantially. That means that the older population runs a greater risk of developing chronic diseases and conditions. In 1981, about 30 percent of the elderly assessed their health as fair or poor, compared to only 10 percent of those under the age of 65.[10]

A similar survey, conducted by the National Center for Health Statistics, points out the other side of the equation: that about 70 percent of the elderly report their health as good to excellent.[11] The presence of a chronic condition or illness may not mean that the daily activities of those affected are impeded. "Although more than 80 percent of older people report a chronic condition, those who said they could no longer carry on daily activities numbered only one in six," wrote Hollenshead and Miller.

Future Demographics

Finding out who the elderly are—and what their needs are now and will be in the future—is a key task for local, state, and federal agencies in planning services for the elderly. Much of the data on the elderly has been developed from the 1980 census, and further projections are available from two state agencies. The governor's Office of Budget and Management provides specific data on population projections and other sociological and economic data.

Table 3. N.C. Population by Age, Race, and Place (1980)

	WHITE			BLACK		
Age	State	Urban	Rural	State	Urban	Rural
65-69	176,889	80,537	96,352	43,547	23,510	20,037
70-74	133,579	62,253	71,326	31,121	17,127	13,994
75-79	86,756	41,305	45,451	20,518	11,667	8,851
80-84	50,718	25,648	25,070	9,680	5,506	4,174
85+	36,285	18,280	18,005	8,323	4,411	3,912
	484,227	228,023	256,204	113,189	62,221	50,968

Source: 1980 U.S. Census

Table 4. Elderly Population in the Labor Force (65 and Over in North Carolina, 1980)

Status	WHITE State	WHITE Urban	WHITE Rural	BLACK State	BLACK Urban	BLACK Rural
Males:	188,460	81,073	107,387	44,751	22,746	22,005
Employed	39,241	19,083	20,158	8,359	4,568	3,791
Unemployed	1,144	515	629	618	254	364
Not in Labor Force	148,047	61,456	86,591	35,735	17,897	17,383
Females:	295,767	146,950	148,817	68,438	39,475	28,963
Employed	23,117	12,827	10,290	7,923	4,995	2,928
Unemployed	1,123	503	620	682	416	266
Not in Labor Force	271,527	133,620	137,907	59,818	34,064	25,754

Source: 1980 U.S. Census. Note: Data are estimates and may not add up to totals shown.

And the Department of Human Resources' Division on Aging has taken the subject a major step further. Through the use of sophisticated computer models, that office has developed detailed projections on the needs of the elderly in the future and on the number of health-impaired elderly citizens. Those projections, which have been drawn for each of the state's 100 counties (but not for the state as a whole), provide a mass of information on the elderly.

So do other available statistics that help paint the picture of the elderly as a heterogeneous, diverse group in this state. For example, more elderly North Carolinians live in rural areas than in urban areas, but fewer of the black elderly live in rural areas than in the state's urban areas (see Table 3). Among the elderly, more males are employed than females, even though the number of females far exceeds the number of males in this population (see Table 4). Tables 2, 3, and 4 suggest the vast data that are available on this subject.

This diversity of the elderly in North Carolina is a mirror-image of the elderly in the region and the country. As a 1984 report by the Southern Growth Policies Board noted, "The elderly often are perceived as needy; however, their situation has improved dramatically over the last 25 years . . . . Improvements in the physical and financial situation of the elderly population make it time to reassess perceptions of older people, not only because improvements have occurred, but also because they are expected to continue. The elderly no longer conform to an image of a frail, dependent person; older people still have a great deal to contribute to society. The image of the elderly as an ever-heavier albatross hung around society's neck is both false and harmful, because it encourages the development of structures that force a dependency upon the elderly."[12] □

FOOTNOTES

[1]C.E. Odell, and Louise Minter Odell, *You and the Senior Boom*, 1980, Exposition Press, p. 95.

[2]*Economic Report of the President*, February 1985, U.S. Government Printing Office, p. 160.

[3]N.C. Population Trends, N.C. Office of Budget and Management and the Division of Aging, July 1984.

[4]Carol Hollenshead and Jeanne E. Miller, "Behind the Myths: A Demographic Profile of the Elderly," *Frontiers of Health Services Management*, Vol. 1, No. 2., November 1984, Health Administration Press, p. 3.

[5]Pat Dusenbury, "The Elderly: Our Oldest Human Resource," Southern Growth Policies Board, 1984, p. 1.

[6]*Economic Report of the President*, p. 160.

[7]Hollenshead and Miller, p. 7.

[8]Stuart Rosenfeld and Mary Eldridge, "Growing Old Southern," *Southern Exposure*, Vol. XIII, No. 2-3, March-June, 1985, pp. 130-132.

[9]Hollenshead and Miller, p. 7.

[10]A Profile of Older Americans 1984,", a pamphlet published by the American Association of Retired Persons, p. 12.

[11]Hollenshead and Miller, p. 9.

[12]Dusenbury, p. 2.

Courtesy Mayview Convalescent Home

"Targeting" Older Persons for Services

by Cynthia Lambert and Bill Finger

The Christmas spirit lives—with the Adopt-a-Grandparent program.

When discussing programs for older persons, two landmark dates stand above all others: 1935, when Congress passed the initial Social Security Act, and 1965, when Congress passed Medicare, Medicaid, and the Older Americans Act. The federal government *funds and administers* Social Security and Medicare, but it only *funds* the programs mandated by the Older Americans Act. State governments *administer* the programs funded by the Older Americans Act in various partnerships with regional councils of governments, local governments, and private non-profit groups. The states also administer Medicaid, the health care program designed for poor people.

From these landmark years, most government programs important to elderly persons have evolved under a "targeted" approach. Social Security, Medicare, and the Older Americans Act established programs generally designed for older persons. These federal laws also mandated separate administrative systems.

Some important exceptions to this "targeted" approach have emerged, however, often resulting in fragmented service delivery and administrative systems. This is particularly true when viewing programs designed for the poor. Last year in North Carolina, elderly persons

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received some *$23.6 million* in social services through county departments of social services. Most of these funds came from federal programs designed for poor people. At the same time, Older Americans Act funds totaling some *$21.1 million* went for similar types of programs but through a separate administrative system.

Much larger amounts of money are involved at the state Division of Medical Assistance. This office administers the Medicaid reimbursement system, which pays for health care for qualifying persons. While intended to serve the poor of all ages, Medicaid has been used increasingly in recent years by the elderly poor, primarily because it covers nursing home costs. Last year, almost two of every five dollars in Medicaid expenditures in North Carolina went to persons 65 and over ($242 of $648 million).

on state and local governments and on regional councils for implementation. In this article, terms like "elderly" and "older persons" refer to groups of varying ages, depending upon the program under discussion.

The Aging Network

Born during the Great Society years of the Johnson administration, the Older Americans Act reflects a "targeted" philosophy. The various types of programs mandated by this act—from in-home and nutrition services to legal counseling and support for senior centers—are aimed only at older persons. The act also requires a separate administrative structure, which has come to be known as the "aging network."

History of the N.C. Division of Aging

The Older Americans Act, passed by Congress in 1965, required each state to designate an official agency for the aging. Hence, the North Carolina General Assembly created in 1965 the Governor's Coordinating Council on Aging, which was to serve as the coordinating and information center for the planning, communication, and advocacy of programs aiding elderly persons.[1] In 1973, under State Government Reorganization, this council was placed under the new secretary of the Department of Human Resources. In 1973, Congress further delineated the requirements for an official state agency on aging. In North Carolina, that agency became the Department of Human Resources, which had responsibility for:

- developing and administering a statewide plan;
- coordinating state activities related to implementing the Older Americans Act;
- dividing the state into planning and service areas and approving plans from these areas;
- monitoring and assessing the implementation of the area plans; and
- carrying out any other functions and responsibilities under the plan of the state agency.

In 1975, the Secretary of Human Resources designated an Office for Aging to administer these functions, and in 1977 the General Assembly changed the name of the Office for Aging to the Division of Aging.[2] Nathan Yelton, the first director of this new division, served from 1977 until his death in 1981. Ernest Messer, a former state representative (D-Haywood County) and chairperson of the legislative Study Commission on Aging, directed the division from 1981 until May of 1985. Elaine Stoops of Greensboro succeeded Messer (see page 32 for interview with Stoops). □

FOOTNOTES
[1]Chapter 977, 1965 N.C. Session Laws.
[2]NCGS 143B-181.1.

This article focuses on programs targeted for older persons, particularly those programs involving state government. State laws and agencies have little involvement in the Medicare and Social Security programs. But the Older Americans Act and Medicaid depend largely

Since its initial 1965 national appropriation of $6.5 million, the Older Americans Act has been amended and reauthorized by Congress nine times, now with a national pricetag of $701.5 million and six separate titles (see Figure 1). The act requires each state to designate an

agency on aging.[1] In North Carolina, this is the Division of Aging within the Department of Human Resources (see sidebar on page 10).

In state fiscal year 1983-84, the Division of Aging administered some $21.1 million in programs under the Older Americans Act. Most of this money comes through Title III of the act, which mandates a funding formula of 85 percent federal funds, 5 percent state funds, and 10 percent local funds. These monies are known as Title III funds or Administration on Aging (AoA) funds, referring to the federal agency within the U.S. Department of Health and Human Services that administers the Older Americans Act. In addition, $2.7 million from other sources funded programs through the aging network. The Division of Aging is the only state-level agency that directs its efforts solely toward serving the elderly.

The Division of Aging itself has an *operating* budget of $1.0 million, which covers 29½ positions. It functions as an advocate for elderly persons and—together with the regional "area agencies on aging"—as an administrative vehicle for monitoring and distributing the federal AoA funds. Services are provided directly at the local level by councils on aging, county government offices on aging, and various nonprofit groups. Together, these agencies are known as the aging network.

The term "aging network" implies a comprehensive administrative system for all governmental efforts to help older persons. In fact, it refers only to the six-tiered bureaucracy that implements the Older Americans Act (Figure 2 illustrates the tiers). As mandated by this act, local service providers receive AoA funding through a system of planning and service areas called *area agencies on aging,* usually referred to as "AAAs."

To most North Carolinians, the acronym AAA might bring to mind a minor league baseball team, an auto club, or perhaps a bond rating. But in the aging network, the "triple As" are a key level in the bureaucracy that decides which local providers will spend millions of dollars on social services, nutrition programs, advocacy, and volunteer activities for older persons. In North Carolina, the AAAs work through the 18 Lead Regional Organizations (commonly referred to as Councils of Governments or COGs). Working with the same multicounty areas as COGs (and housed in the COG offices), the AAAs contract for services on the local level.

This contracting system allows AAAs to "do what's right for each individual county—to provide the services each county most needs," says Karen Buckle, who directs the Centralina AAA covering the eight-county region around Charlotte. Buckle points out that the Older Americans Act permits 8.5 percent of its funds to go for administration at the AAA level. "Our agency spent only 5.9 percent (of the AoA funds) on administration," says Buckle. "We're not just another level of government that skims off dollars." Statewide, the AAAs averaged spending about 7 percent of the AoA funds on administration at the AAA level.

Figure 1. The Older Americans Act of 1965, as Amended*

Title I:	Declaration of Objectives.
Title II:	Administration on Aging established in the Department of Health and Human Services.
Title III:	Grants for states and community programs on aging; provides 85% federal funds with a 5% state and 10% local matching ratio.
Title IIIA:	Provisions and funds for state administration.
Title IIIB:	Funds for area agencies on aging, community and social services, and multi-purpose senior centers.
Title IIIC:	Nutrition services. Part 1: funds for congregate meals; Part 2: funds for home delivered meals.
Title IV:	Training, research, and discretionary projects and programs. Funds for short- and long-term training of individuals employed in fields related to aging.
Title V:	Senior Community Service Employment Program which provides needy persons over 55 years old with part-time community service jobs.
Title VI:	Grants for Indian tribes for the above services.

*See Public Law 98-459, Older Americans Act Amendments of 1984, 42 U.S. Code, Sections 3001 et seq.

Figure 2. The Aging Network: A Six-Tier Administrative System for Older Americans Act Funds

Federal

1. Administration on Aging (AoA), in the U.S. Department of Health and Human Services (Southeast Region IV, regional AoA office in Atlanta)

State

2. N.C. Department of Human Resources
3. Division of Aging

Regional

4. 18 Area Agencies on Aging

Local*

5. County Office on Aging or Council on Aging
6. Other Service Providers

*In some cases, the county office or council on aging is also the service provider; hence it is a five-tiered system. In other cases, another agency is the service provider.

Other planners, however, criticize such regional structures as an unnecessary level of bureaucracy, duplicating efforts of counties, municipalities, and special purpose districts. "The COG concept came to fruition in the Great Society antipoverty and economic development programs of the 1960s," explains Jones C. Abernethy, a planner and a consultant to local governments in a 15-county region around Winston-Salem. "But COGs have lingered past the demise of many of these programs."[2]

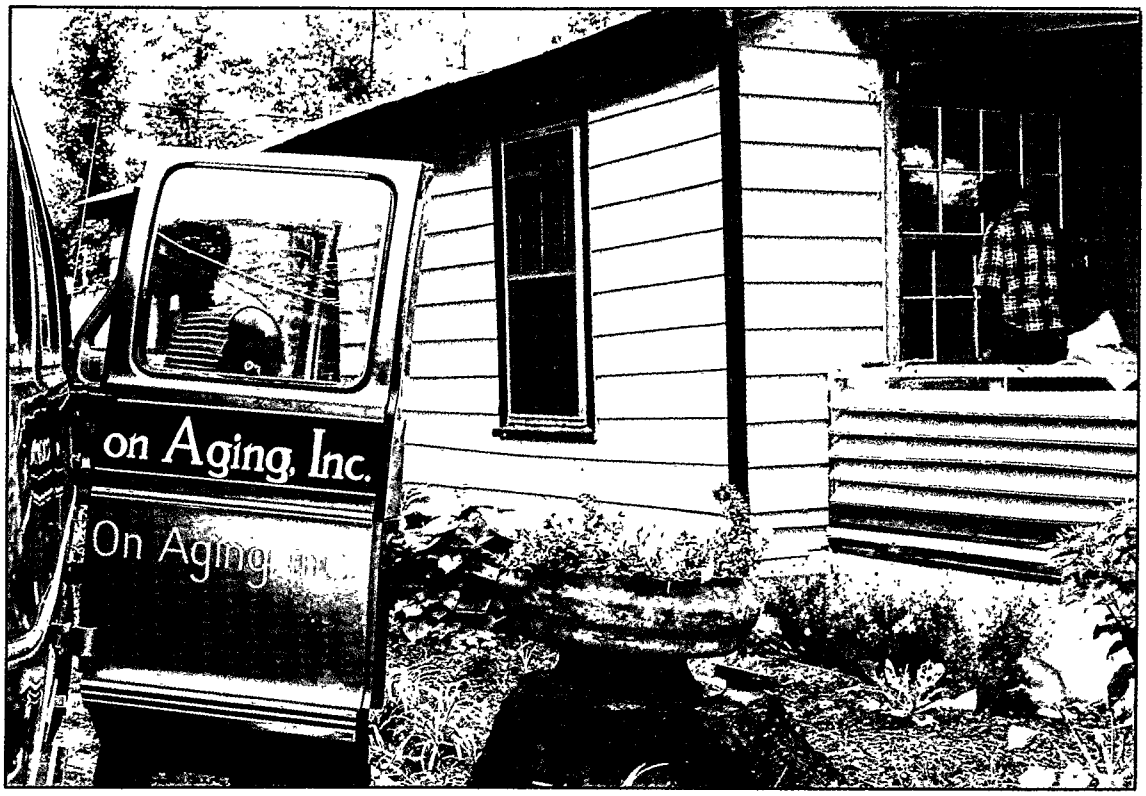
Courtesy Division of Aging

Due to the growing political power of the elderly, however, the AoA programs have survived, even in an era of federal budget cuts. As AoA funding has remained and other programs have been cut, the AAAs have become one of the main planning projects of the COGs.[3] While formally under the general guidance of the state Division of Aging, the AAA directors work closely with the regional council personnel and with contacts generated through the COGs. The AAAs contract services to all 100 counties. Every county has either a county government office of aging, a council on aging (usually a private, non-profit agency), or a designated "focal point" (such as a center for congregate meals).

These offices serve as the major county-level clearing house for services and information for the elderly. While not part of the "aging network," county departments of social services play a similar role for elderly persons who are poor. In addition, there are 90 senior centers in 68 counties around the state, usually part of either the county aging office or the council on aging. Finally, the AAAs contract with: 1) other county agencies, such as departments of social services and public health agencies; 2) private non-profit agencies that work with various groups, including the elderly, such as community action agencies and churches; and 3) other government agencies, such as community colleges. The AAAs might contract with only a handful or literally dozens of agencies in a single year. The Centralina AAA, for example, contracted with 21 service providers in 1984.

Each AAA develops a "blueprint for action," as Karen Buckle calls the area plan, which must comply with the Older Americans Act and be approved by the Division of Aging.[4] Within the limitations of the plan, the AAAs decide *what services* to fund, *who* should receive the funding (usually, a targeted group within the 60 and over population), and *what providers* to use.[5] The Centralina AAA's plan for 1985-86, for example, projects that AoA funds can provide transportation services to 400 elderly people and 26,000 units of service in Gaston County. (A unit of transportation is a one-way trip, such as home to the doctor's office.)

The area agencies serve multi-county areas, but each county will have different needs. The area agencies study the needs of each county,



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although the depth of a "needs assessment" varies widely among the AAAs. The assessments are supposed to serve as a basis for the services an AAA decides to provide to each county. Hence, the range of services vary not only from one AAA to another but among the counties in a single AAA as well.

Gaston and Mecklenburg counties, for example, provide different services with AoA funds, even though both counties are in the Centralina planning area. Both counties provide information and referral, transportation, chore services, home delivered meals, congregate meals, homemaker-home health aides, and senior center services. But only Gaston County provides counseling and case management services. Mecklenburg County, though, provides some home health, health screening, and legal services not available in Gaston County.[6]

The aging network has evolved over its 20-year life into a system that varies widely in quality, structures, and sense of purpose. One council of aging staff member describes her agency like this: "We live according to grant cycles. The director discovers that a proposal is due in three days, and everybody drops everything to get the proposal in. We never seem to develop a long-term mission." On the other hand, some AAAs and local service providers have excellent reputations throughout their communities—as places where an elderly person can go and get assistance regardless of the problem.

Within the aging network, how well can an elder find support, get regular hot meals, or learn about other services in the community? It depends upon the area, unfortunately. Moreover, the network implementing the Older Americans Act does not administer the three programs most important to elderly persons—Social Security, Medicare, and Medicaid. In addition, in FY 84, the Division of Social Services administered some $24 million in social services alone to older persons. The policy-making and reimbursement systems affecting the long-term care of elderly persons are spread among many federal, state, and local agencies. Only an exceptional office within this network could help guide an elderly person through the maze of agencies involved in formulating policy and delivering services to the elderly.

The following sections of this article, viewed together with Table 1, provide an overview of government services for elders: income, health, social services and nutrition, transportation, employment and training, and housing. While summarizing most programs that have large components for older persons, these sections focus on services targeted for the elderly and on state-level efforts.

Income Programs

Old Age Survivors and Disability Insurance (OASDI), commonly referred to as **Social Security**, provides retirement and disability benefits for insured workers and also provides benefits for survivors and dependents of insured workers. The amount received varies, based in part on contributions into the Social Security system (compulsory for each person and the person's employer, depending upon quarters of the year worked and amounts earned). The benefit amount also reflects a weighting in favor of the lower income earner in an effort to achieve some minimal standard of benefit. Over 93 percent of all individuals 65 years and older receive Social Security benefits. A person must be 62 to receive Social Security retirement benefits; a widow may receive survivor benefits at age 60. Between the ages of 62 and 70, a person who earns more than a specified amount will have benefits reduced proportionately. After age 70, a person can earn any amount and receive Social Security too. Income from savings and investments does not affect benefits.

In North Carolina last year, 537,552 people 62 and over received a monthly Social Security check that averaged $402. Put another way, the Social Security Administration pumped a total of $216.4 million *per month*—or almost *$2.6 billion a year*—into North Carolina's economy via Social Security checks just to persons over 62. (For *all* OASDI checks—to widows and children and for disability benefits—the figures jump to: 925,931 people receiving monthly checks averaging $359, or a total of $332.8 million per month and $4 billion a year.)

A second major income program is **Supplemental Security Income (SSI)**, which provides benefits over and above Social Security to people in need. To be eligible for SSI, a person must be 65 years or older, blind, or handicapped, in addition to having limited assets and income. The benefit level varies according to the income a person is already receiving. Hence, income above an allowable amount per month will reduce SSI benefits. To receive SSI, a person's monthly income must not exceed $345. The average SSI benefit in FY 84 was $178 per month; the maximum amount paid to a recipient was $325. In North Carolina in FY 84, 132,000 people received a total of $282.2 million in SSI payments. The U.S. Social Security Administration administers both Social Security and SSI, but SSI is paid for out of general revenues rather than from Social Security contributions. Amounts paid to recipients do not vary according to region of the country.

For more on income programs, see article on page 47.

Health

Medicare, a health insurance system sponsored by the federal government, has two parts. Part A is a free *hospital* insurance system for persons over 65 who are eligible for Social Security. It basically covers minimum costs for illnesses, very limited care for treatable conditions that require a skilled nursing facility, and

Table 1. Government Programs Targeted for the Elderly

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
I. INCOME			
Social Security (Old Age Survivors and Disability Insurance)	Retirement and disability benefits for insured workers and benefits for survivors and dependents of insured workers	U.S. Social Security Administration	40 branch offices in state
Supplemental Security Income	Provides benefits to individuals in financial need	U.S. Social Security Administration	40 branch offices in state

some types of home health services. Part B Medicare, a *voluntary medical* insurance system, is available to persons at age 65 for a $15.50 monthly premium (provided a person enrolls at age 65). Part B covers *physician services, hospital outpatient services, and other medical services and equipment.*

Nationally, the Social Security Administration has ultimate responsibility for administering Medicare, but the Health Care Financing Administration within the U.S. Department of Health and Human Services coordinates the reimbursement schedule. Each state has a designated agent to handle all claims and reimbursements. In North Carolina, there are two designated agents, Blue Cross and Blue Shield of N.C. for Part A and Prudential Medicare (a subsidiary of Prudential Insurance Company) for Part B. In North Carolina for FY 84, Blue Cross and Blue Shield paid $870.6 million for Part A reimbursements and Prudential paid $259.7 million for Part B. North Carolinians, meanwhile, paid $126 million in monthly premiums for Part B coverage.

Medicaid is a federally regulated medical assistance program for the poor. Federal, state, and local funds pay for Medicaid according to a formula established by Congress. Federal funds pay 66.4 percent of a state's total Medicaid appropriation; state and county funds pay the other 33.6 percent. Each year, the Division of Medical Assistance within the N.C. Department of Human Resources estimates what each aspect of the program—from nursing home care to prescription drugs—will cost. Then, the General Assembly establishes the amount for the whole Medicaid program, according to projected costs. In FY 84, the total Medicaid expenditure in North Carolina was $648 million; $242 million, or 37 percent, went to people 65 and over. Of the portion going to older persons, $199 million went for institutional care.

Federal law mandates that Medicaid cover some services, such as hospital care; states may choose to cover other services. North Carolina, for example, decided to cover, in addition to standard medical care, some dental services.

Courtesy Mayview Convalescent Home

A group of older persons at the N.C. State Fair.

Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
Retirement: age 62 and over	Worker and employer contribute to programs	$0	$2,596	$0	$2,596	42 USC 402
Other OASDI: varies		$0	$3,994 (all OASDI)	$0	$3,994 (all OASDI)	
65 and over, blind, or disabled *and* must meet a means test	None	$0	$282	$0	$282	42 USC 1382(e)

table continued page 18

Medicaid is known as an "entitlement" program. That is, once persons are determined eligible for Medicaid through a county Department of Social Services, then they are guaranteed all the services approved for Medicaid. Persons become eligible for Medicaid by being classified either "categorically needy" or "medically needy."

In most states, a person who either receives or would be eligible for a cash assistance program—Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI)—is "categorically" eligible for Medicaid. North Carolina, however, has chosen *not* to follow this method for determining which elders are categorically needy but has instead adopted income guidelines that are *more restrictive* than those for SSI. To receive SSI, a person's monthly income may not exceed $345. To be categorically needy for Medicaid in North Carolina, a person over 65 must either receive or be eligible for SSI or AFDC. In addition, the person's monthly income—not counting SSI benefits—may not exceed $200.

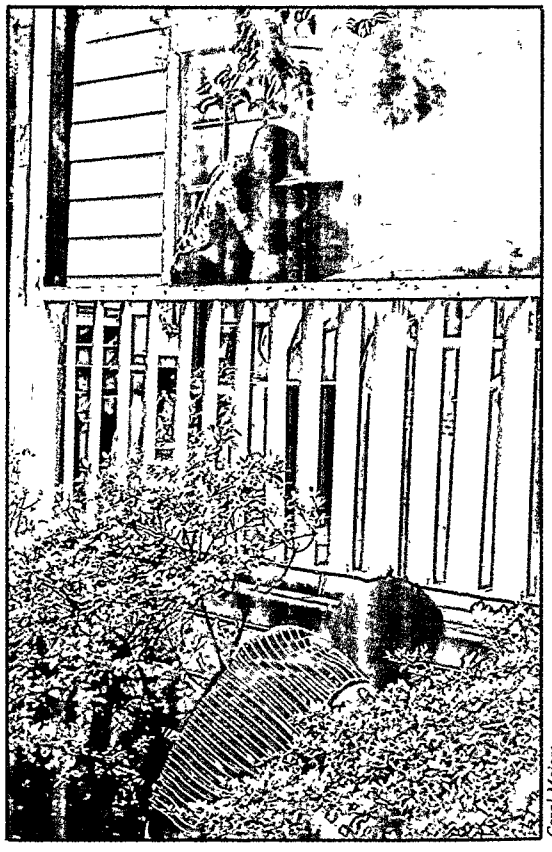
To qualify for Medicaid as "medically needy," a person must have medical expenses sufficient to reduce one's disposable income to $200 per month. This process is called "spending down." For example, if a person (elderly or not), has a monthly income of $500 and monthly medical bills of over $300, that person *would not* qualify for a cash assistance program but *would* qualify for Medicaid through the "medically needy" category. The elder would pay for the first $300 of medical bills; Medicaid would pay for the rest.

A state may choose whether to certify people eligible for Medicaid under this category, as North Carolina has done. The policy to make benefits available to the "medically needy" category is what makes Medicaid so valuable to older adults in North Carolina. Between Social Security and SSI, not many elders are categorically needy, yet many have such high medical bills that they would be wiped out financially without Medicaid. While $200 a month is hardly enough to live on under any circumstances, at least an older person's resources are not totally wiped out by medical bills, such as care in a nursing home. In FY 84, of the $199 million in Medicaid reimbursements that went to older persons for institutional care, $167 went to nursing homes.[7]

Medicare and Medicaid are reimbursement systems, providing payment to providers for services rendered—to hospitals, doctors, nursing homes, home health agencies, pharmacists, etc. Several smaller but important government reimbursement systems—together with Medicare, Medicaid, individuals' resources, and some private insurance plans—pay for health care through what has come to be called the "long-term care continuum." Generally, this continuum refers to health care systems and health-related programs from the most restrictive to the least restrictive setting. The major points on the continuum are hospitals, nursing homes, domiciliary care homes, retirement villages, community care systems, and in-home services.(See the article on page 60 for more on the long-term care issue.)

Dividing government programs into "health" and "social services and nutrition" categories (as this article does) is somewhat artificial, when viewed from the perspective of a long-term care continuum. For example, chore and homemaker services are more social services than health programs. Yet without chore workers, far more elders would enter the traditional health care system—nursing homes and hospitals. Moreover, programs such as home-health aides and home health provide similar services but are classified as health or as social services, depending upon the administrative system employed. Some of the services described in the rest of this health section and in the social services section, which follows, should be

Home maintenance program at work.



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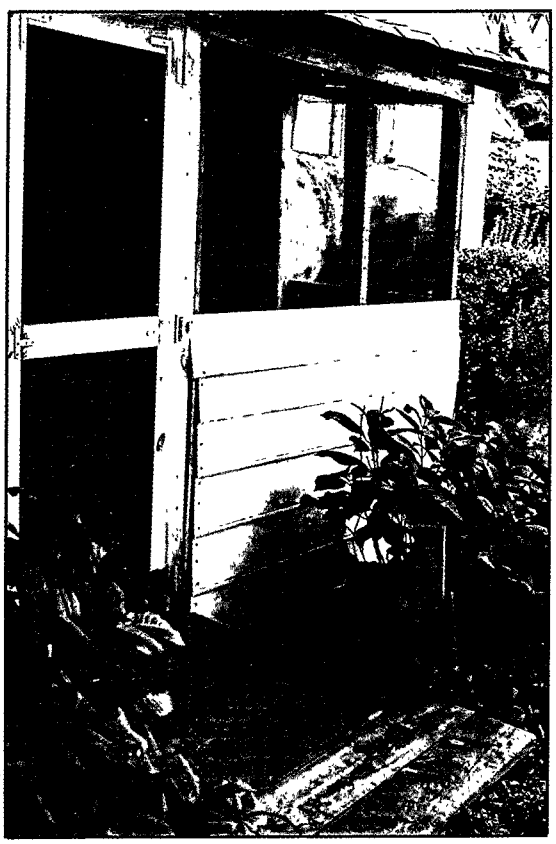
viewed together—as part of the long-term care continuum.

North Carolina **State-County Special Assistance for Adults** (called Special Assistance for short) assists needy persons 65 years or older, blind, or disabled. This program is mandatory for persons who were eligible for the now defunct federal program called "aid to the aged, blind, and disabled." For other persons, the program varies from state to state (and the amount of assistance for all persons varies among the states). In North Carolina, by far the largest portion of this program goes to pay for domiciliary care for older persons.

"Domiciliary" care refers to three basic types of rest homes: family care homes (up to six persons per home); homes for aged and disabled (usually 60 to 80 persons); and group homes for developmentally disabled persons (up to nine persons). In FY 84, $31.6 million went to persons qualifying for this program. The state paid 70 percent of the cost, the counties 30 percent; beginning in FY 85, the funding portions will go to a 50-50 arrangement. The Division of Social Services within the Department of Human Resources administers this program through the county departments of social services (DSS).

New ramp allows easier access for homebound.



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Social workers in county DSS offices determine eligibility using a means test for persons 65 and over. Some disabled persons over age 18 can also qualify. In FY 84, an average of 11,184 elderly persons in domiciliary homes received Special Assistance; only 154 disabled persons received Special Assistance. For FY 86, the Division of Social Services anticipates a case load of 12,127 older persons qualifying for this program, at a cost of $36.8 million.

The General Assembly determines the payment level for Special Assistance. Last year, a rest home got $565 per month for an ambulatory person who qualified for Special Assistance ($594 per month for a semi- or non-ambulatory person). Older persons may pay some portion of this $565 or $594, depending primarily upon their monthly income, as determined by the county DSS.

The state and the Older Americans Act fund **home health services** through the divisions of Aging and Health Services. (Medicare and Medicaid also pay for many types of home health services, under the administrative systems described above.) The AoA funds allow area agencies on aging to allocate funds to home health programs in a county, depending on the needs assessments (see discussion on needs assessments on page 13). For example, the Triangle J Council of Governments has contracted with the Orange County Department of Aging to provide home health services. But other counties may not have a home health program funded with AoA funds. Home health services go to all ages, but AoA funds may be used only for persons 60 and over; there is a fee, which varies according to income.

In addition to the AoA-funded home health program administered through the Division of Aging, the state since 1979 has funded home health services through the Division of Health Services, also in the Department of Human Resources. These funds, totaling $1.5 million in FY 84, went to public health departments and private home health agencies throughout the state, providing free services to a person with an income below $6,225 ($8,400 for a two-person family, $12,750 for a family of four). These income levels were 125 percent of the federal poverty thresholds.[8] A person might receive free services with higher incomes as well (125 to 199 percent of the federal poverty level), depending upon the service, the amount of funds available to the public health department or private agency delivering the service, and other mitigating circumstances. A three-person staff within the Division of Health Services administers this program.

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Table 1. Government Programs Targeted for the Elderly, cont'd.

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
II. HEALTH			
Medicare:	Health insurance system.	U.S. Social Security Administration and Health Care Financing Administration	Doctors, hospitals, and other medical services qualified under state and federal standards
Part A	Covers some hospital, skilled nursing facility, and home health costs	Blue Cross and Blue Shield of N.C.	
Part B	Covers physician costs, hospital outpatient services, and other medical treatments	Prudential Medicare	
Medicaid	Provides medical assistance for the poor	Health Care Financing Administration; N.C. Division of Medical Assistance; eligibility by county DSS offices	Doctors, hospitals and other medical services qualified under state and federal standards
N.C. State-County Special Assistance for Adults	Provides benefits to individuals in need of rest home care and who are financially needy	Division of Social Services	County DSS offices
Home Health	Provides physical and speech therapy, routine nursing care, and other health-related services	Divisions of Aging and Health Services	County aging office, council on aging, non-profit organization, or public health department
Comprehensive Screening	Determine where person might best meet health and social needs	Division of Social Services	Lead agency designated at county level
Health Screening	Detect medical problems in early stages	Division of Aging	County aging office, council on aging, or non-profit organization
Long-Term Care Ombudsman	Monitors nursing home and rest home issues	Division of Aging	Ombudsman based in area agency on aging
Health Support	Finding and using appropriate medical care, including nursing homes	Division of Social Services	County DSS offices

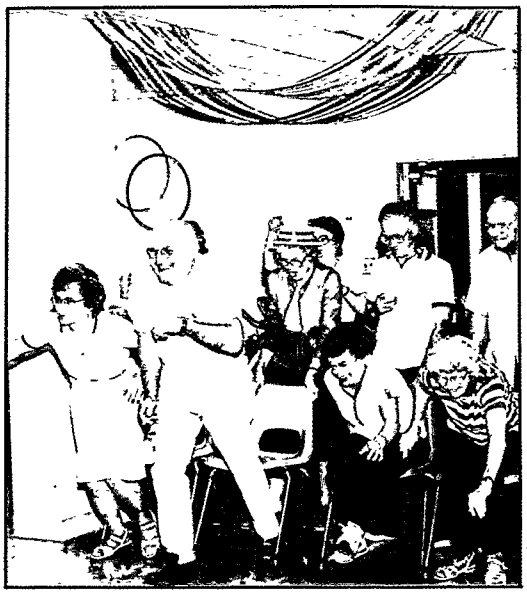
Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
65 and over						Title XVIII, Social Security Act:
	None	$0	$871	$0	$871	42 USC 1395c-e
	$15.50 monthly premium	$0	$260	$0	$260	42 USC 1395j-xx
Based on need	None	$168	$426	$54	$648	Title XIX, Social Security Act: 42 USC 1396 et seq.
		(*all* Medicaid payments)				
		$62	$161	$18	$242	NCGS 108A, Article 2, Part 6
		(65 and over payments)				
65 and over, blind, or disabled *and* must meet a means test	None	$22.1	$0	$9.5	$31.6	NCGS Chap. 108A, Article 2, Part 3
60 and over	Fee, sliding according to income	Aging: Title IIIB funds (see Table 2)				42 USC 255; see also, Home
		Health Services:				
		$1.5	$0	$0	$1.5	Agency Licensure Act, NCGS 131E-135 et seq.
Need for service	None or fee	$0	$.5	$0	$.5	NCGS 143B-181.6
60 and over	None	Title IIIB funds (see Table 2)				42 USC 3027(a)(12); NCGS 131E-128
—	None	$.02	$.20	$.03	$.25	42 USC 1397 et seq.
60 and over; means test	None	$0	$1.0	$.3	$1.3	42 USC 1397 et seq.

table continued page 22

Another relatively recent program that affects the long-term care continuum is the **comprehensive screening** program administered by the Division of Social Services. Some 25 counties are now participating in this program, which is designed to help determine where elders might best get their social and health needs met—in a nursing home or through some system of community or in-home services. This is part of a larger and complicated program often referred to as the Medicaid waiver or Community Alternatives Program (for more on this, see page 70).

The Division of Aging administers a **health screening** program through the aging network. This screening attempts to detect medical problems in the early stages before serious problems develop.

Finally, in the health area, the area agencies on aging designate a staff person to spend some portion of his or her time as a **long-term care ombudsman**. These ombudsmen, together with committees established by statute and appointed by the county commissioners at the local level, try to monitor and resolve problems between patients, their families, and the administrators of nursing and domiciliary homes.



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Fourth of July festivities at the Whitaker Mill Senior Center in Raleigh.

Social Services and Nutrition

While the federal government plays the lead role in many income and health programs for the elderly, the state takes the lead in administering most social service and nutrition programs. The Division of Aging, through the network discussed above, and the Division of Social Services administer these programs, which can be grouped into four general categories: in-home services, other social services, access to services, and nutrition (see Table 1).

In-home Services. These services are designed to help older persons remain in their own homes and carry out activities of daily living. **Chore services** provides elders with personal care and home management assistance. **Home maintenance** helps older persons with minor home repairs, which includes some weatherization efforts. The **homemaker-home health aide** programs provide social workers or nursing assistants to cook meals or help with routine health maintenance for homebound persons aged 60 or over (there's a fee for this program, which slides upward according to a person's income). Both the aging network and county departments of social services (DSS) provide these services.

Services available only through the aging network include **in-home security** and **companionship** programs. In-home security provides a daily check for an elderly person at home alone and concerned about possible medical difficulties; the check usually comes through a telephone network or a postal safety check. Through the **companionship program**, groups such as Adopt-A-Grandparent visit elderly persons on a regular basis. (These visits might go beyond the home to a hospital, nursing home, or rest home.)

The county DSS offices administer a major low-income **energy assistance** program, providing free home-heating fuel during the winter months. In FY 84, this program provided fuel costing $10.3 million to persons 60 and over, all with federal funds. (Another $15.8 million went to persons under age 60.) The county DSS offices also distributed over $900,000 in weatherization funds to persons over age 60.

Other Social Services. Services outside the home are also available to older persons. The 90 **senior centers** across the state offer a wide range of recreational and educational activities. At the Gaston County senior center and the Whitaker Mill Road Senior Center in Raleigh (centers visited in researching this article), scores of elders work with ceramics and quilts, play ping pong and croquet, take field trips to outdoor

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dramas, and organize holiday parties. At the Whitaker Mill center, a clutter of scenery from a play the regulars had just put on blocked the path into the browsing library, composed of books on loan from the public library system.

Another kind of facility emphasizes care for persons who are more dependent—**adult day care centers**. These centers are designed to serve elderly persons who no longer can take care of themselves—where safety, for example, is a concern—but who are not bedridden, do not need to be in a nursing home, and have someone to care for them at night. The Division of Social Services certifies these centers. Certification is voluntary, but a center must be certified to receive state funds. Currently, there are 40 certified adult day care centers in the state. They receive funds from five sources: the federal Social Services Block Grant, state in-home service funds, state adult day care funds, private contributions (United Way, etc.), and fees (on a sliding scale).

County DSS offices also administer a **foster care** program for older persons. In FY 84, the DSS offices spent $1.3 million on this program, which helped elders find appropriate rest home care and monitored the compliance of rest homes with licensure standards.

Another kind of social service is **protective services**, administered through the county DSS offices. Under this program, local DSS offices work to provide help to elderly or disabled persons who are abused, neglected, or exploited. Last year, some 4,000 cases of abuse were reported to DSS offices. These included "self" abuse, such as when a very old person was not eating properly. Where a DSS office believes criminal abuse might be involved, the office reports the case to the local district attorney.

Finally, DSS offices and the aging network provide **counseling**, helping older persons with a variety of problems. The aging network also provides some basic **legal services** (contributions are requested from clients).

Access to Services. Older persons and their families can usually find out which programs exist in their county through their local council on aging, county office on aging, or the county DSS office. Many of these offices have a formal **information and referral** service available. Some have a case management service, which can help an elderly person identify the specific services in the county he or she needs. A case manager might also serve as an advocate for a person if problems concerning these services develop. Finally, the aging network sponsors an **outreach**

program in many areas in an effort to link hard-to-reach older adults with services in the community.

Funds for all the social service programs provided through the aging network come primarily from Title IIIB of the Older Americans Act. Other funds also come into the aging network, such as weatherization grants from the Energy Division of the Department of Commerce, the state in-home service fund, and contributions from private agencies such as the United Way. The state Division of Social Services distributes funds for social service programs to county departments of social services. These DSS funds come primarily from the federal Social Services Block Grant (Title XX), the state in-home fund, and the adult day care fund. County DSS offices might also get funds from the United Way and other public and private sources.

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Nutrition. There are basically three kinds of food programs utilized by elders: group/congregate meals outside the home, in-home meals, and food stamps. **Group/congregate meals** are

Table 1. Government Programs Targeted for the Elderly, cont'd.

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
III. SOCIAL SERVICES and NUTRITION			
A. *In-Home Services*			
Chore Services	Provides assistance with personal care and home management	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency; County DSS
Home Maintenance	Provides minor home repairs	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency; County DSS
Homemaker-Home Health Aide	Provides personal care, nutrition, and home management services	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency; County DSS
In-Home Companion-ship	Provides regular visits by volunteers such as Adopt-a-Grandparent or Friendly Visiting	Division of Aging	County aging office, council on aging, or non-profit organization
In-Home Security	Provides telephone reassurance and postal alert safety checks	Division of Aging	County aging office, council on aging, or non-profit organization
Energy Assistance	Provides home-heating fuel during winter months and funds for cooling in summer for those with special needs	Division of Social Services	Lead agency determined through county DSS offices

provided only through the AoA aging network. In FY 84, more than $7 million in AoA funds alone went to meals for persons 60 and over in designated sites in a county, often at the senior center. This program provides not only a hot, nutritional meal but also a setting for fellowship.

Both the aging network and the county DSS offices fund **in-home meals**. In many cases, private non-profit organizations such as community action agencies (or restaurants, in a few instances) actually operate the in-home meals programs, often using both AoA and DSS funds. In-home meals are available to those over 60 who are medically homebound and have no one to prepare their meals. Hot meals are delivered once a day, often by volunteers working with the community agency that has the contract for this service. Under DSS administration, certified persons may receive home-delivered meals free, while others pay a sliding-scale fee.

In the aging network, contributions are suggested for these two meal programs. In the Centralina area last year, contributions covered 13 percent of group meals ($195,920 of the total cost of $1,399,861) and 8 percent of in-home meals ($49,830 of $598,933).

The other major nutrition program used by elderly persons is **food stamps**, a federal program under the U.S. Department of Agriculture. In North Carolina, the Division of Social Services administers the program statewide through county DSS offices. North Carolina began participating in the program in 1974, 10 years after it was established by Congress.

Persons qualify for food stamps through a two-step test: a resource and an income test. First, a person over age 60 may not have more than $3,000 in reserve funds (a one-person

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Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
60 and over; means test (DSS only)	Contribution suggested (Aging); None or sliding scale (DSS)	Aging: See Table 2, IIIB fund Social Services: $3.2	$5.1	$1.3	$9.6	42 USC 3026(a)(2)(B); 42 USC 1397 et seq.
60 and over; means test (DSS)	Contribution suggested (Aging); None or sliding scale (DSS)	Aging: See Table 2, Title IIIB fund Social Services: $.05	$.04	$.01	$.1	same as above
60 and over; means test (DSS)	None or sliding scale	Aging: See Table 2, Title IIIB fund Social Services: $.9	$3.5	$.7	$5.1	same as above
60 and over	None	See Table 2, Title IIIB fund				42 USC 3026(a)(2)(B)
60 and over; live alone or couple with medical problems	None	See Table 2, Title IIIB fund				42 USC 3026(a)(2)(B)
Means test	None or sliding scale	$0	$10.3	$0	$10.3	42 USC 8601 et seq.

III. SOCIAL SERVICES and NUTRITION, cont'd.

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
B. *Other Social Services*			
Senior Centers	Provides a variety of educational, social, and recreational activities	Division of Aging	Senior Centers
Adult Day Care	Provide a day-care setting for older adults	Division of Social Services	County DSS offices and private agencies
Adult Foster Care	Find appropriate rest home care and monitor compliance with licensure standards	Division of Social Services	County DSS offices
Adult Protective Services	Means of providing help to elderly or disabled adults who are abused, neglected, or exploited	Division of Social Services	County DSS offices
Counseling	Counsel persons on various problems	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency, county DSS offices
Legal	Provides legal assistance	Division of Aging	County aging office, council on aging, or non-profit organization
C. *Access to Services*			
Information and Referral	Provides information by telephone or visit	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency, county DSS offices
Outreach	Links hard-to-reach older adults with services in the community	Division of Aging	County aging office, council on aging, or non-profit organization
D. *Nutrition*			
Meals: Group/ Congregate	Provides meals in group settings at designated community sites	Division of Aging	County aging office, council on aging, or non-profit organization
Meals: In-Home	Provides hot meals for homebound persons	Divisions of Aging and Social Services	County aging office, council on aging, non-profit agency, county DSS offices
Food Stamps	Supplements low-income households ability to buy food	Division of Social Services	County DSS offices

Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
60 and over	None	See Table 2, Title IIIB fund				42 USC 3026(a)(1)
Means test	None or sliding fee	$.1	$.8	$.2	$1.1	42 USC 1397 et seq.
Need for service	None	NA	$1.0	$.3	$1.3	42 USC 1397 et seq. NCGS 131D-2
Need for service	None	NA	$1.1	$.4	$1.5	NCGS 108A, Article 6
60 and over; means test (DSS)	None	Aging: See Table 2, Title IIIB fund Social Services: NA	$1.4	$.5	$1.9	42 USC 3030d(a)(6), (9), and (12) 42 USC 1397 et seq.
60 and over	Contribution suggested	See Table 2, Title IIIB fund				42 USC 3026(a)(2)(C)
60 and over	None	Aging: See Table 2, Title IIIB fund Social Services: NA				42 USC 3026(a)(2)(A)
60 and over	None	See Table 2, Title IIIB fund				42 USC 3026(a)(5)(B)
60 and over	Contribution suggested	See Table 2, Title IIIC				42 USC 3027(a)(13)(A)
60 and over; Medically home-bound with no one	Contribution suggested (Aging); none or sliding fee (DSS)	Aging: See Table 2, Title IIIC Social Services: $.2	$.1	$.1	$.4	42 USC 1397 et seq.
Means test	None	$.2	$2.4	$2.3	$4.9	7 USC 2011 et seq. NCGS Chap. 108A, Article 2, Part 5

Courtesy Division of Aging

The opening ceremony for the Senior Center in Benson, N.C.

household); the figure is $1,500 for anyone younger than 60. The requirements in the second step, the income test, also differ for persons over age 60. Elderly persons must meet only a *net income* test, $415 for one person or $560 for a couple, per month. (The general population must meet a *gross* and a *net* income test.) The amount of food stamps a person may receive per month varies by income, but cannot exceed $79 per month, per person.

Transportation

Government funds help elderly persons get around in two ways. First, the aging network and county DDS offices administer **individual pick-ups** and **group trips** for persons aged 60 and over. The individual pick-ups are designed to provide transportation for elders to nutritional, health care, shopping, and recreational services. In theory, persons must make reservations with the council on aging or county office. Volunteers usually pick up the riders, helping them to and from the car if necessary. Some AoA-funded programs also offer group trips with vans.

The N.C. Department of Transportation (DOT) administers another type of program targeted specifically for elderly and disabled persons, known as the **section 16(b)(2) program**. A federal mass transit program, section 16(b)(2) funds are distributed by the State Board of Transportation through a grant system, usually following DOT staff recommendations. In FY 85, $804,825 went to 19 agencies; of this, $643,860 (80 percent) was in federal funds and $160,965 was in state and local funds (10 percent each). These funds are available only for capital assistance, primarily for purchasing vehicles. In the ten-year life of the program, section 16(b)(2) funds have paid for some 550 vehicles used in almost every North Carolina county. Grantees, which must be private, nonprofit agencies and be considered a "lead" agency for this grant, often share the vehicles with other groups. In 1984-85, grants went to such groups as the Johnston County Council on Aging ($60,900 for four, 15-person vans) and the Caswell County Council on Aging ($15,255 for one van). The local councils on aging are an important component of most coordinated transportation systems receiving these 16(b)(2) funds, and hence benefit from these funds even if they are not a direct recipient of a grant.

Table 1. Government Programs Targeted for the Elderly, cont'd.

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
IV. TRANSPORTATION			
Individual pick-up	Provides transportation to grocery stores, doctors' offices, and government agencies	Divisions of Aging and Social Services	County aging office, council on aging, nonprofit agency, county DSS offices
Group trips (vans, etc.)	Provides transportation for groups	Division of Aging	County aging office, council on aging, nonprofit agency, county DSS office
Capital purchases (vans, etc.)	Provide vehicles for group trips for elderly and handicapped	Division of Transportation	Lead agency at local level, as designated by DOT

Employment and Training

Two federal employment and training programs assist persons over age 55 who need and want to work: **Title V of the Older Americans Act** and the **Job Training Partnership Act (JTPA) "set-aside"**. Most of the Title V funds, which total $317 million nationally, go for salaries and wages. The JTPA set-aside for persons over 55, some $56 million nationwide, goes primarily for job training. In FY 85, North Carolina received $1.7 million in Title V funds and $1.3 million in JTPA funds targeted for persons over 55. To qualify for either program, a person must be at or near the poverty level ($5,250 for an individual or $7,050 for a family of two).

Title V, by design, is a subsidized, community service jobs program. The U.S. Department of Labor has overall administrative responsibility for the program. At the state level, the governors designate the administrative agent for about 20 percent of the funds; in North Carolina, that designee is the Division of Aging. The other 80 percent of the funds go to the states through six national contractors, distributed in North Carolina according to a formula worked out by the Division of Aging.[9]

Title V placements must be in the public or private non-profit sectors. Many placements are made at senior centers, thus helping to support the aging network. The Title V positions are designed to encourage the transition of older workers to the unsubsidized job market and to provide part-time employment to low-income older persons. People paid with Title V funds are paid minimum wage or slightly higher, get a free annual physical exam, and have the flexibility of part-time work.

The Job Training Partnership Act, the federal manpower act that in 1983 replaced CETA (Comprehensive Employment and Training Act), includes a **3 percent "set-aside"** designated for persons over 55. The Department of Natural Resources and Community Development administers the entire JTPA program, through the Division of Employment and Training and the Job Training Coordinating Council (see Table 3 for more on this group). At the local level, "private industry councils" or PICs approve how the funds should be spent, according to a complex system of service delivery areas—11 in urban regions and a 12th covering the rest of the state through the COG network.

For more on these programs and other employment issues, see article on page 42.

Housing

Housing for the elderly is primarily a federal effort through the U.S. Department of Housing and Urban Development (HUD) and the Farmers Home Administration. Farmers Home provides **grants in rural areas** to low-income persons 62 or over. These grants, available by application through the Farmers Home office in each county, are for home repairs and improvements.

Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
60 years and over; No one available to provide transportation	Contribution suggested (Aging): none or sliding scale (DSS)	Aging: see Table 2, Title IIIB fund Social Services; NA	$.7	$.2	$.9	42 USC 3026(a)(2)(A) 42 USC 1397 et seq.
60 years and over; No one available to provide transportation	Contribution suggested	See Table 2, Title IIIB fund				
60 years and over; disabled persons	None	$.08	$.64	$.08	$.8	Section 16(b)(2), Urban Mass Transportation Act of 1964, as amended, 49 USC 1612

Over the years, HUD has provided a variety of **rent subsidies** to elders through its **Section 8** program. Many of these programs were reduced in the first round of federal budget cuts under the Reagan administration.[10] In FY 84, only $2.2 million in "new" Section 8 money came into North Carolina, all of it in conjunction with HUD's **Section 202** program. Under Section 202, which is restricted to elderly and handicapped persons, HUD provides approved non-profit borrowers money at below-market interest rates. The owners of the completed projects receive Section 8 rent subsidies according to the income levels of the elderly tenants. Under Section 8, elderly persons can pay no more than 30 percent of their incomes for rent. The $2.2 million in Section 8 subsidies for FY 84 were approved for 21 projects with 476 housing units.

Section 8 funds continue to come into North Carolina over the life of housing projects approved in past years, but tabulations of the amount of such "old" Section 8 funds are not available from HUD.

Conclusion

In highlighting the programs most important for elders, the wide variations in standards, procedures, reimbursement systems, and administrative structures become clear. But the variations grow even larger when discussing *all* government programs that benefit older persons. Some programs not discussed here cost the state substantial sums.

The state Division of Mental Health, Mental Retardation, and Substance Abuse Services, for example, in FY 84 spent $29.7 million on persons 60 and over—$22 million for care in mental hospitals and special care centers and

Table 1. Government Programs Targeted for the Elderly, cont'd.

Service	Purpose	Agency Responsible for Program in N.C.	Service Provider
V. EMPLOYMENT and TRAINING			
Job Training and Partnership Act (3 percent set-aside)	Provides job training for elderly persons	Department of Natural Resources and Community Development	Private employers
Senior Community Service Employment Program (Title V of Older Americans Act)	Provides elderly with access to employers and opportunities for community service	Division of Aging	County aging office, council on aging, or non-profit organization
VI. HOUSING			
Rural	Grants to low-income elderly home owners for home improvements	U.S. Farmers Home Administration	County FHA office
Rent Subsidies	Provides housing assistance for low-income elderly	U.S. Department of Housing and Urban Development	Non-profit group developing housing project

Note: Table 1 summarizes the major government programs targeted for older persons. The general authority for the N.C. Division of Aging is provided in NCGS Chapter 143B, Article 3, Part 14, especially at NCGS 143B-181.1. The N.C. Division of Social Service receives its funds and statutory authority for social services from various sources, especially NCGS Chapter 108A and the federal Social Services Block Grant. The term "means test" refers to the maximum income a client could receive to be eligible for a program. Means tests are used particularly by the Division of Social Services to determine eligibility for programs.

$7.7 million in community programs.[11] Older persons received four types of tax breaks, including the "homestead" exemption (a reduction in property taxes) and a "double" exemption on the state personal income tax. Together, the four cost the state some $41.1 million per year (see article on page 55 for more).

The administrative systems that focus on elderly persons are constantly evolving. The Division of Aging, for example, has begun to focus its planning process according to whether the persons served through the aging network are well, moderately well, or frail. For the upcoming fiscal year, 9 of the 18 AAAs targeted the services in their annual plans according to these three levels of health. By July 1986, all 18 AAAs will use this planning process.

Similarly, the Division of Social Services is taking a close look at the administration of the State-County Special Assistance program, which helps pay for care in domiciliary homes. The population groups in domiciliary homes are sicker than in previous years because changes in Medicare reimbursement procedures seem to be pushing people out of hospitals sooner (see page 67 for more on this issue). The result is that county departments of social services are getting more involved in the health delivery system. The Division of Medical Assistance is having to cope with this and other health issues, as the article on page 60 explains.

While Table 1 contains a lot of information, it also suggests many unanswered questions. For example, is the role of government properly balanced between those who are poor and those who have money? Are services designed more for those who have their health or for those who are no longer independent?

Eligibility	Cost to Client	Expenditures in N.C. (FY 84, in millions) State	Federal	Other	Total	Citation
60 and over; Income restrictions	None	$0	$1.3	$0	$1.3	29 USC 1501 et seq.
55 and over; Income restrictions vary by county	None	$0	$1.7	$0	$1.7	42 USC 3056 et seq.
62 and over; Income restrictions	None	$0	$.9	$0	$.9	42 USC 1474 et seq.
62 and over; Income restrictions	None	$0	$2.2	$0	$2.2	Housing Act of 1959, as amended: Section 202, 12 USC 1701q; and Section 8, 42 USC 1437 et seq.

Table prepared by Cynthia Lambert, Bill Finger, Ran Coble, and Jody George of the N.C. Center for Public Policy Research.

Table 2. Older Americans Act Expenditures, by Title and Program (FY 84)

Title	Program	Expenditures (in thousands) State	Federal	Local[1]	Total
Title I A	State Administration	$ 85	$ 1,277	$ 341	$ 1,703
Title III B	Social Services[2]	$405	$ 6,892	$ 811	$ 8,108
Title III C	Nutrition				
subpart (1)	Congregate Meals	$389	$ 6,616	$ 778	$ 7,783
subpart (2)	In-Home Meals	$ 81	$ 1,385	$ 163	$ 1,629
Title IV	Training, Research, and Discretionary Projects and Programs	$ 0	$ 77	$ 0	$ 77
Title V	Senior Community Service Employment Program	$ 0	$ 1,589	$ 178	$ 1,767
Totals		$960	$17,836	$2,271	$21,067

FOOTNOTES

[1] The funds shown in this column represent matching amounts mandated by the Older Americans Act. In addition, local service providers in the aging network receive U.S. Department of Agriculture payments of 55.6 cents per meal for group and in-home meals, contributions from clients. and other miscellaneous donations.

[2] Social services include health screening, home health, chore services, home maintenance, homemaker-home health aide, information and referral, companionship, in-home security, counseling, legal services, outreach, transportation, and senior centers. Title III funds are allocated to each area agency on a formula basis; each area agency then awards contracts for services to sub-grantees. The sub-grantees, such as councils on aging and private non-profit groups, actually divide these funds among particular services. To determine total funds spent throughout North Carolina for a specific service, a researcher would have to contact all sub-grantees individually.

Source: N.C. Department of Human Resources, Division of Budget and Analysis.

If this article has provided a useful overview of current programs and services for the elderly, then the articles that follow—on income programs, employment, tax breaks, and health issues—will attempt to tackle the larger policy issues that lie ahead. □

FOOTNOTES

[1]42 U.S. Code 3025.

[2]Jones C. Abernethy III, "Con: Time for a Change," included in a three-part section called "Regionalism in North Carolina—What Course for the Future?," *North Carolina Insight*, October 1984 (Vol. 7, No. 2), p. 43. Jonathan B. Howes and Bradley S. Barker presented the case supporting COGs, "Pro: An Effective Resource."

[3]In 1974, Governor James E. Holshouser Jr. initiated a state-local counterpart to the Nixon administration's New Federalism and delegated planning authority for five major programs to the lead regional organizations (manpower; child development; family planning; food programs for women, infants, and children; and services to the aging). By 1983, of those five programs, all 18 regional councils were still administering only the AoA programs. (The 18 councils still do planning for the current manpower program, the Job Training Partnership Act.)

[4]42 U.S. Code 3026.

[5]An AAA plan must include the number of persons to be served, the number of units of service, and the definition of the various units of service for each county that receives funds from the AAA. In addition, the area plan—which must be approved by the Division of Aging—includes statements on accomplishments and initiatives to be undertaken in the next five years.

[6]To determine how to target services within a county, an AAA must first conduct a needs assessment of each county and consider what services are already being provided in that county (through private agencies, etc.). An AAA then attempts to provide those services most needed. If for example, the needs assessment shows that counseling is needed in Mecklenburg and Gaston counties but that another organization is already providing counseling in Mecklenburg, then the AAA would provide only limited funds to Gaston County.

[7]The other Medicaid funds for institutional care for persons 65 or older were: mental retardation ($2 million), mental hospitals ($6 million), and general hospitals ($24 million). In addition, a portion of the following costs went for institutional care: drugs ($19 million), doctors ($5 million), outpatient services ($2 million), dental ($1 million), and administration ($36 million). The Division of Medical Assistance does not break down these costs according to location of care.

[8]The Division of Health Services was using the federal poverty standards set prior to the beginning of the state FY 84-85. Beginning July 1, 1985, the division began using the current federal poverty thresholds: $5,250 (family of one), $7,050 (family of two), and $10,650 (family of four).

[9]The six contractors are: Green Thumb, National Council on Aging, National Center on the Black Aged, U.S. Forest Service, National Urban League, and the National Council of Senior Citizens.

[10]See Priscilla Cobb, "Cutbacks in Federal Housing Programs," *North Carolina Insight*, Vol. 5, No. 2, August 1982, p. 27.

[11]Only one of the 14 mental hospitals, mental retardation facilities, and other special care centers has a specific emphasis on older persons—the North Carolina Special Care Center in Wilson. Formerly a tuberculosis sanitorium, this center includes mostly psychiatric patients who have grown old in this institutional system.

Table 3. Executive Branch Boards, Commissions, and Councils Serving Older Persons

Board, Commission, or Council	Established by	Purpose	Members, Appointed by	N.C. Department where Group is Housed
1. Governor's Advisory Council on Aging	NCGS 143B-181	To review existing programs and make recommendations to the Secretary of the Department to improve services to the elderly and to promote public understanding of problems of the aging through information exchange.	29-Governor 2-Lt. Governor 2-House Speaker 33-Total	Human Resources
2. State Health Coordinating Council	PL 93-641, Sec. 1524(a); Executive Orders #19,6/76; #91,2/83; and #13, 6/85	To advise the Department of Human Resources on issues related to state health needs including the development of a yearly medical plan that includes planning for long-term care and services.	25-Governor 1-Ex-Officio (non-voting)[1] 26-Total	Human Resources
3. State Medical Care Advisory Committee	42 CFR 431.12(b); Secretary Directive AC 8-78, 8/78	To advise, review, and make recommendations to the Division of Medical Assistance on problems and policies involving all aspects of Medicaid.	13-Secretary of Human Resources 2-Ex-Officio[2] 15-Total	Human Resources
4. Social Services Commission	NCGS 143B-153	To adopt, amend, and rescind rules that govern the state's social service program, including an Adult Services Section which develops policies for nursing homes, adult day care, and abuse and neglect of the elderly.	11-Governor	Human Resources
5. Employment Security Commission	NCGS 96-3	To plan and implement programs which reduce and prevent unemployment and assist in vocational training; includes a specialist on services for older workers.	7-Governor	Commerce
6. N.C. State Job Training Coordinating Council	PL 97-300, Sec. 122 (Job Training Partnership Act, 10/13/83; Chap. 543, sec. 4 of 1985 N.C. Session Laws (HB 1333)	To advise the Governor on goals, objectives, and policies regarding employment and training and to review plans and programs of agencies or service delivery areas operating federally funded programs or employment-related services, including review of JTPA (3% designated for older persons).	17-Governor	Natural Resources and Community Development

FOOTNOTES

[1] Designee of Chief Medical Director of Veteran's Administration.

[2] Director, Division of Social Services; Director, Division of Health Services.

Table prepared by Cynthia Lambert and Jim Bryan. For more, see the Center's report, Boards, Commissions, and Councils in the Executive Branch of N.C. State Government, *1985, pp. 297, 314, 329, 343, 207, and 373.*

An Interview With Elaine Stoops

Courtesy N.C. Division of Aging

Gov. James G. Martin with Elaine Stoops, Assistant Secretary of Human Resources and director of the N.C. Division of Aging.

Elaine Stoops, 60, became Assistant Secretary of Human Resources and director of the Division of Aging on May 20 when she was appointed by Gov. James G. Martin to succeed Ernest B. Messer. Mrs. Stoops has been active in political, civic, and professional affairs. Prior to moving to North Carolina in 1970, she was a member of the Charleston, W. Va., City Council. She also served as an aide to former U.S. Rep. Eugene Johnston (R-North Carolina's 6th District) in 1981 and 1982.

Mrs. Stoops is a nursing educator by profession, having served as director of the Duke University employee's clinic and as a medical-surgical instructor at the Duke University School of Nursing. Most recently, she was the In-Home Services Director of United Services for Older Adults, a private, non-profit group in Greensboro. She has also chaired the Guilford County Board of Social Services and has served on the Guilford County Mental Health Association board, where she was chairman of the aging committee. She also has been a member of the North Carolina Republican Central Executive Committee.

Jack Betts and Cynthia Lambert conducted this interview with Mrs. Stoops on June 4.

How do you view your role as director of the Division of Aging?

I'm going to be mostly an advocate. I will be going out across the state and giving speeches, learning about the 18 regions, the area agencies, learning the staff, finding out the projects they're involved in. Sitting on top of happenings here in the office, a deputy director, Lisa Morris, will be responsible for the management and the everyday activities that go on.

I think that people want to hear what's going on in our division and what new ideas we have. I want to work as closely as I possibly can with the other staff, meet the older adults across the state. I come from the grassroots level. I have been in grassroots programs for 10 years in Guilford County. I have a different perspective from what the other directors of this division have had. I want to keep close contact with older adults. I can only do that if I start traveling across the state.

One priority of mine is to have a closer relationship with the Division of Social Services and other divisions of Human Resources, because we really work as a team in taking care of these older adults.

Why should the elderly be singled out for special attention and have a separate division set up for them?

North Carolina is going to have such a rise in what we call the gray population, 60 plus, that it's overwhelming at the present time. If we don't zero in on their needs, I don't know what would happen. It's rising as fast as you can go. The Older Americans Act requires that we serve our older American population. The other factor is that by the year 2000, we are expecting nearly a million older adults in North Carolina.

What would you like to see North Carolina do in the field of aging?

We need to look beyond 1985 to what's down the road in 1990 and 2000. We need to stop right now and see how well we are doing with these programs under the Older Americans Act. We want to involve older adults in helping to assess how we are meeting the needs and solicit suggestions from all of these organized groups like the N.C. Senior Citizens Association and the American Association of Retired Persons. These are very strong organizations, and they are helping us to know what's happening and how well we are meeting the older persons' needs.

Can you enumerate two or three problems with suggestions that have been made by those groups?

We need to focus on motivating these individuals so that they want to stay healthy during their retirement years. Some of them we haven't even reached yet. Now, how we are going to reach them, I'm not sure. Some of these people don't have television, they don't listen to the radio. Somehow we've got to reach them. They're sitting in their homes, in their rocking chairs, and deteriorating.

Another problem is insufficient transportation. That's a big problem with our aged. They want to go to these things, but we don't have enough transportation. We've got to get some more community support for transportation. For instance, could we use some church buses that sit five days a week anyway? I'd like to reach out into the community and see if we can't use some of those. And we have school buses that sit idle during the summertime. How about using some of those to take the older adult out to a picnic or to the grocery store?

And outreach programs, getting out in the community and finding these people, is another item. Part of that is what we call case management, a process of letting older adults know that we're there ready to help them work out their problems in their homes. For instance, we can work with their budgets, and a case manager will go in and help them pay the bills. A lot of people don't know we have this good service in case management. We are just getting into it now in North Carolina. Case management can also help, for instance, in things like getting wood on the back porch during wintertime. I don't know how many tons of wood we put on people's back porches. Some county Councils on Aging also have weatherization programs.

Also, we need to do a better job of education, especially in health promotion. One particular health education program that we absolutely need to stress is medication awareness for the older adults. Some of these older people are taking 18, 19, 20 pills a day. They are just as bad as anyone who's addicted because they overdose. They can't read the labels. We plan to work with pharmaceutical companies and the doctors getting a new kind of label for the aged, using large type so it's easier to read. I have found that in many cases, the older adult just guessed what they were supposed to take because they couldn't read the labels. Some of them have a difficult time trying to read, finally guess at the dosage, and they overdose. Or they may counteract what the medication is supposed to be doing. They take too much of this, and not enough of that, and they just zero out what the action is supposed to be. So, we have a program with the Mental Health Association to promote medication awareness for older adults. We have recently published a brochure on "Do's and Don't's" on taking medication. It has been endorsed by the N.C. Medical Society.

Part of the problem is a fad. They call it doctor shopping. And, if their pain doesn't go away today, and they've taken a good many of the pills that have been prescribed, then they go see somebody else. That's good. Sometimes you want a second opinion. But it is bad from the standpoint that they still continue taking this doctor's medication. So to try to prevent that, we started a "brown bag" program in Guilford County. We ask the older adult to put all their medicine in a bag and take it in to show the nurse. She'll check it out. In Guilford County we found one patient with medication that was several years out of date. But they never eliminated that and they just think that they are supposed to take all of that medicine.

Should there be a division of responsibility or partnership in the way services are delivered? Why should the state address these services rather than local governments or the federal government? Who's best equipped?

The federal government has the money. It's a shame you can't do anything much without money, but we do have to have money. But, the state and local agencies need to be involved—the state from the administration angle of it. I am a strong advocate on the local level that we need to get more community support and not just depend on the government handling it, because we run a big business now. With the number of older adults we have, it's just like running a big business.

What changes, if any, will the Martin administration seek in programs for the aging?

Governor Martin is certainly an advocate for the older adults. Many times he has said that he would meet the needs of the older adults in the state of North Carolina. He wants to see more volunteers involved. Using the aged to serve the

aged, that's a beautiful picture. To see a 70 year old helping another 70 year old who doesn't have quite as good health as this individual—that's beautiful. I don't know whether it's a new concept or not, but I think it's one that we need to build on. And that's why we need to tap the talents that these people have. I mean, they can work with other ages too. It's great to be helping somebody who is less fortunate than you are.

As the population ages, how should the state go about planning programs for the needs and services in the future while you're dealing with the ones you've already got? Is there any long-range planning?

There is long-range planning. We don't have a large staff to do research or surveys or talk with people to find out all of their needs down the way, because the needs of the 65 year old are a lot different from the needs of someone 75 or 80 or 90. The churches are getting heavily involved now with older adults. When I was growing up, it was the church that was looking after older adults, doing things for them. Then the pendulum started swinging, the government came in, and it took over, so the church people dropped out. Now it's swinging back again, with the decreasing funds[1] that we have and so forth, the pendulum is swinging back to the churches.

Why is that pendulum swinging this way?

I think that when the first cuts came, we forgot these people that we hadn't used for awhile to help with the elderly. But they got concerned that people weren't going to be fed, weren't going to have housing, that they weren't going to have basic needs met. So they jumped in. An example is my own church in Greensboro. We got heavily involved right away, when these cuts started coming down, and we felt that was what we should be doing. And then the civic groups got started—groups like the AARP.

The Division of Aging itself does not perform direct services. We are a planning unit. The 18 Area Agencies take the programs and administer them based on need in their counties. The actual services to the elderly come through the Area Agencies on Aging to the county Councils on Aging or their counterparts.

Are the elderly better off in North Carolina these days? Or does it depend upon where you live?

That's difficult to generalize about, because the economic and physical and social well-being of the elderly differs geographically. You may have one section of the state where there is a mass of older people who are generally well off, partly because they receive various services in urban areas. That's because we know their needs and we know they are there. Then there are some sections in North Carolina, mostly in the more rural parts of the state, where we're not meeting the needs of the people because they are scattered and we have to get out there and find them. We know that they are there, particularly in the rural areas. I'm just not sure that we have reached enough people.

One example is my own experience in Guilford County. Transportation was a big problem in reaching rural residents with Mobile Meals. But then we started a program of delivering frozen meals, taking enough frozen meals for five days, putting them in the freezer, and then all they have to do is take them out and warm them up.

And our Homemaker Health Aides are doing this. They go pick up the meals for the five days and make sure that they would be prepared and then even if the client didn't have a freezer—some only have an icebox—we would get somebody down the road to let us use their freezer and that meal would get prepared for the older adult. Rural areas are applying for that type of service. The frozen meal concept is a very new concept and it's worked out. I've seen it work.

To keep an elderly person healthy, one of the first things to do is to keep them eating. And remember, when you get older your appetite diminishes, but if you don't eat, you're going to get weak. If you get weak, you are going to get fragile, and diseases start to creep up. So these are well-balanced meals, and they include fruit and milk.

How do North Carolina's programs for the elderly compare with the other states such as South Carolina, Virginia, and the like?

I haven't made any survey, which I am certainly going to do for my own satisfaction. But what I am hearing is that we are doing a good job. Some of the other states look to us for the way we are handling our programs. And the reason is the number of volunteers we have involved. We had 56,716 volunteers working with the elderly just in programs under this department alone last year. A lot of the other states have not gotten as many volunteers involved in programs as we have. We couldn't do it without volunteers. We wouldn't have the money to hire the staff, but every one of these area agencies has their volunteers coming in, for instance, for home delivery meals. I know that we had 1,200 right in Guilford County alone. Isn't that amazing? They are out there in all kinds of weather delivering those meals. That's just one program.

There are about 14,000 volunteers in the meals program statewide. Can you imagine if we

had to hire 14,000 people? Or just 1,200 right there in Guilford County? We couldn't have the program. We couldn't exist. So we do it with volunteers.

How do you assess the political impact of the elderly? Do they have strong preferences as a group?

I am quite amazed. They have a big impact. They are starting to speak out. They are their own best spokespersons. A lot of these groups study the legislation before the General Assembly and the Congress. They help to educate other people by having public forums, inviting people to come in. The ones that have studied and are able to digest what is happening are sharing with ones who do not have newspapers, televisions, radios, and things like that. And they are trying to get them involved too. They are teaching them to write letters to their Congressmen, to their legislators. This was never done before.

A few years ago there was a move to defeat the Senior Aides program, and every congressional office got bags and bags of mail about it. The older adults feel that they have a right to say, "Look, we are here, we want to be noticed, we are not just going to go away and die." And they saved the program.

I know from my standpoint as a former member of a City Council, that they have a big impact. They are standing up and asking their questions. And if they don't get an answer within a certain amount of time, they are back up there again. You know, we didn't see that before. It was sitting and listening and being quiet. Now they make it clear they want an answer. They don't let it drop.

Should age or income be the determining factor in eligibility for programs and services—especially keeping in mind the federal budget deficits?

I personally would rather not see any means tests at all. Some programs, of course, do have means tests. The Homemaker Health Aide program is one. We don't quarrel with that because that program gives people the opportunity to have these aides come into their homes. These people who are able to pay the fee are so appreciative of the services. And because of the fees, that enables us to reach others who cannot pay and otherwise might not receive the help.

There are certain state tax breaks designed specifically for the elderly (see p. 59 for a list). Should there be more, or has the state done enough?

I think there should be more such benefits for our older Americans. I think any way that we can give these good citizens who have helped us all these years and who have paid their taxes, and who now when they have reached this age may need some help in return, any way that we can help them is fine.

Another way we can help them is with discount programs, which give, say, 10 percent discounts to senior citizens. That doesn't cost much money, but it helps. It's awfully nice when you can go in and get a 10 percent discount or a 15 percent discount. All that adds up to savings for the older adults.

Do the elderly make good workers for employers?

Yes, absolutely. We are one state that has done a real good job of this. I know from personal experience with it. Under the Homemaker Health Aide Program, I trained a minority aide in Guilford County who was just fantastic. She became an excellent aide. And from this she has gone to another good level job now. And that job is fantastic and she's living a different life than she's ever led. And, she's one of the older adults with us.

Should the Division of Aging have more responsibility for job training?

I don't know. It's divided now. We have part of it, and the Division of Employment and Training at the Department of Natural Resources and Community Development has the other. So, I don't know. I would have to study that. We handle the Senior Aides Program, which works fine under us. I think we could handle more.

Do you foresee the state Division of Aging taking on a role that is bigger or smaller in relation to that of the federal government?

We're going to grow. Look at the number of the graying population that North Carolina will have by the year 2000. The year 2000 is just around the corner. I don't think we will ever become smaller.

FOOTNOTE

[1]The Omnibus Budget Reconciliation Act of 1981 cut federal funds for some programs for the elderly in North Carolina. Among the cuts were a $14.4 million reduction in Social Services Block Grant programs, which provided funds for senior citizen day care centers among other programs, and a $9.1 million reduction in the state's allocation of Food Stamps, part of which had provided increased food supplies for the elderly poor. For further information on cuts in aid to the elderly, see the Center's report, *Federal Budget Cuts in North Carolina,* April 1982, pp. 9-17.

Courtesy Division of Aging

Lt. Gov. Robert B. Jordan III leads older adults on a walk for fun and fitness.

Politics and the Elderly: The Potential and the Reality

by Jack Betts

Just a decade ago, the elderly segment of North Carolina's population was almost ignored politically. After all, those over 65 amounted to less than 8 percent of the population, and most politicians were preoccupied with other issues, such as the economy, the environment, and education. Besides, didn't federal programs like Social Security and Medicare already take care of old folks? What could the state do, anyway?

Lots, as it turned out. Since 1977 the elderly have quietly and steadily gained influence at the ballot box, in city hall and the county courthouse, and especially in the N.C. General Assembly, where the elderly no longer must wait in line for statutory handouts and a pat on the back. They have become, if not a powerful force, at least a political entity to be reckoned with.

Several factors account for the turnaround in the political fortunes of the elderly. One, no doubt, was the realization by those in public office in the early Seventies that demographers were forecasting startling changes in the makeup of the nation's—and the state's—population. Where once the elderly could be overlooked because of their small portion of the population (a scant 4 percent of the populace at the turn of the century and by 1960 not yet twice that percentage), the latter part of the Seventies and the Eighties would bring about a wholesale graying of the population. By the end of the 20th century, North Carolina's elderly would grow to about 15 percent of the population, the experts warned.

In 1977, Gov. James B. Hunt Jr. initiated an emphasis on programs and policies designed to benefit the elderly. He upgraded the state's chief advocacy agency for the elderly, the Office of Aging in the Department of Human Resources, to division level, renaming it the Division of

Aging. He also designated the head of the division as an assistant secretary of Human Resources. In addition, Hunt recommended and the legislature approved a general beefing-up of budget and staff for the new division.

Concurrently, the legislature recognized that older North Carolinians needed their own advocates. In the House of Representatives, House Speaker Carl J. Stewart (D-Gaston) appointed the first standing House Committee on Aging and named state Rep. Ernest Messer (D-Haywood) to be chairman. "We are plowing new ground in a field that has been hardly touched," declared Messer on January 22, 1977, shortly after his appointment.

John Young, human resources analyst in the legislature's General Research Division, gives credit to Messer for recognizing and pushing the aging issue into a major concern of the legislature. "Messer had pushed for the appointment of the elderly committee," Young said in an interview. "He carved that out and brought it to the General Assembly. He saw the need and advocated the cause."

However, it would not be until 1981 that the Senate, presided over by Lt. Gov. Jimmy Green, would get its own committee on the elderly. That year, Green named state Sen. Rachel Gray (D-Guilford) to chair the Senate Committee on Senior Citizens Affairs. That committee was downgraded to a subcommittee of the State Government Committee in 1983, but was restored to a full committee by Lt. Gov. Robert Jordan in the 1985 session.

The legislature also saw fit to study the problems of the aging on an annual basis, authorizing the first Legislative Study Commission on the Aging in 1977. That commission has been reauthorized each year since and has produced annual reports to the General Assembly on varied topics of interest to the state's older citizens. The continued existence of that study commission is further evidence of the clout the elderly have with the General Assembly. Only those issues which the legislature deems to be of utmost importance are given study commission status more than once. Among study commissions, only the Revenue Laws Study Commission and the Mental Health Study Commission have greater longevity.

Young, who has worked with the study commission on aging, estimates that the General Assembly passed "close to 80 percent" of the commission's recommendations in past years. "Most of the bills that have been recommended have been passed," said Young. "We really haven't had many failures."

Helping keep the elderly issue before the legislature has been Messer himself, although he has not been a legislator since 1981. That year, Governor Hunt tabbed Messer to become assistant secretary of Human Resources and director of the Division on Aging. Messer succeeded Nathan Yelton as the state's chief advocate for the elderly, who in turn had succeeded the late Dr. Ellen Winston, credited with creating the Office of Aging in the early 1960s. When Gov. James G. Martin succeeded Hunt in the governor's office, Martin replaced Messer with Elaine Stoops of Greensboro as assistant secretary and director of the Division of Aging (see page 32 for an interview).

Messer has, through extensive personal and political contacts, kept the aging issue before the General Assembly. He is still regarded as one of the most effective spokesmen for older persons with the legislature. Other groups which frequently appear before the legislature are the N.C. State Legislative Committee of the American Association of Retired Persons (AARP), the N.C. Senior Citizens Association, the Retired Governmental Employees Association, and the Retired School Personnel of North Carolina.

Among the issues for which the elderly have lobbied in recent sessions of the legislature are bills dealing with taxation, including the homestead exemption (reduced property taxes for older persons), the inheritance tax, the intangibles tax, sales taxes on food and nonprescription medicine; legislation creating day-care centers for senior citizens; improvements in health care; and toughening penalties for crimes committed against the elderly. As a lobbying group, the elderly may not be as powerful or as successful as, say, the bankers or the insurance

Former state Rep. and ex-director of the Division of Aging Ernest Messer, left, and former Gov. James B. Hunt Jr., right, flank the late Dr. Ellen Winston, generally regarded as the founder of the state's programs for the elderly.

Courtesy N.C. Division of Aging

companies, but each year those who represent the elderly manage to win legislative support for a growing body of laws designed to benefit the elderly (see summary of tax breaks on page 59). Yet lobbyists for the elderly say their greatest achievement is not any specific legislation, but maintaining continued legislative support for overall programs for, and studies of, the elderly (see list of lobbyists below).

Rufus Forrest of Wake Forest, a retired educator and chairman of the AARP's state legislative committee, says the annual study commission is of critical importance to the elderly. "Our biggest thing on behalf of the elderly is the Legislative Study Commission on the Aging. That's been a great move forward, just terrific in getting our legislative program developed and approved."

The elderly no longer must wait in line for statutory handouts and a pat on the back. They have become, if not a power force, at least a political entity to be reckoned with.

Forrest's group claims a dues-paying membership of nearly 300,000 in North Carolina, easily the largest of the organized groups representing the elderly. Yet another group is the N.C. Senior Citizens Association, which claims 30,000 members, about one-tenth the size of the AARP's state membership. Frank H. Jeter Jr., of Raleigh, a retired newsman and president of the group, believes the elderly's greatest legislative accomplishment is generating continued legislative support for the Division of Aging and its programs and budget. Both Jeter and Forrest say that the division has done more for the elderly in the state than any other agency, group, or institution.

As Forrest puts it, "I think the legislature *does* listen to the elderly. But the most important punch we have is the Division of Aging, particularly with Mr. Messer in the past and, we hope, with Mrs. Stoops in the future."

Legislators themselves confirm that they are listening—and acting. Former state Rep. Al Adams (D-Wake), who has himself become a lobbyist this year, notes that "people down here seem to be right much concerned about the elderly. And when Ernie Messer was here, they surely did listen. Generally, I'd have to say their concerns are still pretty well received."

Rep. Marie Colton (D-Buncombe), a member of the House Aging Committee, perceives "a growing sensitivity on the part of the General Assembly to the elderly population." Rattling off a list of bills affecting the lot of the elderly, Colton says the attention given to the needs of older citizens "shows that we are increasingly aware of them, much more so than when I first came here eight years ago."

But that does *not* mean that the elderly are in the front lines of the powerbrokers in the legislature. While the aging committees in both legislative chambers have had their successes, for instance, their chairpersons—Rep. Sidney A. Locks (D-Robeson) and Sen. Wanda H. Hunt (D-Moore)—are on the periphery of the legislative leadership. When the key decisions are made behind closed doors of the offices of Speaker Liston Ramsey and Lieutenant Governor Jordan, the participants are likely to be Sens. J. J. Harrington (D-Bertie), Kenneth Royall (D-Durham), Anthony Rand (D-Cumberland) and Charles Hipps (D-Haywood); and Reps. Dwight Quinn (D-Cabarrus), Billy Watkins (D-Granville), and Bobby Ethridge (D-Harnett)—but not Locks and Hunt. Much the same situation existed in the 1983 session, when former Rep. Gus Economos (D-Mecklenburg) and Sen. Rachel Gray (D-Guilford) chaired the aging committees. Neither was among the inner circle of legislative leadership, and both were defeated for reelection.

Major Lobbyists for the Elderly in North Carolina

Lobbyist	Group Represented
Rufus Forrest	N.C. State Legislative Committee, American Association of Retired Persons
Frank H. Jeter Jr.	N.C. Senior Citizens Association
Martha R. McLaughlin	N.C. Retired Governmental Employees Association
John R. Rice	N.C. Retired Governmental Employees Association
A.C. Dawson	N.C. Retired School Personnel
Woodrow B. Sugg	N.C. Retired School Personnel

The Elderly and the Ballot Box

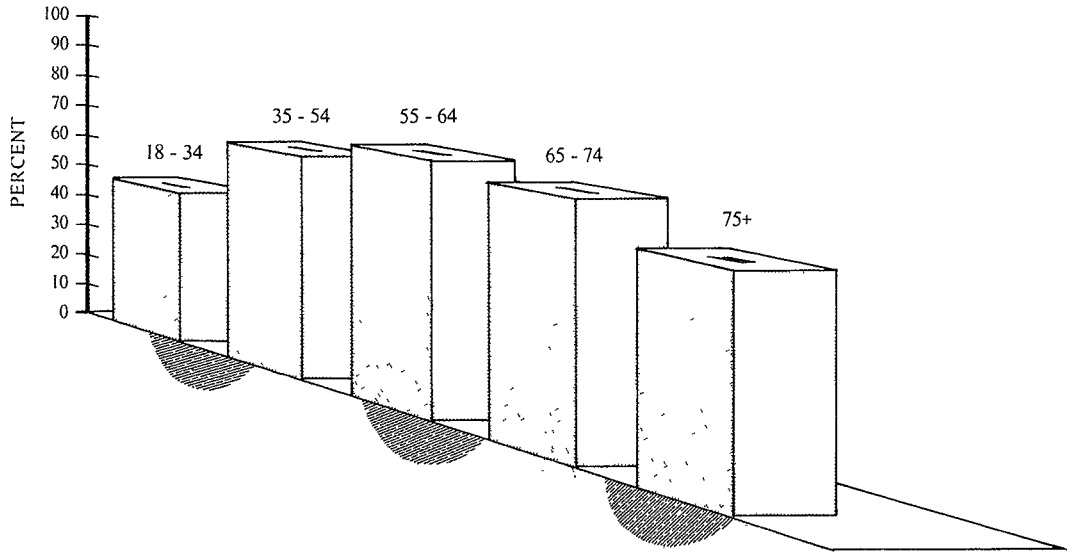
The increase in the size of the elderly populace is not the only reason that the legislature listens to the elderly. Another reason, no doubt, is the growing awareness that the elderly go to the polls in large numbers. They vote regularly, and they can have a profound impact on local, state, and federal elections.

According to the U.S. Bureau of the Census, the middle-aged and the elderly generally are registered to vote in higher numbers and participate in elections in higher numbers than the rest of the country's population. For instance, the 1980 Census showed that nearly 75 percent of those aged 65 and over were registered to vote and 65 percent of them voted. By contrast, about 67 percent of the total population—young and old, was registered, and slightly less than 60 percent actually voted in the 1980 election.[1]

The U.S. Senate Special Committee on Aging provides a further breakdown of the Census figures in its report *Aging America: Trends and Projections.* According to that breakdown, 71 percent of those aged 55-64 voted in the 1980 presidential election while 69 percent of those aged 65-74 voted—the two heaviest voting groups in the population. In other words, those who are soon to be elderly, and those who already are elderly (by the age 65 standard) are those most likely to participate in elections.[2]

In 1984, *Public Opinion*, the bimonthly journal of the American Enterprise Institute, studied the political preferences within the population, including the elderly.[3] Their survey found that substantially more of the population over 65 considered themselves Democrats than Republicans, but that neither of the major political parties could claim a clear majority of the elderly. In that survey, 45 percent of the elderly identified themselves as Democrats; 10 percent called themselves Independents closer to Democrats; 11 percent considered themselves Independents; 6 percent considered themselves Independents closer to Republicans; and 29 percent considered themselves Republicans. From these surveys and data, it is clear that the elderly *are* active participants in the political process. But what is not clear is any real sense of unity of political purpose or homogeneity in voting patterns of the elderly. That is due most likely to the broad diversity of the elderly themselves. Save for age (that is, the fact that all

Figure 1. Percent Reported Voting in 1980 Presidential Election, by Age Group



Source: U.S. Bureau of the Census, Voting and Registration in the Election of November 1980. Current Population Reports. Series P-20, No. 370, 1982

Carol Majors

"They (the elderly) tend to vote a little on the side of their own interests, but they have so many different *interests that they do not vote right down the line in any one way."*

—Former state Rep. Ernest Messer (D-Haywood)

elderly are in some sense "old"), the elderly are not necessarily alike.

Some generalizations can be made, according to Walter DeVries, of N.C. Opinion Research of Wrightsville Beach. Based on his own research over the years, says DeVries, the elderly are generally conservative, and as the population grows older, the elderly are likely to become more conservative, favoring conservative candidates. But the elderly voters do share a common commitment to preserving and, where possible, strengthening the benefits from the Social Security system and Medicaid and Medicare.

Those who assume that the elderly can be molded into a single-minded political force, to coalesce behind a certain philosophy or belief, will find what social researchers and political scientists have found—that the elderly are no more likely to conform to their expectations than any other age group. Says Messer, "They (the elderly) tend to vote a little on the side of their own interests, but they have so many *different* interests that they do not vote right down the line in any one way."

For instance, in North Carolina's most recent statewide election, the U.S. Senate race between former Governor Hunt and U.S. Sen. Jesse Helms, the elderly population was split between the two candidates—just like most other voting groups in the state.

Joseph W. Grimsley, Hunt's long-time political adviser, for instance, believes that at least among elderly whites, both candidates got their share of the vote, with the edge to Hunt. "White seniors voted slightly more Democratic than the population at large, and that was because of the Social Security issue," says Grimsley.

The elderly do have clout, both on the national and the state levels. Charles E. Odell, an expert on gerontology who makes his winter home in North Carolina, sees the evidence everywhere. The fact that President Ronald Reagan backed off on his plans for changes in Social Security benefits is directly attributable to opposition of the elderly, says Odell. "A lot of Mr. Reagan's early efforts to tamper with the Social Security system were frustrated by the opposition of older people and organizations representing older people," says Odell, a former director of the United States Employment Service and former director of retired workers' programs for the United Auto Workers before he retired to Pinehurst.

The elderly particularly have clout at the local level, says Odell. That means not only that the elderly exert influence over new programs, but that they also—sometimes—stand in the way of such programs as bond issues for education or public works projects.

John T. Denning of Clinton, who will take over the national presidency of the American Association of Retired Persons in 1986, acknowledges that tendency to sometimes stand in the way of progress. "These are areas where we need to do a great deal of education," says Denning. "It can be a problem and we need to do a good educational program. These people often have children and grandchildren, and they need to be reminded and educated to the fact that voting against a bond issue might really be a vote against the future of their children."

While older persons do influence elections, making generalizations about their specific voting performance remains difficult—if not impossible. Despite all the organizations representing the elderly, there still is no sure-fire method of attracting, or even predicting, their vote. As Charles Odell puts it, "I don't think the seniors in North Carolina are all that well organized politically."

Young, the legislative analyst, doesn't think there's much chance of the elderly in the state becoming organized, either. "I'm not sure you could weld that group into a political force," says Young. "I don't think the people who are most affected by programs for the elderly vote that much alike."□

FOOTNOTES

[1] *Voting and Registration Highlights from the Current Population Survey: 1964 to 1980,* U.S. Bureau of the Census, February 1984, Table 2, p. 4.

[2] *Aging America, Trends and Projections,* U.S. Senate Special Committee on Aging, 1984, Chart 72, p. 93.

[3] "Independents Demographically Defined," *Public Opinion,* bimonthly magazine of the American Enterprise Institute, April/May 1984, p. 29.

Conflict or Consensus?

Generally, federal and state policies continue to provide older persons, as a group, with special benefits simply because they are old—not because they are needy. For 50 years, the government has gradually expanded benefits for older persons. But now we are approaching a crossroads. In the not too distant future, decision makers may have to stop expanding benefits—and then perhaps even cut back.

As the elderly population swells in numbers and grows more expensive for taxpayers, the differences among the elderly are becoming clearer. Some want to retire, others to work. Some feel entitled to special treatment, by their families and their country; others favor self-reliance.

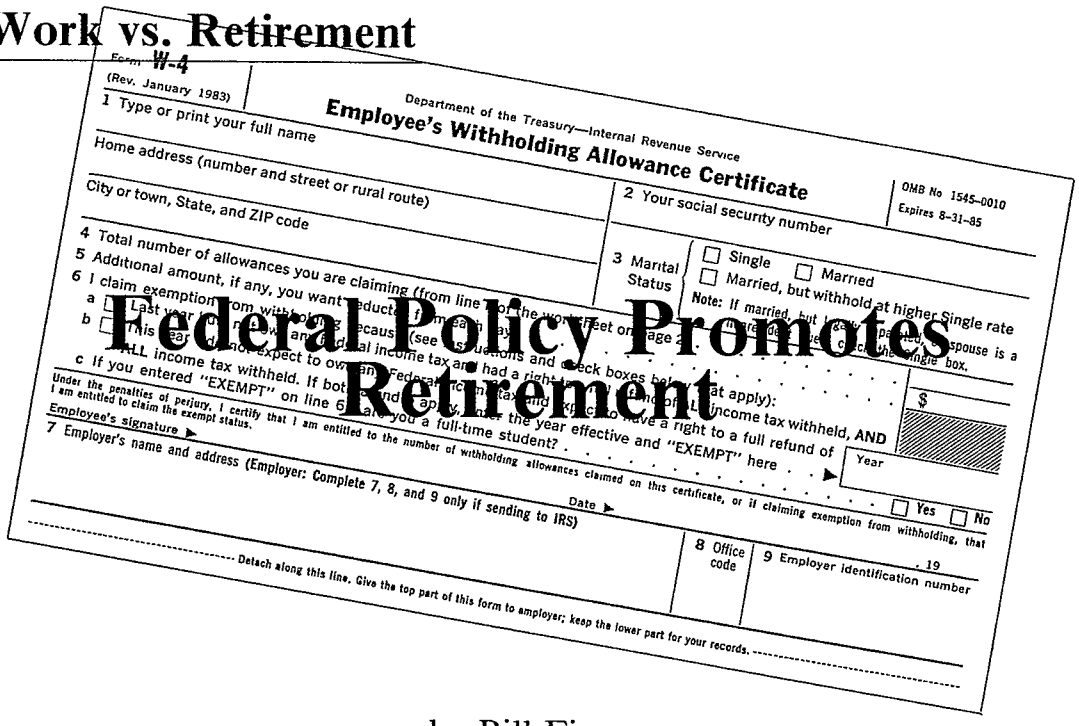
In three ways, policies are evolving which may be in conflict—or at least may reflect a lack of consensus among policymakers and even among older persons.

Work vs. Retirement: Should federal policy encourage retirement or employment after age 65? Federal law prohibits discrimination in employment against persons aged 40 to 70. Two federal programs also help persons 55 or over who want to work. But these policies pale in impact next to the federal Social Security program, which basically encourages a person to retire at age 65.

Age vs. Need: Where does the "right" to a benefit begin—at a certain age or under a certain income? Currently, only one of every 10 dollars in federal funds goes to older persons because they are poor; the rest goes on the basis of age and past work experience. Robert Clark takes the view that age remains an appropriate eligibility condition for Social Security. Phillip Longman takes a contrasting view.

Attracting Retirees: Tax Benefit or Burden? Should North Carolina try to attract retirees to the state through tax breaks? The state ranks seventh in attracting retirees and has four of the seven major tax breaks used by states for older persons. How does an influx of retirees affect a county's budgetary needs—the demand for new services and for new taxes?

Work vs. Retirement


Form W-4
(Rev. January 1983)
Department of the Treasury—Internal Revenue Service
Employee's Withholding Allowance Certificate
OMB No 1545-0010
Expires 8-31-85
1 Type or print your full name
Home address (number and street or rural route)
City or town, State, and ZIP code
2 Your social security number
3 Marital Status
Single
Married
Married, but withhold at higher Single rate
4 Total number of allowances you are claiming (from line
5 Additional amount, if any, you want
6 I claim exemption
a
b
c If you entered "EXEMPT" on line 6
Under the penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming exemption from withholding, that I am entitled to claim the exempt status.
Employee's signature ▶
Date ▶
7 Employer's name and address (Employer: Complete 7, 8, and 9 only if sending to IRS)
8 Office code
9 Employer identification number
Detach along this line. Give the top part of this form to employer; keep the lower part for your records.

Federal Policy Promotes Retirement

by Bill Finger

In 1978, Morris Karpen retired as president of his own sheet metal manufacturing business. "Two months of doing nothing was enough to send me to the nuthouse," remembers Karpen, now 68. "So I decided to start a small business." From Weaverville, North Carolina, just north of Asheville, where Karpen built a 75' by 175' plant, he carved out a national market for special-order, fire-resistant steel doors. But this time around, profits don't absorb Karpen's attention as much as passing on his knowledge to younger workers.

"Twenty-one of us just went to China," says Karpen, referring to a trip sponsored by SCORE, the Senior Corps of Retired Executives. "We were helping (the Chinese) to set up small businesses." Karpen came away from China with as much as he gave. "It's like the Chinese say," smiles Karpen, white socks and cuffs of blue work pants falling over his wing tips. "I want to use the brains of the old people to teach the young."

Karpen is doing just that. He has trained all 15 workers in his plant on the sheet-metal machinery he designed himself. And he believes in hiring older workers as well. "Older workers can be a steadying influence," says Karpen, nodding toward Walter Ray Tipton, 58.

Tipton has recently completed a year-long apprenticeship program, sponsored by the Buncombe County Employment and Training Office, at Karpen Steel Products. Last year, that office got jobs for 14 workers like Tipton, persons 55 or over and below federal poverty income guidelines. The Buncombe County office administered funds for the program—which paid roughly half of Tipton's salary—through the federal Job Training Partnership Act (JTPA). The JTPA includes a mandatory "3 percent set-aside" for older workers.[1] Last year, some $67 million in JTPA funds came into North Carolina—$1.3 million of it designated for older workers.[2]

Mary Joan Ferell, 49, coordinates the older worker program for the Buncombe County office. "My thing is not 'older is better,'" says Ferell, "but that older workers will be on the job as long as a younger person." As the working population ages, Ferell believes employers of all sorts must "draw on these older people."

Ferell has helped older persons who need to work to find jobs as secretaries and switchboard operators, sheet-metal workers and library supervisors. Visits to four of these persons on the job showed why workers like Madelyn Webber can be valuable to employers.

"It was a blessing to me," says Webber, a 58-year-old switchboard operator, between phone calls at the First Commercial Bank in Asheville. After her husband died of a heart attack, Webber tried to find a job on her own. "People wouldn't talk to me," says Webber. "Then my daughter saw an ad in the paper about helping get older individuals back into the work force. I knew I was better off working so I went to see Mary Joan."

Across downtown Asheville, at the county office building, another 58-year-old woman, Louise Britt, echoes Webber. "Mary Joan helped me out, helped me realize that it wasn't just me (not being able to get a job)." From a room adjacent to the county office law library, Britt answers the switchboard for all calls coming to the Buncombe County information number. She monitors the library, helps with research requests, and reshelves law books.

"At my age, I don't know if I'd ever have gotten another job," says Britt, juggling calls during an interview. "Working keeps you out among people, more aware of your appearance, and up to date." Britt and Ferell lock arms and hug shoulders as the visit ends. "It keeps you younger," adds Britt.

"Our misconception of the capabilities of the elderly has often limited our vision and influenced our public policies. As a result, government often creates programs and policies which deter rather than encourage older people from living a full and productive life."
—Walter Mondale

* * *

People like Britt, Webber, and Tipton are at work, in large part, because federal policy has recognized the importance of older workers. This policy is evident in three main ways: through the Job Training Partnership Act's 3 percent set-aside; through Title V of the Older Americans Act, called the Senior Community Service Employment Program; and through the Age Discrimination in Employment Act. The JTPA program, explained above, is basically a training program in conjunction with the private sector. The Service Employment Program, by contrast, is a job subsidy program.

The Service Employment Program is designed to encourage the transition of older workers to the unsubsidized job market and to provide part-time employment to low-income older persons.[3] The program pays minimum wage or slightly higher for persons 55 or older who meet federal poverty income guidelines ($2,625 for an individual or $3,525 for a family of two for a six-month period). The person must work for a non-profit agency. The Title V funds often go for elders working at local councils on aging and "senior centers" (see pages 10-13 for more on the Older Americans Act).

Also in North Carolina, the Employment Security Commission (ESC) helps older people to take advantage of ESC job placement services. Each of the 84 local ESC offices has a designated specialist for older workers, says Bob Campbell, the state ESC's public information director. Recently, the ESC and the Division of Aging combined forces on a slide/tape show to encourage employers to hire older workers. The two agencies are now considering more extensive cooperative efforts, adds Campbell.

The Age Discrimination in Employment Act (ADEA), as amended by Congress in 1978, addressed employment issues for persons aged 40 to 70.[4] The law protects applicants and employees of these ages from discrimination in hiring, promotion, discharge, pay, fringe benefits, and other aspects of employment. So as not to

Maxine Atherton, 81, of Pinehurst writing book on "Fishes" at her microcomputer.

Courtesy The Pilot, *Southern Pines*

discriminate against older workers, the law also raised the mandatory retirement age (for most employees) from 65 to 70.

In North Carolina, the state equal employment law covers discrimination based on age.[5] In addition, state agencies and local political subdivisions must provide equal job opportunities for persons aged 40 to 70.[6] Finally, in 1984, the General Assembly abolished a mandatory retirement age for state employees (except for some school personnel).[7]

In theory, the ADEA and state law represent major steps forward in protecting older workers. In practice, older workers often face subtle forms of discrimination—as Louise Britt and Madelyn Webber found while looking for work in Asheville.

The JTPA, Older Americans Act, and Age Discrimination in Employment Act affirm the value of employing older workers. Yet major federal policy in effect *functions in just the opposite way: to encourage workers to retire.* "Existing federal policies both facilitate and encourage retirement through the provision of retirement income and other policies that reduce the rewards for working," begins a Congressional Budget Office (CBO) report.[8] The CBO report identifies three main areas where federal policy encourages older persons to *quit working*: mandatory retirement at age 70; features of the Social Security system that provide disincentives for continued work by older persons;[9] and existing provisions in private pension regulations.[10]

The amount of money spent to help people like Madelyn Webber and Walter Ray Tipton *find jobs* is a mere drop compared to the sea of federal money spent to help people *in retirement.* In fiscal year 1982, the CBO study points out, federal spending on retirement income for persons 65 and over accounted for *19 percent of the total federal budget*—nearly one of every five federal dollars—more than $130 billion. "This spending has increased in recent years not only because of the growing size of the elderly population, but also because of increased benefits, expanded coverage, and *more earlier retirements*" (emphasis added).[11]

The CBO study analyzes federal policies that affect retirement within the context of federal budget deficits and the growing number of older persons. The preface of the report includes the traditional CBO disclaimer: "In accordance with CBO's mandate to provide objective and impartial analysis, this paper contains no recommendations." Despite this disclaimer, the very structure of the report emphasizes the hazards of federal policies that promote retirement rather than work. "The Congress might wish to consider policy changes that would encourage older persons to continue in, or reenter, the work force," advises the report.[12]

> *"Ours seems to be the only nation on earth that asks its teenagers what to do about world affairs and tells its golden-agers to go out and play."*
> *—Julian F. Grow*

* * *

Advocates of older persons rally around Social Security above all other causes. Any effort by Congress to restrict benefits (curbing cost of living increases, stiffening income

Table 1. How Federal Programs and Policies Affect Older Workers

Encourage Employment	Encourage Retirement
1. Job Training Partnership Act	1. Social Security (retirement portion)
2. Title V, Older Americans Act (Senior Community Service Employment Program)	2. Employment Retirement Income Security Act (ERISA)
3. Age Discrimination in Employment Act	3. IRA deduction in tax code (indirectly)

Assumptions About Older Workers

In 1983, the Institute of Lifetime Learning, part of the American Association of Retired Persons (AARP), released a booklet promoting the value of the Job Training Partnership Act for older workers. The booklet, called "Training Older Persons for Employment," included common assumptions about older workers with the AARP's findings about these assumptions. The chart below summarizes this work by the AARP's Institute of Lifetime Learning.

Assumption	AARP Finding
1. Productivity declines.	1. No consistent pattern exists to demonstrate superior productivity in any age group.
2. Attendance is poor.	2. Older workers' attendance is as high or better than younger workers' attendance.
3. Learning capacity is obsolete.	3. Little evidence exists to suggest any significant change in learning capacities.
4. Intellectual functioning decreases.	4. Intelligence remains constant for most persons until at least age 70.
5. Compared to younger workers, older workers are not worth the investment to train.	5. Employees aged 20-30 stay with a company an average of 3.4 years; those aged 50-60 stay an average of 15 years.
6. Motivation decreases.	6. Older workers demonstrate greater job satisfaction, less stress on the job, and fewer admissions to psychiatric treatment.
7. Accidents on the job increase.	7. Older workers have fewer accidents in situations that require judgment based upon experience and expectation of hazard.

restrictions) prompts an outcry, not only from the Washington-based advocacy groups but from every corner of America. Nearly one of every nine Americans depends upon a Social Security check for a part of his monthly income.

These same advocates, however, espouse the *vitality* of older persons, the fact that a person's abilities should not be judged by age alone but rather by health, vigor, and ability to work. Should government policies encourage work—or should they encourage retirement—at age 65?

If Social Security is a sacred cow, take a closer look at this ecclesiastical pasture—at employer-controlled pensions and at "the good life" of retirement. While The Employment Retirement Income Security Act (ERISA) does regulate private pensions, it permits private pensions "certain latitudes that can create work *disincentives* when an employee reaches the age of pension eligibility," says the CBO study.[13] Usually, for example, a person must quit working in order to receive pension benefits. In other words, federal pension laws generally require a person to *quit* working in order to get his pension check—even if he wants to *keep* working.

In recent years, the financial industry has promoted retirement as "the good life." Banks, brokerage houses, and others compete for IRA (Individual Retirement Account) accounts, annuity plans, and other investment income. The IRA deduction in the tax code, indirectly, has contributed to this new wave of promotion.[14] Ads promise that you can afford the $1 million ranch from your IRA if only you would start saving now. The inducement through the tax code to save might help the economy in a number of ways (building up capital rather than spending, etc.). But the IRAs have also resulted in the promotion of "retiring in style"—rather than continued work for those who are healthy and have some contribution to make to the economy.

People need to have the option of working as long as they are healthy and can contribute. But federal policies—especially Social Security incentives—encourage retirement more heavily than work. Until policymakers and advocates of older persons can resolve this contradiction, many older persons will find, as economic and social consultant Harvey Shapiro puts it, "Their later years are like their earliest ones: They find society unwilling to entrust them with any meaningful tasks."

Many retirees, of course, prefer—even relish— their leisure. As the wife of a recently retired agricultural extension agent explains, "The push with our children and my husband's job is over. Our income is adequate, and we have looked forward to retirement—to travel, to take things a little easier. It's a time in our sixties to enjoy our retirement before any serious aging problems."

There are two groups of older persons now—those who are able, and want to retire; and those who want to continue to work, for financial reasons or simply because they like to work. Certainly, persons should have the freedom to choose which of these camps they fall into—favoring retirement or work.

What seems in conflict, however, is the federal policy of promoting retirement—at tremendous cost to taxpayers—while giving only piecemeal attention to promoting work for older persons. Those who want to retire certainly have that right. But they have the responsibility of recognizing the impact their retirement has on the society as a whole. Not only does the Social Security price tag continue to soar, but the wisdom and experience of work-force veterans are lost to the next generation as well.

Fortunately for Buncombe County, Louise Britt landed a job, even at age 58. And the First Commercial Bank in Asheville now has a reliable switchboard operator in 58-year-old Madelyn Webber, instead of younger women who kept quitting. As Morris Karpen reminds us, maybe we do have something to learn from the Chinese. Maybe we should use the brains of the old to teach the young—on the job, not just on a front-porch rocker.□

History is replete with examples of people who continue to use and enhance their creative gifts into very old age. Verdi composed his "Ave Maria" at eighty-five. Pablo Casals played the cello, conducted orchestras, and taught up to the time of his death at ninety-six. Ralph Vaughan Williams composed his eighth and ninth symphonies in his eighties. Grandma Moses took up painting at the age of seventy-seven and continued to do her quaint and appealing work to the end of her life at ninety-nine. Michelangelo worked on his sculptures virtually until the day of his death at eighty-nine.

Arthur Fiedler vigorously conducted the Boston Pops orchestra in his eighties, and Arthur Rubinstein at eighty-eight received tremendous ovations for his piano concerts. Will Durant, with the collaboration of his wife, Ariel, wrote five volumes of the massive ten-volume History of Civilization *between the ages of sixty-nine and eighty-nine.*

You may say these are unusually gifted and exceptional people, and you would be right. But they give proof that creativity, freshness of ideas, and the power to enrich one's society and culture need not vanish with old age.

Professor [Archibald] MacLeish points out—and I agree—that creativity in one's later years does not fall like manna from heaven. It requires an abiding interest in life and a conviction that we can continue to grow, learn and create to the very end of our days.

—Alice Van Landingham

FOOTNOTES

[1]29 USC 1501 et seq.

[2]An excellent background resource on the Job Training Partnership Act, as it applies to older workers, is *A Practitioner's Guide for Training Older Workers* by Brenda Lester, National Commission for Employment Policy, 1522 K Street, N.W., Suite 300, Washington, D.C. 20005, 1985. This 213-page research guide contains a wealth of information on older workers in general, including a valuable annotated bibliography.

The $1.3 million is 3 percent of the JTPA Title IIA funds coming into the state, which totaled about $43 million.

[3]42 USC 3056 et seq.

[4]29 USC 631.

[5]NCGS 143-422.2.

[6]NCGS 126-16.

[7]Chapter 1019 of the 1983 Session Laws (2nd Session, 1984, SB14).

[8]*Work and Retirement: Options for Continued Employment of Older Workers,* Congressional Budget Office, 1982, pages 4 and xv.

[9]42 USC 402.

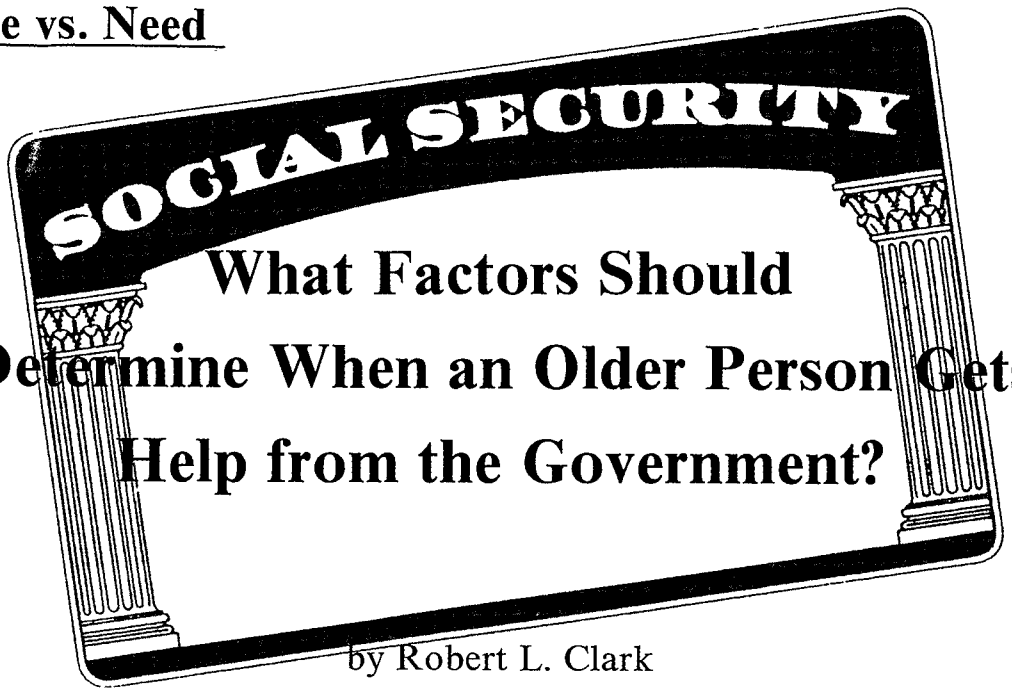
[10]29 USC 1001 et seq., especially section 1056.

[11]*Work and Retirement*, page xiii.

[12]*Ibid.* In addition, see other resources that explore this issue: Herbert S. Parnes, editor, *Policy Issues in Work and Retirement*, the W. E. Upjohn Institute for Employment Research, 1983; the journal *Aging and Work;* and Robert L. Clark and David T. Barker, *Reversing the Trend Toward Early Retirement,* American Enterprise Institute, 1981. 1981.

[13]*Work and Retirement*, page 30.

[14]26 CFR 1.219-1 ("Deduction for Retirement Services"), August 1980.



What Factors Should Determine When an Older Person Gets Help from the Government?

by Robert L. Clark

Should government programs continue to provide benefits to people simply because they have attained a certain age? Or should programs be redirected to provide benefits only to older persons who are also poor? Those questions are being debated seriously as the nation's elderly population swells and as the federal budget receives greater and greater scrutiny.

Social Security and Medicare account for more than seven of every 10 dollars going to persons 65 and older (See Table 1). Eligibility in these programs is based primarily on age and past work experience. Another dollar of every 10 goes for other federal retirement and survivor programs. These programs, like Social Security and Medicare, are not based on need. By contrast, about one of every 10 dollars in federal funds goes to older persons simply because they are poor. Put another way, older persons get most of the federal dollars by virtue of age and past work experience—not because of current income level.

An examination of the eligibility conditions for benefits from various federal programs shows age to be an inappropriate eligibility criteria for welfare programs (perhaps a less pejorative term is income maintenance) whose objectives are to reduce poverty. But age remains a reasonable eligibility condition for social insurance programs, whose objectives are to guarantee a certain minimal amount of support for older persons regardless of economic circumstances.

The cost of government programs for older persons has increased tremendously in recent years, from $12.8 billion in 1960 to $196.2 billion in 1982 (see Table 2). When these expenditures are adjusted for increases in consumer prices, the 1982 expenditures are five times—500 percent of—the level in 1960. By contrast, the number of people aged 65 and over increased by only 58 percent. The increase in real expenditures raised the proportion of the federal budget necessary to finance these programs from 13 percent in 1960 to 27 percent in 1982, and the proportion of the Gross National Product allocated to these benefit programs rose from 2.5 percent to 5.9 percent.

The average annual federal expenditure per person aged 65 and over increased from $768 in 1960 to $7,948 in 1982 (see Table 3). If benefits had been increased only to reflect prices increases, the average benefit would have been $2,516 in 1982; but if benefits had risen in accordance with the growth in per capita disposable income, the benefit per elderly person would have been $3,663. Therefore, the expansion in federal spending per older American has significantly exceeded the growth of annual per capita income.

These jumps in federal dollars have resulted from new programs, higher benefits under

Dr. Robert L. Clark, a professor of business and economics at North Carolina State University, has contributed several groundbreaking studies to the literature on older persons. For example, his book (with David T. Barker) Reversing the Trend Toward Early Retirement *served as a basis for much of a recent Congressional Budget Office report on this subject.*

existing programs, and less restrictive eligibility conditions. Most of the increases stem from the federal government's response to the perceived needs and growing political power of older persons—not simply from the graying of the population.

But do the perceived needs match the reality? The real and relative economic status of older Americans—taken as a whole—has improved substantially since the 1960s. The real (price adjusted) cash income of older families has risen by 20 percent or more during each of the past three decades (see Table 4). During the 1970s, the real income of older families rose faster than the real income for the general population.

Another indicator of the improving economic status of the elderly is the decline in the incidence of poverty among older persons. The poverty rate among persons 65 and older declined from 32 percent in 1959 to 14 percent in 1983. After years of being well above the national average, the incidence of poverty among the elderly has now fallen below the poverty rate for the total population. These data indicate that being old should not be equated with being poor.

For most of the numerous programs providing benefits to the elderly, the specified objective is to provide economic assistance to persons with relatively low income.

Improvements in the income status of the elderly probably understate the rise in their well-being. This is due to the substantial increase of in-kind benefits that older persons receive from federal, state, and local governments. These include in-kind benefits in the form of health care from Medicare and Medicaid, from food stamps, and from various age-based benefit programs (see tables on pages 18-29). Finally, the evidence indicates that the elderly are not more vulnerable to loss of real income due to inflation than other demographic groups.[1]

The rapid increase in federal money going to older persons has stimulated public debate on Social Security revisions and welfare benefits. These discussions at the federal level have focused on whether old age or low income should be the appropriate eligibility criteria, and if age is used, should the age of eligibility for benefits be raised from current levels. In North Carolina, the question is also gaining increased importance as more administrative responsibility for programs for the elderly is shifting to the state level and as the N.C. General Assembly increasingly turns its attention to the state's growing elderly population (see "Politics and the Elderly," page 36).

In a generalized way, programs for the elderly can be grouped into welfare, or income maintenance programs, and social insurance programs. Budgetary constraints, the rapidly increasing costs of programs for the elderly, and the increased numbers of older persons are forcing policymakers to recognize the economic rationale behind income maintenance programs and social insurance programs.

Society initiates poverty programs to prevent unfortunate individuals from falling below some predetermined standard of living. This standard is typically influenced by the national per capita income and varies over time with changes in political and social preferences. Poverty programs contain economic incentives that may result in workers with low earnings leaving the labor force to accept benefits. To limit this possibility, beneficiaries are often required to be from clearly "deserving" groups. Designated groups historically have included the blind, disabled, families with dependent children, and the elderly. Income maintenance programs require that the recipients have income and assets below a specified level. These "means tests" are an important factor that differentiates these programs from social insurance.

For most of the numerous programs providing benefits to the elderly, the specified objective is to provide economic assistance to persons with relatively low income. Some programs such as Supplemental Security Income provide cash benefits; others, such as food stamps, housing subsidies, and Medicaid, provide in-kind assistance—that is, direct benefits but not hard cash. These programs have low income as their eligibility criterion and also award benefits to non-aged persons. Elderly recipients are eligible for benefits because of their economic status, *not* because of their age. All of the programs taken together total only about one of every 10 dollars going to the elderly (see Table 1).

In addition to these income maintenance programs, there are other public transfers designed to aid *all* older persons. For example, the aged receive several types of favorable tax treatment, including double exemptions from

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Unless a number of fundamental trends are soon reversed, the Baby Boomers are headed for a disastrous retirement.

JUSTICE BETWEEN GENERATIONS

by Phillip Longman

Not all analysts agree that some benefit programs for the elderly should be means tested while others should be universal once a certain age is reached. Some contend that in a time of federal budget deficits and a fast-growing elderly population, the day is approaching when benefit programs must ***have eligibility criteria based on economic circumstances. Representing that viewpoint is Phillip Longman, research director at Americans for Generational Equity, a Washington-based advocacy group. He is currently writing a book for Houghton-Mifflin on the idea of generational equity. Reprinted here are excerpts from an article he published in*** The Atlantic Monthly ***in June 1985.***

The amount of help that each generation requires from its children may vary, but the demand for assistance in old age never vanishes. Today Social Security and Medicare are all but universal programs, with the typical recipient collecting benefits costing at least three times as much as the taxes he or she contributed. This year nearly 28 percent of all federal spending is going to the 11 percent of the population that is 65 and older. The budgets for all of the federal government's various retirement programs, including Medicare, are four and a half times bigger than the budgets for means-tested welfare programs.

Despite the huge cost of old-age subsidies, one hears only a modicum of complaint from taxpayers. It is easy to understand why. Not only would people in the work force, regardless of class, prefer to be relieved of direct financial responsibility for their parents, but also they themselves expect someday to take advantage of Social Security, Medicare, special tax breaks, reduced bus fares, and the like. For these reasons the majority of voters are inclined to favor generous benefits to the old. But there may be a point at which the young say "enough" and rise up in revolt against their elders. Today's older generation need not worry; though the cost of their entitlements is extraordinarily high, it is bearable, because it's spread across an unusually large working-age population. The 75 million members of the Baby Boom generation—all those Americans born between 1946 and 1964—have good reason to fear desertion by their successors, however. Unless many fundamental trends are soon reversed, the Baby Boomers are headed for a disastrous retirement.

* * *

The idea that Americans are bound by destiny to experience ever-greater affluence has been an article of faith since the Second World War. That idea helps to explain why until recently almost nobody considered that public borrowing might encumber future generations. It seemed to follow that as long as the economy continued to grow at a robust rate, the transfer of debt from one generation to another would be painless. Borrowing against the future would be like taxing the rich to help the poor.

* * *

F. Scott Fitzgerald, famously, defined a generation as that reaction against fathers which occurs about three times a century. In discussions of political economy, however, the more useful distinction is between dependent youths, working-age adults, and the also dependent retired population. In the United States today these three generations share the stage, and each, according to law, has its own set of rights and privileges. Members of each generation begin life entitled to public subsidy from their elders for the cost of education if nothing else. They end life entitled to subsidy from their juniors—specifically, for the full public cost of health-care and retirement benefits.

The long-term interdependence of the three generations makes questions of reciprocity, and therefore of justice, inevitable. The middle generation in any given era either must strike a prudent balance between the demands of its parents and the demands of its children or prepare itself for an unhappy retirement. If, for example, the government spends so much on the elderly that it must skimp on the education of the young or on investment in economic growth, then when it is time for the young to govern, they may be unable to provide their elders with enough support. Alternatively, if the government is stingy with the elderly, the young may come to feel free to shirk their responsibilities to the old.

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(continued from page 48)

federal income taxes, exemptions from capital gains in certain housing sales, and tax breaks in state and local tax systems (see tax break chart, page 59). The prices to the elderly of certain publicly provided goods and services are sometimes reduced through the use of "senior citizen" rates, such as lower fares for public transportation.

Generally, the implications of these very specific measures to provide benefits to all older persons are less desirable as a means of income redistribution than transfers to the poor, among whom are many of the elderly. These welfare or income maintenance programs were developed because of society's concern for the poor. Benefit programs solely for older persons may have been justified in times when a larger proportion of the elderly were poor. However, in recent years, as the poverty rate of older persons has fallen, these programs have become an increasingly inefficient method of transferring resources to the poor. In addition, some of these programs probably are more valuable to the higher income elderly. The tax deductions provide a greater net benefit to wealthier persons in higher tax brackets. High income elderly are also more likely to use the reduced fares for such items as admission to national parks.

Table 1. Estimated Federal Outlays for Persons 65 and Older, by Program, Fiscal Year 1982 (in Billions of Dollars)

Program	Outlays
Social Security	111.8
Medicare	39.7
Other federal retirement and survivor programs	21.1
Medicaid	6.5
Veterans benefits	4.3
Housing assistance	3.3
Supplemental security income	2.9
Other federal health programs	2.3
Administration on Aging	0.7
Food Stamps	0.6
Title XX social services	0.4
Energy assistance	0.2
Other	2.4
Total	196.2

Source: U.S. Congressional Budget Office, *Work and Retirement: Options for Continued Employment of Older Workers* (Washington, D.C.: Government Printing Office, July 1982). p. 55.

Within a family transfers of wealth between the generations are usually based on need. A rich father is not likely to receive payments from his children merely because he has reached his sixty-fifth birthday. In contrast, almost all federal benefits to the elderly are distributed with no consideration of need. Yet as the senior-citizens' movement constantly stresses, many retirees continue to be active, healthy, creative, and useful until very advanced ages. Moreover, as we have seen, many are affluent, as well. Why, then, should we persist in subsidizing them as generously as we do? More than a tenth of all Social Security spending goes to households with independent incomes totaling $30,000 or more a year. Much of this independent income is in the form of interest payments and capital gains. To demand across-the-board benefits merely on the basis of age is in effect to advocate welfare for the rich.

Americans have good reason to make such a demand, however. From the start politicians have described Social Security programs as forms of insurance—a conceit in no sense justified by the actual financial mechanisms underlying the system. Naturally, the elderly have based their retirement strategies on the assumption that the government will keep its promises to them, come what may. It would not be right to change the rules of the game on those already collecting or soon to collect benefits, however expensive it may be to keep those rules in force.

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If age is not a good criterion for income maintenance programs, can a specific age be a useful eligibility condition for social insurance programs such as Social Security and Medicare? To answer this question, we must examine the economic rationale for these programs and assess their cost relative to depending on private savings for retirement income and medical care.

There are several economic rationales for Social Security. First, Social Security may enhance economic efficiency through risk-pooling and the absence of, for instance, selling costs associated with the sale of commercial insurance. Second, some analysts contend that, on average, people's expectations regarding their needs for retirement income are unrealistically low, and inadequate preparations are made for health catastrophes or long life. The resulting extreme poverty in old age creates severe personal hardships and may result in society having to provide assistance to these individuals.

Social Security has both social insurance and redistribution components in its current structure. With respect to the insurance function, the issue becomes whether the government or the private sector can most efficiently provide this service. An "adequate" retirement income depends upon several factors that are beyond the

Table 2. Annual Federal Expenditures for Persons Aged 65 and Older, 1960-82

Year	Total Expenditures (Billions)	Total Expenditures in 1967 Dollars[a] (Billions)	Percentage of GNP	Percentage of Federal Budget
1960	$ 12.8	$14.4	2.5	13
1965	18.8	19.9	2.7	16
1970	38.2	32.8	3.9	19
1975	75.7	47.0	4.9	23
1978	112.5	57.6	5.3	24
1982	196.2	67.9	5.9	27

Source: Robert Clark and John Menefee, *"Federal Expenditures for the Elderly,"* The Gerontologist 21 (April 1981): 132-37. The 1982 figures are based on estimates from U.S. Congressional Budget Office, *Work and Retirement* (Washington, D.C.: Government Printing Office, July 1982); and Barbara Torrey, "Guns vs. Canes: The Fiscal Implications of an Aging Population," *American Economic Review* 72 (May 1982): 309-13. The 1982 data pertain to fiscal year 1982.
[a] Nominal dollar values are deflated by annual averages of monthly figures of the CPI.

Many younger readers are likely to ask, Why should the burden of reform fall only on us and our children? Why should the old escape the consequences of their own shortsightedness as a generation? Whether or not one can see a moral justification for preserving the older generation's entitlements, one should consider a purely political reason for doing so. The power of the Gray Lobby is overwhelming. No reform is possible unless today's senior citizens are largely exempted from sacrifice.

In any case, the challenge for members of the Baby Boom generation will be not how to meet the demands of their parents but how to provide for their own retirement without putting an impossible economic burden on their children. In the 1960s economists called into question the need for one generation to provide for the future well-being of its descendants. Today the more pertinent question is how much one generation can rightfully *borrow* from its descendants to subsidize its own consumption.

* * *

Some people have optimistically observed that the cost of supporting the Baby Boom generation through retirement may be offset, at least in part, by a decrease in expenditures for the young as they decline in numbers. But if current spending patterns persist, we will be left nevertheless with a huge gap. The most recent study on the subject to date, by Robert Clark, an economist at North Carolina State University, was published in 1977. In 1975, according to Clark's estimates, total per capita expenditures for the elderly, at all levels of government, exceeded the

control of individuals. For example, the individual has an uncertain lifetime. By pooling risk through insurance, annuities, or pensions, the risks of long life and of exhausting one's savings can be reduced. Much the same argument can be made to explain the existence of health insurance, public or private. Of course, inflation is another important determinant of an adequate retirement income that is beyond the control of the individual.

Both government and the private sector provide mechanisms for reducing risk. Social Security benefits, which are paid as long as the recipient lives, and Medicare provide essentially the same service as would annuities or private health insurance. At present, the private sector has no financial instrument that, like Social Security, is explicitly keyed to the rate of inflation. However, there are variable annuities whose yields have been highly correlated with the rate of inflation. Other investments also can serve as hedges against inflation. Thus, the private sector is capable of providing mechanisms that can reduce the effects of the three forms of uncertainty—longevity, health, and inflation—that may determine the adequacy of an individual's retirement income. However, the individual may lack important information relevant to his choice, and the private sector may encounter substantial problems in offering a constant real level of benefits.

The benefits of social insurance programs are achieved at the expense of individual diversification. The preferences of people clearly are not identical. Some are willing to assume more risk than others. In addition, some people

Table 3. Annual Federal Benefits for Persons Aged 65 and Older, 1960-82

Year	Actual Expenditures	Benefits Rise to Reflect Price Increases	Benefits Rise to Reflect Growth in Per Capita Disposable Income
1960	$ 768	$ 768	$ 768
1965	1,019	818	966
1970	1,902	1,007	1,337
1975	3,379	1,396	2,002
1978	4,678	1,692	2,592
1982	7,948	2,516	3,663

Source: Table 2 and U.S. population and economic data. The price increases are determined using the CPI.

amount spent for children 17 and under—including the total spent on public education—by more than three to one.

* * *

The long-term solvency of these programs depends on robust economic growth. Barring extraordinary good luck the only way any generation can bring about such compounding prosperity for its children is to build up capital and invest it wisely. In effect, then, the terms of the social contract have remained the same. Each generation, in exchange for support in old age, still must provide its children with a legacy. All that has changed is that the necessary sacrifice falls not just to the individual but to the whole of his generation.

* * *

Giving to each according to his circumstances rather than his age seems the fairest principle. Such a policy may encourage some people to be spendthrifts, but if we provide a strong incentive to save for retirement, the problem should be manageable. As currently written, the tax code rewards large borrowers, by allowing full deductions of interest payments, and discourages most forms of saving. Given the Baby Boom generation's long-term need for capital formation, this is a perverse arrangement.

What becomes of Social Security, Medicare, and other retirement programs in the future is not an issue for senior citizens. It is an issue for their children and grandchildren to decide, before time runs out. □

prefer to save more for their later years than do others. Social Security maintains a relatively constant relationship between income and savings (through Social Security taxes) regardless of the preferences of an individual with respect to risk and savings.

Another argument for a mandatory Social Security program is that, on average, people are overly optimistic about their needs for retirement income. In other words, people will generally save too little. As noted, an "adequate" retirement income is dependent upon several factors (longevity, health, inflation) that are partially outside the control of individuals. Forecasting events is always difficult even if accurate information is available. For those who *over*estimate the income in retirement necessary to satisfy their desired lifestyles, the private and social costs are minor. Such is not the case for those who *under*estimate their income requirements during retirement.

The presence of other social support systems means that people who have suffered adverse health events, planned poorly for late life, or

Being old should not be equated with being poor.

chosen to consume early in life will be cared for at some level by the state. Within this system of social welfare, mandatory savings for a minimum retirement income are a prudent social policy which requires individuals to "save" for their own retirement through Social Security.

Social Security includes two redistribution components. First, current tax revenues are used

Table 4. Change in Real and Relative Income, 1950-80

Period	Percentage Increase in Real Cash Median Income	
	Family Head Aged 65 and Over	Family Head Aged 45 to 54
1950-60	23.8	42.9
1960-70	33.0	42.7
1970-80	20.0	5.9

Source: Robert Clark, George Maddox, Ronald Schrimper, and Daniel Sumner, *Inflation and the Economic Well-Being of the Elderly,* Baltimore: Johns Hopkins University Press, 1984, p. 46.

to pay current benefits instead of being accumulated to fund accrued liabilities. Thus, there is an inter-generation transfer, because the retired generation must rely on income transfers (through taxes) from those currently working. Second, the benefit structure provides that, upon retirement, low-income workers will receive a higher return on their taxes than will middle and upper-income workers.

When viewed as a compulsory life-cycle savings mechanism, the economic rationale for the Social Security system is that it requires each person to contribute a minimum amount toward his or her retirement income and the purchase of health insurance in old age. This savings by the individual requires only a small administrative expense because it is uniform across the population and should provide a minimum level of retirement income. This conclusion does not necessarily imply that age 65 is the most desirable age for full retirement benefits or access to Medicare. Increases in life expectancy, improvements in health, and increases in the elderly population suggest that higher ages may be used for eligibility. The 1983 amendments to Social Security schedule a phased increase in the age for full benefits from 65 to age 67 beginning in the next century. This change substantially reduces the long-run deficit in the financing of Social Security but maintains age as the primary criteria for benefits.

"Past my next milestone
waits my seventieth year.
I mount no longer when
the trumpets call;
My battle-harness
idles on the wall,
The spider's castle,
camping-ground of dust,
Not without dints,
and all in front, I trust."
—James Russell Lowell

The economic rationale for income maintenance programs demonstrates that *age is an inappropriate* eligibility criteria. The economic rationale for social insurance programs, on the other hand, shows that *age is an acceptable* criteria. □

FOOTNOTES

[1]Robert L. Clark, et al., *Inflation and the Economic Well-Being of the Elderly,* Baltimore, Johns Hopkins University Press, 1984.

Mrs. E. L. Harris rides a float in the Aberdeen 4th of July parade.

Courtesy The Pilot, *Southern Pines*

Tax Benefit or Burden?

Attracting Retirees to North Carolina

Carol Majors

by Bill Finger and Jack Betts

"What about those intangibles like mood, ambience, friendliness of the residents, and community spirit?" asks the 1983 *Rand McNally Places Rated Retirement Guide.* "Brevard has them all . . . in abundance," concluded the study, which ranked Brevard *the* most attractive town in America for retirees. Bordering the spectacular Pisgah National Forest in southwestern North Carolina, Brevard (pop. 5,640) has wonderful views and weather, a music festival and a junior college, low unemployment and high per capita income, planned developments for retirees with 24-hour security forces, and a place to buy *The New York Times* daily.

"We've had a tremendous number of inquiries since the Rand McNally report came out," says Esther Wesley, the director of the Transylvania County Chamber of Commerce. Brevard is the county seat. Pulling a clipboard off the wall, Wesley begins to count her tally marks by each state, where she records every request for information about retiring in Brevard. "By June of last year, we had had inquiries from every state, even Alaska and Hawaii," she says. The top states for the inquiries were in order, Florida, New York, North Carolina, California, Pennsylvania, Ohio, Illinois, Minnesota, New Jersey, and Michigan. In 1984, potential retirees also wrote from Japan, The Netherlands, France, Germany, and England. In 1985, requests about retiring in Brevard have come from Saudi Arabia, Poland, and Canada.

The Transylvania County experience with retirees tracks what has happened in other parts of North Carolina in recent years. All three regions of the state—the mountains, Piedmont, and coast—have seen their elderly populations swell, largely from the in-migration of elderly retirees.

Wesley herself moved from New Jersey to Brevard in 1976 when her husband retired. "We've always had retirees coming here," she says, "I would guess the number has doubled in my nine years at this job."

Counting the number of retirees coming to Transylvania County is not an easy matter. The Census data for the county show the 65 and over population jumped from 1,583 in 1970 to 2,940 in 1980—an 86 percent increase compared to a 19 percent increase for the population as a whole. "These figures indicate a large in-migration of elderly persons into the county," says Gerald Green, the county's planner. But these figures only show part of the picture.

"We have two types of retirees," says Transylvania County Manager David McNeill. "People who live here year-round and those who live here six months and keep their residency in Florida." There is no state income tax in Florida, a reason for keeping the Florida residency. North Carolina does have an income tax.

Transylvania County is but one of the high-profile areas in the state beckoning retirees to become latter-day Tar Heels in their twilight years. Macon and Haywood counties in the

mountains (among others), Moore County in the Piedmont (Southern Pines), and Dare County (Nags Head) have changed from the rural, isolated areas of recent years. Composition of

> *"Youth is a blunder, manhood a struggle, old age a regret."*
> *—Benjamin Disraeli*

county boards of commissioners and planning boards are taking on a new complexion as retirees—people with time and oftentimes experience—get involved in civic life.

That means potential changes in politics—though how these changes may evidence themselves is difficult to determine. As counties with large elderly populations grow, it appears from recent political registration data that Republican strength—and conservative sentiment—is slowly gaining on the majority-party Democrats.

For instance, a decade ago, Transylvania County was 33 percent Republican; today it is 36 percent Republican. Moore County, long a haven for Republican retirees, had a GOP registration of 33 percent; today, its Republican registration is 39 percent and growing, according to the State Board of Elections. All this comes at the expense of Democratic Party registration, and ultimately could mean a permanent political shift in those counties. Statewide, GOP registration is a third less, about 26 percent of the total registered.

Meanwhile, the needs of the community are changing. The changes in services range from specific, relatively minor items in a county budget, to differences that can affect the entire local taxing mentality. In 1985, for example, the Transylvania County Board of Commissioners added a $65,000 item in the budget for 24-hour-a-day, paid personnel on the county ambulance system. "We were using volunteers before," says McNeill, "but the demand for higher quality medical care was there." If the $65,000 didn't raise any eyebrows, a *cut* of thousands of dollars from proposed expansions for the local school budget did rankle many local residents who have children in the public schools.

That cut in the proposed budget hurt especially because Transylvania County already ranked near the bottom in per-pupil expenditures in North Carolina. In 1983-84, Transylvania County ranked 94th in the state (among 142 school districts) in terms of the money spent on educating its children *(North Carolina Insight,* Vol. 7, No. 4, p. 49).

Responding to local pressure to hold down budget increases and avoid local tax hikes, the school board cut proposed expenditures for, among other things, an elementary school's art budget. "We had to organize volunteers to provide an arts program," says Jim Parker, a board member of an elementary school's Organization of Parents and Teachers (the local PTA). Dick Voso, the principal where the volunteers were needed for the arts program, did get his arts program but through volunteers—some of them elderly. "Now we have some retirees here who are almost full-time staff members in terms of volunteer support," says Voso.

Parker, a local tennis pro whose livelihood to some extent depends upon the trade of retirees, takes the school funding issue one step further. "I like having the older people coming to Brevard. There are some retired people giving a lot back to the community. But it worries me that the older people will not want the same services that we need for our children."

Not every county has the same experience. For instance, in Moore County, world-renowned for its golf courses and mild climate and long a haven for retirees, there isn't much opposition from older persons to providing programs and services for other age groups. That may be because Moore County is generally a wealthy area.

Bob Ewing, a Moore County commissioner and former Moore County manager, explains: "We are witnessing terrific growth here in terms of the county tax basis because of the homes these folks are coming down here to build. And while they are not bringing new industry with them, they are providing a guaranteed payroll (by purchasing new homes and stimulating the construction industry) of sorts with them."

And, says Ewing, while county revenues are growing, the school-age population has shrunk. "In the last 20 years, our population has grown to

Spring Planting - Whispering Pines Garden Club.

Courtesy The Pilot, Southern Pines

more than 50,000, more than double what it was, but we have about 1,000 fewer students enrolled in the schools." So the combination of growing revenues and less pressure on the school budget than other counties experience, has forestalled any budgetary antipathy from the elderly opposed to new taxation or bond issues.

Taxation and In-migration

How much should North Carolina attempt to attract retirees to the state? The 1985 General Assembly grappled with this issue to some extent in debating whether to repeal the state's intangibles tax. Gov. James G. Martin and other backers of the repeal claimed the tax was a deterrent to attracting retirees. Other analysts insisted that the intangibles tax did not deter retirees from coming to the state (see "Rendering Unto Caesar, the Tax Debate of 1985," *North Carolina Insight,* Vol. 7, No. 4, p. 12).[1]

No doubt, however, the collective impact of North Carolina's tax policy toward older persons does influence whether the elderly retire here—and whether North Carolina's home-grown elderly stay here. The state has several specific tax policies designed to benefit the elderly. They include:

- a double personal exemption on state income taxes, which allows those 65 and over to take an extra $1,100 personal exemption (G.S. 105-149[9]);
- tax exclusion from taxable income of public pensions or state government retirement funds (G.S. 105-141[b] [8], [14], and [18]);
- a new feature that allows a tax deduction for amounts of up to $3,000 paid for maintenance and care of a taxpayer's elderly parents, or a dependency exemption of $800 (G.S. 105-147[28]; and
- the homestead exemption, which exempts from local property taxes the first $12,000 in assessed value of property of those over 65 who have income of no more than $11,000 per year (G.S. 105-277.1).

The Fiscal Research Division of the General Assembly estimates that these state tax breaks for the elderly cost about $41.1 million annually. That includes $11.5 million for the additional personal exemption; $12.2 million for the homestead exemption; $15 million for the public pension income exemption; and $2.4 million for the dependency exemption.

By comparison, 32 states allow the additional personal exemption, 37 states allow pension income exclusion, 24 states provide for a homestead exemption and 27 provide some form of dependency exemptions or credits. For a more complete picture of how North Carolina's tax breaks for the elderly stack up against those of other states popular with retirees, see Table 1.

> *"Old Age: When your memory is short, your experience long, your breath short, your eyesight dim, and your safe-deposit box full."*
> *—Author Unknown*

Three other tax breaks for older persons not offered by North Carolina but used by some other states include: an income tax credit for older persons, a deferring of property taxes for homeowners over a certain age until the property changes hands, and a "circuit breaker," which offers a property-tax rebate for low-income elderly homeowners. (The "circuit breaker" works to protect the elderly from a property-tax overload, just as an electrical circuit breaker protects against a current overload; hence the name.)

Are such tax benefits necessary to attract retirees? Determining exactly what causes a person to migrate to an area for retirement is, of course, difficult. The 1983 Rand McNally study included taxes in its ranking system only indirectly in a "money matters" category. The five other categories were climate and terrain, housing, crime rate, health and health care, and leisure living. A 1979 study done for *MONEY* magazine by Chase Econometric Associates used 10 categories to determine which states were most attractive to retirees. Property tax loads were one of the 10 categories.

North Carolina does not rank among the top two or three states in attracting retirees, as the conventional wisdom would have it in Brevard or in Raleigh. The *MONEY* magazine study had North Carolina 12th among 48 states (Alaska and Hawaii were excluded). A major analysis of the 1980 Census data by Charles Longino and others at the University of Miami at Coral Gables ranked North Carolina 7th in the number of persons over 60 who said they lived in a different state in 1980 than in 1975.

But whether North Carolina is 2nd, 7th, or 12th among the states in attracting retirees, the

Courtesy The Pilot, *Southern Pines*

Millie & Ted Hibbetts, of Southern Pines, adopt a dog from the Moore County Humane Society.

question remains: Should the state attempt to lure retirees—and if so, should it do so with tax breaks? The state does *not* have a program aimed at attracting retirees to settle in North Carolina. Charles Heatherly, director of the Commerce Department's Division of Travel and Tourism Development, says his office provides pamphlets to potential retirees who write seeking information on the state. But that effort does not really meet the needs of those considering moving here, he adds.

"It's really something that the legislature ought to debate and decide upon," says Heatherly. "In the absence of such a program, we supply our own Travel and Tourism brochures to those potential retirees who write to us, but that is really an inadequate response to their needs."

Although the state's taxation policies are often cited when the question of attracting retirees come up, tax breaks for the elderly usually are meant more to help older persons already in the state, says General Assembly fiscal analyst David Crotts. "Most of the bills have been offered as a measure of relief to the existing folks in North Carolina, not as an incentive to attract retirees to the state," says Crotts.

Perhaps, as some state officials argue, there should be such a program to attract retirees. June Barbour, public information officer at the Department of Human Resources' Division of Aging, sees a crying need for a comprehensive retirement planning program that would include specific information for those considering moving here. The state should also consider whether attracting new retirees might ultimately cost state and local governments more than they contribute in terms of tax revenues. For instance, it's often assumed that older migrants to North Carolina are fairly well off and can afford to purchase homes, pay for the medical care, and take care of themselves.

> *"Anyone who stops learning is old, whether at 20 or 80. Anyone who keeps learning stays young. The greatest thing in life is to keep your mind young."*
> *—Henry Ford*

But no hard research exists to back up that notion, or to determine whether elders might, for instance, require vast sums in Medicaid, far outweighing the benefit to the county through property and sales taxes. Or, some counties might encounter resistance from older voters on such

Table 1. Tax Breaks Targeted for Older Persons in States Most Attractive to Retirees

Top 10 States in Attracting Persons 60 and Over[1]	INCOME TAXES				PROPERTY TAXES		
	Double Exemption[2]	Pension Exclusion[3]	Income Credit[4]	Family Care Incentive[5]	Homestead Exemption[6]	Circuit Breaker[7]	Tax Deferral[8]
1. Florida	No Income Tax Levied in State				X		X
2. California	(Personal tax credits)	X	X	X	X	X	X
3. Arizona	X	X		X		X	
4. Texas	No Income Tax Levied in State				X		X
5. New Jersey	X	X			X		
6. Pennsylvania		X				X	
7. **North Carolina**	**X**	**X**		**X**	**X**		
8. Washington	No Income Tax Levied in State				X		X
9. Illinois	X	X			X	X	X
10. New York	X	X		X	X	X	
Number of States With Tax Break	32	37	10	27	24	31	16

Source: National Conference of State Legislatures, survey on using state tax policies to enhance the economic self-sufficiency of older people. Survey results published in "State Budget and Tax News," Vol. 4, No. 1, January 3, 1985.

FOOTNOTES

[1]The best ranking of states in attracting retirees comes from a study by Charles Longino et al. *Retirement Migration Project: A Final Report to the National Institute on Aging,* Center for Social Research in Aging, University of Miami at Coral Gables. Using 1980 U.S. Census data, the report ranked the top 10 states acording to the number of persons 60 and over who said they lived in a different state in 1975 from 1980. see Table 2, page 14 of the report, which can be ordered from Box 248092, Coral Gables, Fla., 33124 ($30.00).

[2]Double exemptions allow each elderly taxpayer to double the normal personal exemption on state income taxes.

[3]Pension exclusions allow exemption from income taxes of some or all of income from public pension funds, such as teachers' and state workers' retirement systems.

[4]Income credit refers to personal tax credits allowed by some states for each elderly taxpayer.

[5]Family care incentive refers to exemptions or deductions allowable to taxpayers who pay for maintenance or care of elderly parents.

[6]Homestead exemption refers to exemptions from personal property taxes of home belonging to elderly property owners.

[7]Circuit breakers—property tax rebates for elderly homeowners—protect the elderly from an overload of taxation.

[8]Tax deferrals allow property tax payments to be deferred until the property in question is sold or otherwise changes hands.

items as bond issues, economic development programs, and tax increases for county services.

So far, though, no one is suggesting that the benefits of new retirees is outweighed by any disadvantages. Far from it, in fact. As Moore County Commissioner Bill Ewing, a Republican, puts it, "Their coming here has created a real economic boon. The only rumblings you might hear in Moore County is that some of these retirees are Republicans."

And listen to former Transylvania County Commissioner Bill Ives. "Retirees are an asset," says Ives. "They pay property taxes and demand little in county social services. They have no children in schools." Right now, Ives sees retirees as a "total benefit." But in the future, says Ives, there will be an "increasing need to help them in their *final* retirement. We need to create places where they can go after 15 to 20 years in their homes. That's the only thing that may end up being a real cost or drain."

But Ives doesn't think the county or state should give special tax breaks to older persons in order to get them to come to North Carolina. "I can't see giving somebody a break just because they're 65," says Ives. "That might sound funny coming from a Republican but that's the way I feel. If I'm getting a break, somebody else is paying my fair share. I believe in taxing those who can pay—in basing taxes on income, not on age."□

FOOTNOTES

[1]The 1985 General Assembly repealed the intangibles tax only on cash, money on deposit, and accounts receivable. The tax remains on stock, bonds, and other items.

Long-term Care for the Elderly: What Promise for the Future?

by Robert Conn

The continuum of health services for older persons has widened in recent years to include everything from hospital and nursing home care to home health services and adult day care. Reimbursement for long-term care—usually Medicare or Medicaid—often determines the location of care on this continuum. "Who will pay?" has become the overriding question rather than the more appropriate question: "What kind of health care does the person need?" What can policymakers do to help the long-term care delivery system emphasize the appropriate level of care for an older person?

The Charlotte Observer/The Charlotte News

John and Lois Horn at home, not in a hospital

The Biblical promise of a life of three score years and ten is being fulfilled for millions of Americans, and even a life of five score years no longer ensures a news article. The longer lives are the results of unprecedented medical progress—the eradication or control of most infectious diseases, plummeting heart disease deaths, and millions surviving cancer.

Increasingly accurate diagnostic devices enable treatment of once bizarre diseases, and sophisticated therapeutic equipment produces cures once thought impossible. Invention of life support equipment has changed the very definition of death.

It's an era when the thump-thump of the respirator is heard in the bedroom as well as the hospital room, when the once-feared correction of cataracts has become drive-in surgery, when diseased arteries are routinely bypassed to add decades to life.

But the added years are a mixed blessing, as people push the upper limit of the human lifespan. Longer lives have unleashed lingering, often incapacitating illnesses—problems scarcely identified just a few years ago.[1] Names like Alzheimer's disease have gone from medical specialty texts to newspaper headlines. Many attribute the increasing cancer rates to an aging population, where odds a cell will go awry increase dramatically.[2]

The cost of treating the elderly has soared so rapidly that some experts fear Medicare will be bankrupt by the end of the decade. The numbers are awesome. Already, people 65 and over represent 11 percent of the population. Those over 85—the "very" old—now total 2.2 million people, about 1 percent. In North Carolina, the number of elderly people will climb from about 600,000 in 1980 to nearly one million by the turn of the century. Those over 85 will increase from 45,000 to 103,000 by the year 2000 (see demographics article on page 3).

Though almost everyone knows someone over 85 who is alert, fit, and spry, others are so infirm they are hardly alive. Many need help with personal care—such basic activities as bathing, dressing, going to the toilet, and even eating.

Robert Conn, a reporter for The Charlotte Observer *and* The Charlotte News, *has covered health-related stories for two decades.*

"Over 90 percent of nursing home patients are dependent on personal care," says William G. Weissert, director of the program on aging at the University of North Carolina School of Public Health in Chapel Hill, and consultant to many experimental projects in caring for the elderly in the state.

Many families try to care for an infirm person at home, like the family of John Horn of Charlotte. Interviewed in December 1984, Horn was avidly watching a tennis match on color television in his bedroom. Beside his bed, a respirator thumped steadily. Every few seconds, the machine sent life-sustaining air through a tube attached to a hole in the 73-year-old man's throat. The air pumped into Horn's emphysema-damaged lungs. Arrayed around the bed were other pieces of sophisticated equipment, such as a suction machine.

"We all want to live a long time, but no one wants to get old."
—Author Unknown

Suddenly the respirator sounded an alarm. Too much fluid was in the lungs for John to continue breathing. In rushed his wife, Lois, 67, who has been trained to suction the excess fluid and otherwise care for her husband. A few minutes later, Horn was breathing normally again.

Just a few years ago, such a scene at home would have been unthinkable. Horn likely would have had to stay in the intensive care unit at Charlotte's Presbyterian Hospital indefinitely—and he already had been there 2½ months. (He was considered too sick for a nursing home to accept.) Now it's possible for John to be treated at home.

Though a nurse checks in on Horn weekly, essentially Lois Horn and two daughters share taking care of John. They consider themselves on duty around the clock. When he first got home from the hospital—he was sent directly home from intensive care—family members often were roused in the middle of the night by the sounding alarm.

Though the Horns share the burden, in many families there's only one care-giver. Constant provision of personal care often leads to care-giver burnout and to permanent placement of the parent in a nursing home. As concern grows about the cost of institutional care, many experts are beginning to focus on the care-giver. If the care-giver can get routine relief and assistance, perhaps nursing home admissions could be reduced.

If the Medicare system has severe financial troubles and if care in the home burns out the care-giver, what kind of long-term care system is evolving? Do sick or infirm older persons have to make an either-or choice: go into a nursing home or become a burden on children? Put another way, do reimbursement systems—Medicare, Medicaid, other government assistance programs, and limited private insurance—*force* an older person into an institution when some kind of community care or home care might be sufficient?

These reimbursement systems, plus an individual's personal resources, pay for health care through what has come to be called the long-term care continuum. The spectrum of settings for health care for elders ranges from hospital to home. It includes nursing homes, home health care, rest homes, and in-home services (such as chore workers), as well as newer innovations such as adult day care, hospice, and respite care. At any one time, the vast majority of the elderly are *not* sick at all, and therefore are not part of the long-term *health* care system. Furthermore, many elderly people die quickly, in their own homes, after leading independent and productive lives until virtually the last moment.

A broad view of long-term care includes services for people who can't be classified as sick, but who no longer are truly independent. They include rest homes, life-care facilities, meals on wheels, and various social services. Long-term care means "services to people who are not fully able to care for themselves," says a state pamphlet. "The main idea is to provide what help people need to get them through the day."[3]

Federal and state lawmakers, faced with spiraling health care costs, want to know the least expensive long-term-care option. Meanwhile, UNC's Weissert and others warn against making cost effectiveness the key question in considering home and community-based care. Most people who use home and community-based care would not normally go into a nursing home, says Weissert. "We know this now from nearly a dozen stud-

ies in which control group experiences show that 75 to 98 percent of home and community care users would have avoided a nursing home admission whether they received home care or not," writes Weissert.[4]

Expanded home-health care *and* expanded institutional care will be needed in future years, as the graying of the population accelerates. If government reimbursement systems are strained now, what will happen as the demand for long-term care increases? Will individuals be forced to pay for a growing share of care themselves, or go without—the situation that often prevailed before Medicare and Medicaid began in the mid-1960s?

The Long-term Care Continuum—Who Pays?

Hailed as health care salvation for the elderly during the "Great Society" of the Johnson Administration, Medicare has fallen short. It is supposed to function as a federal health insurance program to "cover" some 27 million older people. But Medicare in fact is paying a steadily declining percentage of their health care costs.

When *all medical bills* are taken into account, the portion paid by Medicare is about 39 percent. "That can leave a very large amount for you to pay out of your own pocket if you have no other health insurance, if your income isn't low enough, or if your assets are too substantial to qualify for Medicaid public assistance," reports the American Association of Retired Persons (AARP), the largest advocacy organization for older persons in the country, in a recent publication on Medicare.[5]

"This decline (in Medi*care* payments) means that Medi*caid* and the state will have to absorb more of the costs, or that the elderly will have to pay more," Ernest Messer, former director of the N.C. Division of Aging, told a 1984 national citizens board of inquiry hearing in Charlotte on problems of aging. "If they can't pay more, they will have to forgo some medical care."

Medicare has two parts. Anyone 65 or over qualifies for Medicare Part A (with a few exceptions such as non-citizens, some government employees, and some prisoners). This is basically a *hospital* insurance system, with limited coverage for skilled nursing homes and home health services. Part B, a voluntary insurance system, covers *physician services*, hospital outpatient services, and other medical services and equipment. Persons 65 or over can purchase Part B for $15.50 a month. In FY 84 in North Carolina, Medicare Part A reimbursements totaled $871 million. Under Medicare Part B, reimbursements were $260 million; North Carolinians paid Part B premiums of $126 million. The Health Care Financing Administration (HCFA), the federal agency that administers Medicare, found that in 1982 Medicare paid about 70 percent of its benefits for hospital care, 22 percent for physicians' services, 5 percent for nursing home care, and 3 percent for other costs.

Despite promising coverage of nursing home costs, *Medicare now pays less than 5 percent of the total bill for nursing home care.* And, sadly, the fine print on most private Medicare supplemental policies—so-called medigap coverage—carefully tracks Medicare coverage. So what is not covered by Medicare often is not covered by the supplemental policies either.

Take doctor coverage. Medicare Part B pays 80 percent of what it deems to be "reasonable" physician charges. The patient or a private policy must make the 20 percent co-payment. But because "reasonable" is not a precise term, Medicare averages paying closer to 50 percent instead of 80 percent, reports the AARP, leaving the beneficiary responsible for a payment of 50 percent of Part B charges.

"Will you still need me,
will you still feed me,
when I'm 64?"
—John Lennon
Paul McCartney

"The required 20 percent co-payment and the all-too-frequent difference between what Medicare allows as 'reasonable' charges and actual doctors' fees can add up to a sizable amount of medical costs," notes the AARP. Moreover, medigap insurance usually pays only the 20 percent co-payment, *not* the difference between the "reasonable" charge and the actual doctor's charge.[6]

In addition to doctor coverage, Medicare administrators are tightening other reimbursement rules. "The nature of what is considered skilled nursing care is under fire," reports Judy Adams of the N.C. Association

for Home Care. Medicare administrators are denying coverage of home care for some of the most severe post-surgery wounds—those that require drainage or are so deep that the bone is exposed—says Adams, who is a nurse. "That is the kind of wound that no nurse would say does not require the skills of a nurse."

When Medicare administrators determine someone has recovered to a reasonable point termed "maintenance," Medicare now routinely cuts off further home treatments, continues Adams. Medicare might cut off further payment, for example, when a stroke victim has progressed from a wheelchair to a walker even though the person could learn to use a cane, which might make the person virtually independent again.

The main reason for such actions is cost. Nationwide, Medicare has soared from a $4.5 billion program in 1967 to a $66 billion program in 1984. In 1983, the Reagan administration and Congress addressed the rising costs by instituting a new *prospective* payment system for Medicare. Under this system, a hospital must classify a patient by type of disease, known as diagnosis related groups, or DRGs, *prior to treatment.* Hence, the hospital knows what it will be reimbursed for that treatment before providing the care. Formerly, a hospital treated a person and then billed Medicare for those services.

Leading spokespersons from the health care industry credit DRGs with holding down costs. "Reports about the impending bankruptcy of the Medicare Hospital Insurance Trust Fund ... have proven premature," says Samuel H. Howard, vice president and treasurer of the Hospital Corporation of America, the nation's largest hospital chain. The fund, once expected to run out of money in 1991, now is expected to be solvent for seven more years, until 1998. The new prospective payment system "has given hospitals for the first time incentives to reduce costs," says Howard. "Hospitals are being forced to manage better their facilities, admissions, and the care of all patients."[7]

But others say the new DRG system pushes people out of hospitals before they are ready, into other parts of the long-term care system. For instance, U.S. Sen. John Heinz (R-Pa.), chairman of the Senate Special Committee on Aging, charges that under DRGs, patients are being discharged "quicker and sicker, and some may even be discharged

A Very Special Nurse: Kay Falls of Presbyterian HomeCare visits one of her home patients, the Rev. William Baxter at Presbyterian Hospital.

Susie Post, *The Charlotte Observer/The Charlotte News*

prematurely." Many are "being sent out into a no-care zone, without access to the health care they so urgently need," adds Heinz. Consequently, some people who still need care in a hospital are going to nursing homes, rest homes, or returning home. As the location of care shifts, so does the payment system for that care.

By far the largest reimbursement system for health care for older persons, outside of Medicare, is Medicaid. In FY 84, total Medicaid expenditures (federal, state, and local) in North Carolina were $648 million; *$242 million, or 37 percent, went to people 65 and over.* This was almost as much as Medicare Part B in North Carolina ($260 million), and far more if you subtract the $126 million in premiums paid for Part B. Of that $242 million, $199 million went for institutional care.

In North Carolina, 66 percent of the persons in skilled nursing facilities receive Medicaid assistance. About 79 percent of the patients in intermediate care facilities receive Medicaid.[8] (Skilled nursing homes—for licensing, certification, and funding purposes —must have more intense levels of care than intermediate care facilities.)

These figures and percentages illustrate what many lawmakers and health-care administrators already know: *While designed as a health insurance program for **poor** people, it has become, in large part, a health insurance program for **older** persons.* Much of the Medicaid funds must come from state and local taxes, so state legislators and county commissioners pay close attention to Medicaid costs. Nursing home populations affect overall state and county budgets—roads, schools, parks, the works.

Federal funds pay about 67 percent of the state's Medicaid expenses; state and local funds pay the other 33 percent.[9] Federal and state laws determine who can qualify for Medicaid and what services are to be covered. Consequently, eligibility and reimbursable services under Medicaid vary from state to state. In North Carolina, persons may qualify for Medicaid by being classified as either "categorically" or "medically" needy. Because you have to receive public assistance to qualify as "categorically" needy, most older persons qualify for Medicaid as "medically" needy.

But the medically needy category often sets up a kind of Catch 22 situation. For example, Medicaid will pay for home health services such as physical therapy and nursing care. But Medicaid eligibility guidelines put a "cap" on a person's living expenses so that, *ironically, few can afford to stay at home*—and hence take advantage of Medicaid's home-health care coverage. Many believe Medicaid's cap on living expenses virtually forces a person who must get assistance from Medicaid into a nursing home.

Typically, that cap limits the Medicaid recipient to $200 a month in living expenses. Any income above $200 must be spent for medical expenses *before* Medicaid kicks in—a process known as the Medicaid "spend down." All household expenses—food, clothing, utilities, rent, transportation, etc.—must be paid from the $200. The good side of the "spend-down" method of qualifying for Medicaid is that elders can meet sudden, overwhelming medical expenses through Medicaid. The bad side, though, is that few people can stay at home on $200 a month; hence they must go to a nursing home. (To enter a nursing home, a person must also have certain medical needs.)

Private insurance and personal resources (other than the Medicaid spend-down) pay only about 20 to 30 percent of nursing home costs. While many companies extend employee health care benefits to retirees, they may or may not cover nursing homes or other types of long-term care; coverage usually depends on how those policies treat Medicare.

Figure 1 illustrates a model of a comprehensive system of long-term care, which addresses the needs of elders as well as other segments of the population. The article accompanying Figure 1 (see page 67) highlights the key points on the spectrum for older persons as they actually function in North Carolina. Within this model system and the North Carolina experience, the type of reimbursement often determines the level of care. Put another way, "who pays" determines the level and location of health care on the continuum—not the more appropriate consideration: the kind of care the person needs.

Federal policy is largely responsible for this, but many state-level decisions also affect the relationship of reimbursement to type of care. What can state lawmakers, health-care administrators in and out of government, and various advocacy groups do to change how cost affects this spectrum of services? Are there true alternatives to institutionalization?

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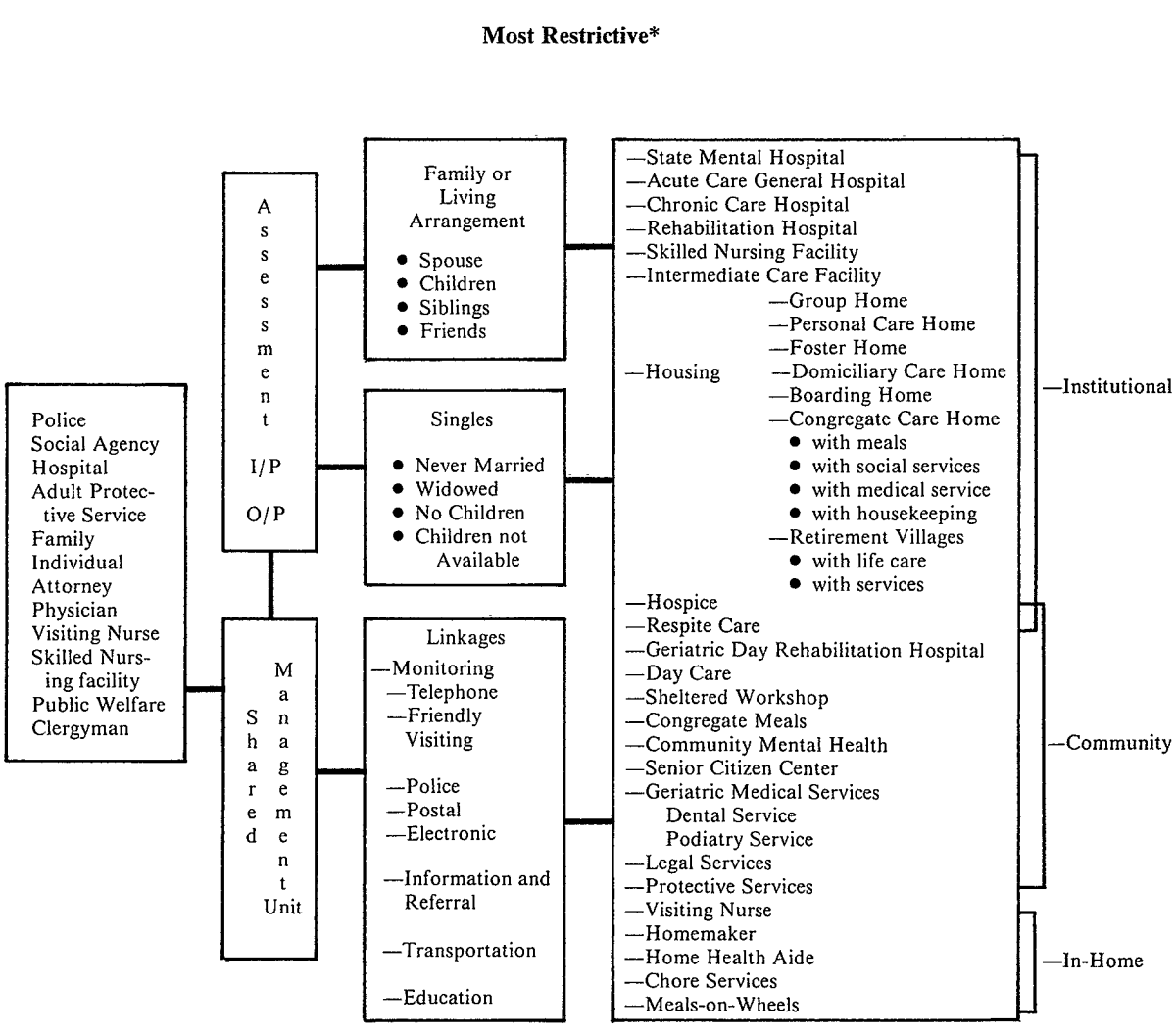
Figure 1. Long-term Support System



*The classification from most to least restrictive is a general view of services and may vary within each service.

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The Long-term Care Continuum in North Carolina

Not long ago, when many people who are now elderly were raising their families, there weren't many alternatives for long-term care. There were hospitals, but the hospitals couldn't offer much—an oxygen tent to help breathing and sulfa drugs (but no antibiotics) to fight infections.

There were places called "nursing homes," but they were mostly converted Victorian houses with 15 to 25 residents that quickly became firetraps when disaster struck. Patient care was primarily custodial. Home care meant hiring a private duty nurse for a shift or to spend the night.

Following World War II, limited hospital care, makeshift nursing homes, and private-care nurses—for the most part—*were* the long-term care continuum. That limited spectrum has expanded greatly in the last four decades—in services, methods of payment, government involvement, and interest by large corporations. In 1945, North Carolina became the first state to separate rest homes from nursing homes, for example, through separate licensing requirements. Hence, in North Carolina, nursing homes are health care facilities while rest homes are places to live with assistance. Many states do not distinguish as well between these two kinds of institutions. Such state-by-state differences make comparisons among states (in beds-per-thousand, for example) difficult.

The advent of Medicare in 1965, with its seeming promise of money to pay for just about any reasonable type of health care, widened the long-term care spectrum and led to the establishment of for-profit chains to provide much of that care. The Medicaid program, also begun in 1965, probably spurred the development of chains of nursing homes.

Today, there are ten key elements in the long-term care continuum in North Carolina, as summarized below. The table beginning on page 14 provides additional information on funding, statutory citations, and other data (see "health" and "social services" sections).

1. **Hospitals.** Virtually all hospitals in the state treat elders. Most hospitals get at least 30 percent of their income from Medicare; many surpass 40 percent. Public hospitals in multi-hospital counties tend to have a greater percentage of elderly patients, primarily because they treat most Medicaid patients.

Until about a decade ago, many communities had two kinds of hospitals: acute general and long-term care. In Mecklenburg County, for instance, Charlotte Memorial, Presbyterian, and Mercy hospitals were acute general hospitals while Huntersville and Charlotte Community hospitals were listed by the state as long-term care hospitals. The charge for an average day was substantially less at the long-term care hospital.

In the first attempt to tighten Medicare outlays in the 1970s, the federal government abruptly eliminated the category "long-term care" hospital from recognition by Medicare and Medicaid. This effectively forced those hospitals to become acute general hospitals. Second, federal authorities began applying acute-care standards of hospitalization to patients in these once long-term hospitals. Auditors from professional review organizations went bed by bed, evaluating each patient. Virtually overnight, these hospitals emptied. Charlotte Community closed; Huntersville Hospital struggled on as an acute general hospital serving northern Mecklenburg until the new University Memorial Hospital replaced it in the spring of 1985. (Huntersville now operates only as a nursing home.)

Now the Medicare prospective payment system is having much the same effect on elderly patients in acute general hospitals. The prospective payment system bases reimbursement to hospitals on the particular diagnosis of the patient (using diagnosis related groups or DRGs). According to some medical leaders, old people are being forced to leave hospitals far sooner than under earlier systems.

"We're sending patients home too quick, too sick," says Dr. James H. Sammons, executive vice president of the American Medical Association. Some hospitals are exerting pressure on physicians to discharge patients prematurely, adds Sammons.[1]

The General Accounting Office, based on visits to six communities, reached the same conclusion. "Patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health."[2]

The important thing to remember is that changes in Medicare reimbursement rules affect

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the entire spectrum of health care for older persons, since most of the discharged patients still require treatment.

2. **Skilled Nursing Facilities** (SNFs). One of two-levels of nursing home care, SNFs provide around-the-clock nursing care, and usually physical therapy, occupational therapy, and speech therapy. Some patients recuperate; some get long-term, virtually custodial care. There are 220 nursing home facilities in North Carolina. Of these 220, 168 have some SNF care; 52 are only SNF facilities. Most SNF facilities are separate—i.e., freestanding. About a dozen are in hospitals, usually as long-term care wings. Nationally, about 800 of the 5,783 hospitals have SNFs. The hospital portion of Medicare Part A covers all of the first 20 approved days of SNF care and part of the next 80 days. Medicaid pays for SNF residency for Medicaid-eligible patients.

3. **Intermediate Care Facilities.** The second level of nursing homes, ICFs, have less intensive nursing care, usually only on one shift. Around the clock staffing is by less skilled personnel. ICFs are not covered by Medicare. More than three in four ICF patients are on Medicaid.

Skilled *and* intermediate care nursing facilities are tightly regulated by the state. They must be awarded a "certificate of need" from the state Division of Facility Services before building new facilities or expanding existing ones. A three-year moratorium on nursing home construction from 1981 to 1984, imposed by the N.C. General Assembly, resulted in a shortage of beds, but the shortage will be partially alleviated with the opening of 1,600 beds now under construction.

4. **Rest (Domiciliary) Homes.** The state has about 1,000 rest homes, which are licensed in three categories: family care homes (two to six persons), homes for the aged (seven or more), and group homes for developmentally disabled adults (two to seven). During the moratorium on nursing home construction, many beds were added in facilities licensed as rest homes but built to nursing home standards. (No certificate of need is required for rest home construction.) Experts estimate that 3,000 rest home beds are empty in North Carolina.

Health services can be provided in rest homes by home health agencies. Neither Medicare nor Medicaid covers rest home care since rest homes are not health facilities. However, Medicare and Medicaid *will* pay for home health services provided in rest homes under the same conditions as provided in the home. Another reimbursement system, State-County Special Assistance, pays for rest-home care for many people (see explanation on page 17).

5. **Home Health Care.** Home health agencies provide services in a patient's home instead of a hospital or nursing home. Services include nursing care, social services, physical therapy, speech therapy, and occupational therapy. In North Carolina, 102 home health agencies are certified to provide home health services under Medicare. Another 10 agencies are licensed by the state, but chose not to be certified for Medicare, according to Gary Bowers of the Association for Home Care. These 10 cannot be paid for treating Medicare patients. Of the 112 total agencies, 14 are hospital-based and 55 are county health departments. Agencies are tightly regulated and were under a certificate of need moratorium for much of 1984.

Home health services involve intermittent visits (not continuous care) by nurses, physical therapists, speech therapists, occupational therapists, and similar specialists. Typically, most visits are less than an hour; the longest are three hours. Increasingly, patients who once were automatically hospitalized are being treated at home. Today's patients may be on respirators, get intravenous therapy for cancer, use machines that pour nutrients into them in a procedure called hyper-alimentation, or take advantage of other high-tech devices.

This care includes para-professional services by home health aides who are supervised by nurses. They can provide more continuous personal care and health support for persons in their homes.

For older persons, most home health visits are covered by Medicare. In addition, Medicaid, private insurance, and other sources pay for some care. In North Carolina, a typical charge is about $50 a visit regardless of the professional (though the average is less than $50 because some health departments don't charge the full cost.[3])

When a person's needs stabilize to a "maintenance" level of care, Medicare will no longer pay and other arrangements for service provision have to be made. This is often when chore or homemaker services are sought, but frequently there is a continuing need for medical (nursing) supervision.

6. **In-home Services:** These differ sharply from home health care. They are provided by county departments of social services, councils on aging, and by private for-profit and non-profit agencies. They generally cannot be paid

for by Medicare-Medicaid (except under the Medicaid waiver program), and rely on funding through the Social Services Block Grant (Title XX), Title III of the Older Americans Act, special state funds, county funds, and private payments.

The largest in-home program is chore services, usually light housekeeping such as cleaning, cooking meals, and washing clothes. Chore workers don't provide a "health" service per se, but they often make the difference in helping an older person remain at home rather than go into an institution. In North Carolina, some 4,000 chore workers serve over 6,000 elderly and disabled clients each year; this care averages two hours a day, five days a week.

Closely related to chore workers are homemakers, who tend to have clients with more serious physical or mental health problems. They may have nurse aide or LPN training in addition to home management and personal care skills; they may assist in financial management in addition to performing as chore workers. In-home care also includes sitters, people who spend the night, and private duty nurses. The minimum visit usually is about three hours, and most are longer.

Agencies that provide in-home services are *not* licensed, though some individuals within the agency—such as the registered nurses—are. Many agencies provide in-home services through a registry of individuals who provide a service; the agency gets a cut of the fee to the individual.

The cost of these services varies greatly ($5-$25/hour). The chore service typically begins at about $6 an hour. For a chore service of three hours each weekday, then, the minimum is some $90 to $100 per week.

7. **Hospice.** These agencies allow a terminally ill person to die at home and to help family members deal with the grieving process. The care emphasizes elimination of pain and symptoms, as well as family support. Though inpatient hospice units are common elsewhere, virtually all those in North Carolina use the home health model, where the patient returns home to die. Hospice includes many aspects of both home health care and in-home care, except the in-home care is often provided by volunteers. Medicare and some private insurance companies pay for hospice care. Medicaid pays for Medicaid-eligible persons.

8. **Life Care Facility.** Life care facilities are designed to house people for the rest of their lives. Generally, the heart of the facility is living units, often cottages, where elderly people move in permanently. Usually that means selling their home and plunking down virtually all their assets in return for lifetime care. Medicare covers people in life care facilities in the same manner as if they lived at home—hospital coverage, SNF coverage after *hospitalization*, and home health care.

9. **Adult Day Care.** Similar to day care facilities for children in many respects, adult day care includes activities during the day as well as limited medical and social services. The elderly client is dropped off in the morning and picked up again at night. Some go every day, some once or twice a week. Adult day care allows the home care-giver, usually a family member, to work and provides relief from constantly caring for the elderly person. A wide variety of agencies operate these programs, including councils on aging, county departments of social services, churches, community nonprofit organizations, and even some for-profit nursing homes. Adult day care centers must meet state standards for such programs.

10. **Respite Care.** Respite care is aimed at relieving the people who ordinarily provide care for the elderly patient. The relief involves either sending a worker into the home or taking the elderly person elsewhere temporarily. This is a new concept and service in North Carolina and is not being widely utilized at present. Recently, it has been adopted as an optional component of chore services. The Medicaid waiver allows for payment of respite care in both an in-home or institutional setting.

—Robert Conn

FOOTNOTES

[1]*Modern Healthcare*, May 10, 1985, page 26.

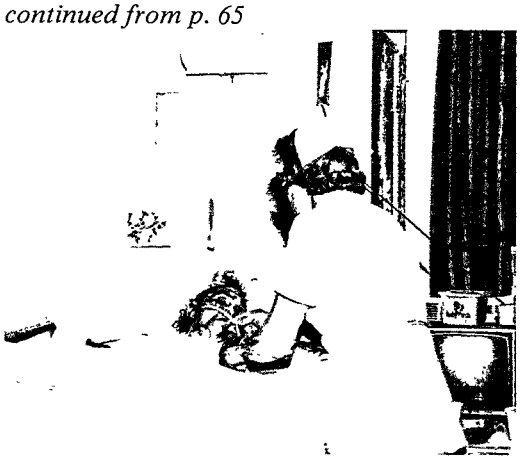
[2]*Modern Healthcare*, March 29, 1985, page 54.

[3]According to the annual report of the Home Health Services Program, N.C. Division of Health Services for fiscal 1983-84, 25,849 of the 33,578 patients served by home health programs were over 65. Based on the total of 758,910 visits during the year, the average patient saw a home health worker 22 times.

Medicare paid $18.9 million of $24.7 million paid out for home health care; Medicaid paid $3.3 million; private insurance policies paid $1.1 million; and people paid $264,000 out of their own pockets. The rest came from other sources.

The charge per visit ranged from $10 to $75.84 for a nurse ($43.42 average), $8 to $50.76 for a home health aide ($28.19 average), $10 to $60.13 for a physical therapist ($38.69 average), $27.27 to $110.05 for an occupational therapist ($50.25 average), $10 to $80.76 for a speech therapist ($48 average) and $31.05 to $110.92 for a social worker ($67.69 average).

continued from p. 65



Can We Save Money and Improve Care?

In 1981, Congress allowed states to begin three-year demonstration programs to see whether the growth of Medicaid expenditures could be curbed by development of home and community services. In states wishing to develop such programs, Congress permitted Medicaid payments for screening, case management, and other services traditionally not covered by Medicaid. North Carolina chose to participate in the federal program, which has since been extended and continues today.

Also in 1981, the North Carolina General Assembly passed House Bill 405 directing the Secretary of Human Resources to establish a screening program for people seeking long-term care. The screening was to occur *before* people were admitted to an institution. The law called for the program to be administered at the local level and to provide "elderly persons with the least restrictive level of care that meets the medical and social needs of the person."[10] A nurse and a social worker (in consultation with a doctor) are to conduct the screening and arrange proper services for those persons who can and want to stay at home.

For those persons who are eligible for Medicaid, the concept goes a step further. If a person qualifies for admission to a nursing home under this screening program, that person can get into what is known as the Medicaid "waiver" program. In other words, Medicaid would waive its normal restrictions and pay for home and community-level care not normally covered.

In North Carolina, the Medicaid waiver program came to be known as the Community Alternatives Program, nicknamed CAP. The program was to include "screening, case management, homemaker/home health aides, chore services, durable medical equipment, home mobility aids, respite care, preparation and delivery of meals, and adult day health care," according to a report developed jointly by the N.C. Health Care Facilities Association (trade group for nursing homes) and the University of North Carolina at Chapel Hill.[11]

About 25 counties are now participating in the CAP program, says Jim Dunn, coordinator of this program for the Division of Medical Assistance, including Mecklenburg, Durham, Orange, Buncombe, Cumberland, and New Hanover counties. "Our most recent request to expand the program, however, was turned down by HCFA," says Barbara Matula, director of the Division of Medical Assistance.

Counties using the program want to keep it, says Dunn, because "we *are* keeping people out of nursing homes, or at least delaying entry." Though the division has no hard figures to *prove* cost effectiveness, federal monitors are watching the North Carolina program closely, says Dunn. Projections based on monitoring utilization of the waiver program and costs from April 1984 through January 1985 "show it (to be) cost effective," he adds.

Conclusions about cost savings remain ambiguous, however. Studies in Wake County and by the N.C. Health Care Facilities Association indicate that with Medicaid reimbursements, home-health care can cost less for some people than nursing home care. Other researchers, particularly William Weissert, insist that people in nursing homes by and large cannot be served as cheaply in a home setting, because of who they are—not because of how care is paid for (see the sidebar on page 72 for more on these studies and their findings).

Most nursing home *patients* stay a short time, says Weissert. Health professionals generally agree that if persons in nursing homes are to be moved to a community or home setting, these short-stay patients are the ones to concentrate on. But most nursing home *beds* are filled by patients who stay a long time. "If you stay three months or more, you almost never get out," says Weissert.

Helping long-term patients move back to the community offers a challenge to some health care professionals. One of these is George Stiles, executive director of the Mecklenburg County Health Care Cost Management Council, which received a $1.5 million

grant from the Robert Wood Johnson Foundation in 1985. Part of the Mecklenburg program is called PACE, Program of Affordable Care for the Elderly.

"I think long stayers are a particularly inviting target for aggressive intervention," Stiles says. "The potential payoff is high." One segment of that long-stay group is patients who were placed in nursing homes to recuperate. But they don't get moved, says Stiles, because they had to "spend down" all their resources to qualify for Medicaid, and now they can't afford to live outside a nursing home.

In the end, then, the Medicaid waiver program might reduce some nursing home costs, but for a limited number of older persons. Weissert and other researchers may well be on the right track in cautioning about the "cost-effectiveness trap."

Policy Considerations for the Future

The nursing-home-care versus home-and-community-care question does suggest one overriding conclusion. Innovative means of both controlling costs and providing needed care must be found. The discussion below, divided into four areas, explores possibilities for the future.

A. Explore new ways of paying for long-term care, such as long-term care insurance. Despite the seeming inevitability of long-term nursing home care, relatively few old people ever use it. That's why many actuaries think long-term care insurance is financially feasible, and why some companies already are marketing it.

"The premiums are surprisingly low and the benefits surprisingly extensive," covering both nursing home care and home care, says Craig Souza of the N.C. Health Care Facilities Association. Souza says coverage costs less than $100 a month.

Prudential Insurance Company has started marketing such a policy to members of the AARP.[12] Matula of the Division of Medical Assistance points out that Fireman's Fund Insurance Companies have had long-term care insurance for more than a decade.

By providing money to pay for long-term care, such insurance protects the elderly person from having to dispose of home, car, and other resources for care. That makes a return home from a nursing home financially possible. Long-term care insurance would emphasize returning home where all but the most infirm are better off. Insurance also would cover in-home care and home health care.

For Gary Bowers, executive director of the N.C. Association for Home Care, the question is how to encourage such insurance. "Option one is to go to the legislature and get them to mandate (health insurance companies to provide) coverage," says Bowers. A second option is to develop a model plan and then market it to insurance companies and employers.

For those elderly persons who could not afford the premium for such insurance, some experts propose innovative financing techniques, such as using home equity to pay premiums. Weissert points out that three-fourths of the aged own their own homes, 80 percent of those free and clear. The average value is $50,000.

Other alternatives for such insurance include:

- *Create Medicare Part C.* People could voluntarily sign up for long-term care, and be completely covered.
- *Permit Health Care Individual Retirement Accounts (IRAs),* devoted to long-term care needs, with a tax credit similar to regular IRAs.
- *Establish a type of HMO* (Home Maintenance Organization) that is aimed at providing home services.[13]
- *Develop a national insurance scheme.* Canada recently expanded its universal health insurance program to include long-term care, both in nursing homes and in the community.[14]

Physical therapy at Mayview Convalescent Home in Raleigh

Carol Majors

B. Examine the role of nursing homes in the long-term care continuum. This task requires answering three separate, yet intertwined, questions.

- Has the state moratorium on growth in the number of nursing home beds been too rigid so that there are too few beds?
- Is there a need for an additional level of care, called Super Skilled Nursing Facilities, between hospitals and nursing homes?
- Should hospitals pay nursing homes to take patients off their hands until Medicaid eligibility has been determined?

There are patients in hospitals who don't have to be there, but who can't get out. "We have documented the problem of hospital backup," says Stiles of the Mecklenburg Council. "Significant numbers of elderly patients who are in acute care hospitals don't need to be there ... but they can't leave because there is no place for them to go." These patients ran up $177,000 of "unnecessary costs" in January alone at Charlotte Memorial Hospital, adds Stiles.

"The condition a man is in can best be judged from what he takes two at a time—stairs or pills."
—Author Unknown

Most blame the state's three-year moratorium on construction of nursing home beds—a moratorium imposed to slow the rapidly rising costs of Medicaid.[15] "Patients never backed up until the supply of nursing home beds became critical (during the moratorium)," says Souza. The moratorium ended in 1984. Currently, some 1,600 nursing home beds are scheduled to be added after approval by the Department of Human Resources (DHR). By 1989, another 3,000 will be authorized, increasing total nursing home beds from about 22,500 to 27,100.[16]

But even 27,100 appears to be low, compared to other states. According to Souza, Georgia has about 34,000 beds and Tennessee, about 29,000. He said North Carolina was among the nation's lowest in beds-per-thousand persons over age 65.[17]

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Cost Effectiveness Studies: How Important Are They for Long-term Care?

Experts disagree on whether cost effectiveness is an appropriate way to analyze the long-term care health system. A number of research efforts in North Carolina are testing whether money can be saved through alternatives to placing people in nursing homes.

AHEC Finds Cost Savings for Home Care

Perhaps the most notable study was conducted by the Area Health Education Center (AHEC), which is based at Wake County Medical Center and affiliated with the University of North Carolina Medical School. The AHEC project, called Care Options Program for the Elderly or COPE, conducted a two-year study on its Medicaid waiver program (see discussion of this program in the main article, page 70). The COPE study reported that for participants in the program "the cost of maintaining individuals in their homes was 36 to 40 percent of Medicaid nursing home costs."[1]

The COPE project had a test group of 201 persons. All 201 met screening requirements for admission to a skilled nursing facility (SNF) or an intermediate care facility (ICF). Of the 201, however, only 101 qualified for the Medicaid waiver program and hence were included in the COPE group. The other 100 were not in the COPE group, usually because they could not qualify for Medicaid. Hence the 201 persons in the study fell into four groups: 1) 58 in the COPE group, SNF-eligible; 2) 43 in the COPE group, ICF-eligible; 3) 39 not in COPE, SNF-eligible; and 4) 61 not in COPE, ICF-eligible.

During the project, *only 13 percent of the COPE group went into nursing homes*

compared with 36 percent of the group not eligible for COPE. The monthly Medicaid SNF charge is $1,369 per person compared with a $501 average at home for COPE patients, a savings of $868 per person, per month. For ICF care, the savings is $652—$1,068 per month in Medicaid ICF costs versus $416 for home care. Moreover, the longer a person stayed in the program, the more the costs decreased. "The people who had been in the project the longest cost us the least," says Teepa Snow, associate project director.

The remarkable thing about this study is not only the cost differences noted above but the fact that the COPE group was actually sicker. In the SNF-eligible group, 83 percent of the COPE group had three or more health problems diagnosed but only 72 percent of the non-COPE group had three such problems. The figures for the ICF-eligible persons are even greater: 79 percent of the COPE group had three or more health problems compared to only 56 percent of the non-COPE group.

To summarize, the COPE study found that many Medicaid-eligible persons can indeed be treated with less expense at home than in a nursing home.

Nursing Home Group Finds Possible Savings

The N.C. Health Care Facilities Association (the state's largest nursing home trade association) made a similar cost-comparison study of 510 persons in eight counties. The association conducted the study in cooperation with the UNC Health Services Research Center and the UNC School of Public Health. All 510 had been approved for admission to a nursing home under Medicaid in 1983, but for a number of reasons only 131 patients actually entered the Medicaid waiver program. The association found results similar to the Wake County program but also questioned the eligibility of patients for the whole Medicaid waiver program.[2]

The study's findings were not as definitive regarding cost as were the Wake County conclusions. And the study raised other questions about the Medicaid waiver program as well. Even though the study found a lower per-person cost associated with the waiver programs than with general nursing home care, "No impact on overall Medicaid nursing home utilization or expenditures could be detected," says Katherine McLeod of the nursing home association.

Two other findings contributed to this conclusion:

- *Persons entering the Medicaid waiver program were not always eligible for it.* To be eligible for the Medicaid waiver program, a person must require nursing home care *and* be eligible for Medicaid, so that some alternative to nursing homes can be explored. But McLeod found that 32 of the 131 patients in the study had no nursing visits planned despite the fact that to qualify for SNF, a patient needs 24-hour nursing care, and for ICF, eight hours of nursing care. About one in four patients in the study, then, were either not eligible for the program or not receiving adequate care—McLeod isn't sure which.
- *Only a small pool of persons can participate in the Medicaid waiver program.* In North Carolina, financial eligibility criteria for Medicaid and medical requirements for the waiver program keep the pool of eligible persons very small. Generally, a person must spend all but $200 a month on medical expenses in order to receive Medicaid. And to qualify for the Medicaid waiver program, a person must be eligible for Medicaid *and* require either SNF or ICF care. Few persons who qualify for nursing home care can afford to stay at home on $200 a month.

But Cost-effectiveness May Not Be the Issue

Some prominent researchers dub cost-effectiveness studies "a trap." William Weissert, director of the Program on Aging at the School of Public Health, the University of North Carolina at Chapel Hill, says that attempts to justify home health care on the basis of cost effectiveness are doomed to failure. "By the mid-70s, everyone thought that home and community-based care would substitute one-for-one for institutional care. Patients in nursing homes or on their way there would choose home and community settings

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instead. Money would be saved. ..."[3] But Weissert says these hopes have failed, listing six main reasons why most people who use home and community based care are not candidates for nursing homes.

- Most nursing home stays are less than three months (people get out or die).[4]
- Most home-care patients who go to nursing homes stay only a short time and then get out; a surprising 25 percent return home.[5]
- Patients who stay in nursing homes longer than three months tend to be very sick, with major disease problems and extreme dependence on others; home-care patients tend to need less intensive help, such as bathing and dressing.[6]
- Patients who need lots of care and supervision are treated more cheaply in nursing homes than at home.[7]
- Most nursing home patients no longer have a spouse while most home or community care patients do.[8]
- Nursing home patients tend to be older than home care patients.[9]

Weissert contends that only a handful of old people currently outside of nursing homes need institutionalization, when considering the number of elders dependent for personal care and not living with a spouse, and such factors as the degree of illness. "Perhaps little more than 1 percent of the aged are at high risk of institutionalization and live in the community," concludes Weissert.[10]

Many programs have a difficult time achieving expected patient participation rates, says Weissert, a technical advisor to both the Wake County and N.C. Health Care Facilities Association studies. If they do a good job of limiting eligibility to those at high risk of institutionalization, the programs may have to operate at smaller than optimal program size, thus driving up operating costs.

To summarize, Weissert says that most patients who use community care are younger, married, and otherwise unlikely to go into a nursing home. Consequently, says Weissert, "When you offer community care, it leads to an overall increase in health service use and is not a substitute for nursing home care."

Conclusion

Experts may continue to disagree over the importance of cost effectiveness within the long-term care health system. Even so, the AHEC and N.C. Health Care Facilities Association studies provide valuable information on concrete experiences in North Carolina. As policymakers debate the broad spectrum of issues involved with long-term care (see main article), cost issues will continue to be uppermost in the minds of many. Perhaps these study results, and the perspectives of researchers like Weissert, will provide a starting point for future discussions. □

—Robert Conn

FOOTNOTES

[1]*Care Option Program for the Elderly (COPE),* special report on the pilot program implementing the Medicaid Community Alternatives Program in Wake County and associated long term care program development, 1982-1984; prepared by the Wake AHEC staff in cooperation with the UNC School of Medicine Program on Aging. The details summarized here come from this study, a gold mine of information.

[2]*Service Innovations in Nursing Homes*, prepared by the N.C. Health Care Facilities Association in cooperation with the Health Services Research Center and the Department of Health Policy and Administration, University of North Carolina at Chapel Hill, under grant #18-P-98188 of the Office of Research of the U.S. Health Care Financing Administration, released October 1984.

[3]William G. Weissert, "Home and Community Based Care: The Cost Effectiveness Trap," *Generations,* summer 1985, page 47.

[4]*Ibid.,* where Weissert cites seven sources, including: D. Ingram and J. Barry, "National Statistics on Death in Nursing Homes: Interpretations and Implications," *The Gerontologist*, Vol. 17, No. 4, 1977, pp. 303-308; K. Liu and Y. Palesch, "The Nursing Home Population: Different Perspectives and Implications for Policy," *Health Care Financing Review*, Vol. 3, No. 2, 1981, pp. 15-23; and K. Liu and K. Manton, "The Length of Stay Pattern of Nursing Home Admissions," *Medical Care,* Vol. 3, No. 2, 1983, pp. 15-23.

[5]William G. Weissert, "Seven Reasons Why it Is So Difficult to Make Community Based Long-Term Care Cost Effective," unpublished paper, April 11, 1985, (to be published in *Health Services Research,* fall 1985), page 5, where he cites four sources, including Liu and Palesch (see note 4), Liu and Manton (see note 4), and E. Keeler, R. Kane, and D. Solomon, "Short and Long-term Residents of Nursing Homes," *Medical Care,* Vol. 19, No. 3, pp. 363-369.

[6]*Ibid.,* page 5, where Weissert cites seven studies from the medical literature.

[7]*Ibid.*

[8]*Ibid,* page 3.

[9]*Ibid.*

[10]*Ibid.*

continued from p. 72

Nationally, an additional 169,000 nursing home beds will be needed by 1990, says Robert Van Tuyle, chairman of Beverly Enterprises, the nation's largest nursing home chain.[18] But he doesn't expect that many to be built because of state limits on new construction. "Severe limitations on capacity make it obvious that available beds will be reserved for the sickest patients," says Van Tuyle. He and other industry leaders see development of home health care and retirement living complexes as two likely results.

Despite Van Tuyle's claim that nursing homes will concentrate on treating the sickest patients, people who require extra care are having difficulty finding beds in North Carolina. Here's why: Heavy care patients require substantially more staff time. Under reimbursement rules, nursing homes get paid the same for these patients as they do for average patients. Too many heavy care patients may force a nursing home to hire additional staffers with no increase in medical reimbursement.

One possible solution is the Super Skilled Nursing Facility (Super SNF), a new level of care between a hospital and an SNF nursing home, which would concentrate on heavy care patients in return for a higher rate of reimbursement. "Super SNF was an idea to solve the problem of hospital backup," says Stiles.[19] An alternative solution, which would require no new institutions, is simply to reimburse nursing homes more for heavy care patients.[20]

Other health officials believe that the shortage of nursing home beds can be addressed by utilizing another section of the long-term care continuum—rest homes. While rest homes are not supposed to provide health care, home health nurses can treat persons in rest homes. The shortage of beds resulted from blinders, says Donna Nixon, formerly of the N.C. Division of Aging. "We don't have to build any additional nursing home beds," she says. Instead, she suggests using the 3,000 empty rest home beds and treating the patients with home health nurses.[21]

Because of the moratorium on nursing home beds, rest homes are playing a more prominent role in the long-term care continuum in North Carolina. Rest homes, which are administered at the state level by the Division of Social Services, are increasingly accepting persons who have specific health-related needs, even though rest homes are not supposed to provide health care.

Preliminary findings from a study still in progress by the Mecklenburg Council suggest that the shortage of nursing home beds and heavy care patients are only part of the hospital backup problem. A third problem is determining Medicaid eligibility, which typically takes 45 days. Medicaid caseworkers are "overwhelmed with applications," says Paul Beck of the Wake County Area Health Education Center (AHEC), which coordinated the county's Medicaid waiver program for two years. The caseworkers take applications "in chronological order. If a patient is in the hospital, he continues to sit in the hospital," says Beck.

Medicaid has become, in large part, a health insurance program for older persons.

Nursing homes are often unwilling to accept Medicaid-dependent patients from a hospital until they become eligible for Medicaid—"understandably so," says Stiles of the Mecklenburg Council. In the council's initial study of hospital backup, the apparent reason for the backup for a significant number of patients was that they had not yet been determined eligible for Medicaid, says Stiles.

One way to address the slow Medicaid process is for hospitals to actually pay nursing homes to take these patients while awaiting Medicaid eligibility. Weissert of UNC suggests that hospitals could save money under such a system. Most of these patients are beyond the point where Medicare will pay (under the DRG specifications), so hospitals are paying for the care from the hospital resources anyway. Moreover, most such patients will eventually become eligible for Medicaid. Nursing homes would repay the money when Medicaid starts paying.

C. Consider more formal interagency cooperative agreements or reorganization. Five divisions of the N.C. Department of Human Resources (DHR) share responsibil-

ity for long-term care of older persons: Social Services, Facility Services, Medical Assistance, Aging, and Health Services.[22] No one is looking at the broad picture, says Beck of the Wake AHEC. Specifically, an older person has difficulty moving from one level of care to another along the continuum without having to apply to two or three agencies.

Some state health officials agree. Maola Jones, acting head of state health planning, for example, says coordination of services "is the biggest problem. Some of the barriers will have to be removed," says Jones, "so a person does not have to go through a whole lot of applications." A task force based in former DHR Secretary Sarah Morrow's office worked to enhance coordination among these agencies. But little has come of the effort.

"I honestly believe we have to bite the bullet," says Nixon. "We'll never have a program that works unless it is pulled together at the top."

Such sentiment does not necessarily mean consolidating functions now in several divisions. In fact, some believe that having different divisions responsible for various elements of the long-term care system is better because they serve as a check and a balance on each other. "I would not like to be licensed, governed, and paid for by one group," says Souza of the N.C. Health Care Facilities Association. "But I would like to see more coordination."

Some officials believe the coordination issue rests primarily at the federal level. "Scattered state administration reflects scattered national policy and funding sources," says Barbara Matula. "It isn't enough alone to pull together these state functions. What's needed is to have a cohesive federal funding policy that identifies sources of federal funds and fills the gaps in the continuum of care."

One effort at better coordination is using case managers. Under the Mecklenburg Council, for example, case managers are working out of private group practices and at hospitals to try to reduce the need for institutionalization. The case managers can make sure patients have support when they need it. This support includes helping the patient determine which agency to deal with.

Current DHR Secretary Phil Kirk is also interested in the case manager system. Kirk's office is now exploring options regarding the single portal of entry concept, which is similar to the case manager approach.[23]

D. Expand the effectiveness of home care by providing support programs for care-givers. John Horn lives at home in Charlotte instead of in an intensive care unit of a hospital—too sick even for a nursing home. He is as dependent on his wife and two daughters as he is on his respirator. Horn is lucky to have three care-givers to share the burden of 24-hour-a-day monitoring of the respirator for an alarm. Having three family members rotate responsibilities for John, however, requires that all three of them learn how the machine works and other essential care-giving tips. There are at least two important issues here, then: burnout of a care-giver and proper training.

A breakdown in the care-giver—not in the person being cared for—is the biggest single reason for institutionalization, says Stiles of the Mecklenburg Council. The care-giver decides, "I can't do this anymore." Two types of support for care-givers can help—respite care and support groups. In support groups, care-givers can discuss common problems and perhaps get relief from their own anxieties by realizing that others have similar problems. Also, group members can try common solutions. Respite care is extremely important as well. It allows families to get away for holidays and vacations and feel secure that an elderly parent is getting proper care.

Conclusion

Respite care and support groups might indeed help John Horn stay at home, despite his damaged lungs. But this is only one piece of a complex puzzle. Health care—from hospitals to home respirators—has evolved into a vastly expensive and fast-changing system. Meanwhile, more of the population is reaching old age, even as the miracles of medicine extend the lifespan.

The long-term care continuum has grown wider and now includes options that few could have imagined just decades ago. But as the range of options has expanded, two interlocking complications have arisen and won't go away: First, who will pay? And second, what kind of care is most appropriate for each person?

The home-health system has already helped John Horn stay at home. But he depends totally on a support system that begins with his family and medical apparatus and includes a home-health nurse and other

assistance. John Horn is just one of the 700,000 North Carolinians over 65. Many are robust and entirely independent, but others are more dependent, just as Horn is. Moreover, those older persons who are sick or require assistance in living take an enormous chunk out of the health care resources. Medicaid has become as much a way to pay for medical care for old people as for poor people, the original purpose of the program.

One health care official, in an interview for this article, called the issue of long-term care for the elderly the second biggest problem facing society—behind nuclear war. Some would say she exaggerates, but few would quibble with the direction of her sentiment. How this country—and this state—address the interlocking and challenging issues in long-term care will in the end affect us all. □

FOOTNOTES

[1]Dr. William R. Hazzard sees the "increasing probability of physical, mental and social dependency" as an "inevitable present consequence of survival into old age." In an August 1983 paper in *Postgraduate Medicine* (Vol. 74, No. 2) and at a 1985 Duke University conference on age and the prevention of age-related disorders, Hazzard says: "While aging per se cannot be prevented, many of its attendant disabilities can be forestalled until the upper limit of the human life span (about 85 years) is approached." Hazzard, director of the program in gerontology and geriatric medicine at Johns Hopkins University, sees a time not far ahead when virtually all the causes of death save accidents will be eliminated. "In such an ideal state, the death rate would be extremely low except near the upper limit of the human life span, when it would be very high indeed. One estimate of the average longevity in that optimal state is 85 +/- 4 years. One in 10,000 individuals would live to be more than 100 years of age, and virtually no one would survive beyond 110 years."

[2]Hazzard says that in the era when everybody lives the maximum, "the specific causes of death ... would be hard to identify (as is currently often the case with the very old). Multiple vulnerabilities in interacting organ systems result in a catastrophic decline in homeostasis and death proceeds from a combination of forces ... rather than from a single, clearly identifiable cause."

[3]"Long Term Care in North Carolina, a continuum of services to the elderly and disabled," a pamphlet by the N.C. Department of Human Resources, February 1985.

[4]William G. Weissert, "Home and Community Based Care: The Cost Effectiveness Trap," *Generations,* Summer 1985, page 47.

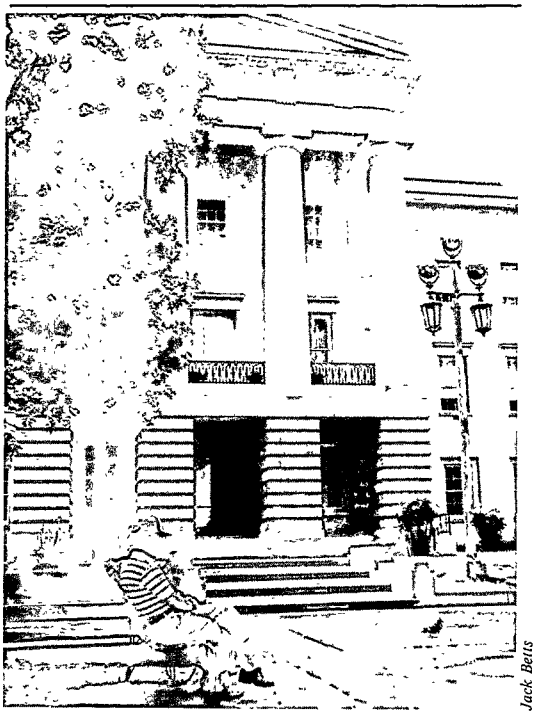
[5]*Information on Medicare and Health Insurance for Older People,* American Association of Retired Persons, no date.

[6]For instance, see the AARP's Medicare Supplement Portfolio. Though the pamphlet boasts of increased benefits for 1985, each of the three plans carefully says: "Note: Eligible charges are determined by Medicare. Your doctor may charge you more." Similar language appeared in other plans, such as National Home Life Assurance Company's Basicare 65 and Secure Care Plus, Colonial Penn Franklin Insurance Company's Maturity 65 plan, and Union Fidelity's Medicare Part B Supplement Rider. Some use potentially misleading language such as "we pay benefits for the eligible in and out hospital surgeon's fees not payable by Medicare," which means just those that meet the Medicare definition of reasonable. Some others, such as Union Fidelity's Medicare Supplement Plan, don't even touch doctor bills. Most of the plans carefully exclude coverage of pre-existing conditions too, which is variously described as sickness or injury treated between six months and a year before the date the policy goes into effect, and extending for three to six months after the policy takes effect.

[7]"Personal Perspective," *Business and Health,* May 1985, page 60. Howard is also president-elect of the Federation of American Hospitals, which represents 1,200 investor-owned hospitals and health care systems.

[8]In Fiscal Year 1983, those in skilled nursing facilities receiving Medicaid paid 17 percent of their bills with personal resources before Medicaid kicked in. Those in intermediate care facilities receiving Medicaid paid 23 percent of their bills with personal resources before Medicaid kicked in.

"Old friends, old friends.
Sat on their park
bench like bookends."
—Paul Simon



Jack Betts

[9]For a full explanation of how Medicaid funding works, see "How Medicaid Cuts Are Calculated" by Leslie Winner in *North Carolina Insight* (Vol. 4, No. 4), December 1981, page 46.

[10]Chapter 675 of the 1981 Session Laws (HB 405), now codified as NCGS 143B-181.6.

[11]Executive Summary, *Service Innovations in Nursing Homes,* prepared by the N.C. Health Care Facilities Association in cooperation with the Health Services Research Center and the Department of Health Policy and Administration, University of North Carolina at Chapel Hill, under grant #18-P-98188 of the Office of Research of the Health Care Financing Administration, released October 1984.

[12]See *Hospitals*, March 1, 1985, page 66, for a discussion of this plan.

[13]An experimental program, called Homeward, is being tested by Lutheran Health Systems of Fargo, N.D., according to a report in the April 26, 1985 issue of *Modern Healthcare* called "Providers will offer care in new settings." The program will—for a fixed, prepaid fee—provide skilled nursing care, intravenous therapy, home delivered meals, and other services at home.

For more on HMOs, see "Health Maintenance Organizations Arrive in North Carolina" by Robert Conn in *North Carolina Insight* (Vol. 7, No. 3), February 1985, page 58.

[14]"The Feasibility of Universal Long-Term Care Benefits, Ideas from Canada," Rosalie and Robert Kane, The Rand Corp., *New England Journal of Medicine,* May 23, 1985. The article summarized these points:

- availability of community services did not reduce the demand for nursing home beds;
- for a relatively controllable cost of about 10 percent of the nursing home budget, the government can provide a good quality program of home health services; and
- residents do not need to impoverish themselves and their spouses to obtain nursing home care.

[15]Chapter 1127, Section 31 of the 1981 Session Laws (October 1981 session).

[16]For the 1,600 figure, see *1985 State Medical Facilities Plan: A Component of the North Carolina State Health Plan,* N.C. Department of Human Resources, Division of Facility Services, 1985, page 131. For the 3,000 figure, see *Draft—1986 State Medical Facilities Plan: A Component of the North Carolina State Health Plan,* July 3, 1985, page 83.

[17]He and his associate, Katherine McLeod, quickly add that definitions of nursing home beds and rest home beds vary from state to state. North Carolina, they said, defines intermediate care beds conservatively, which means fewer beds here are called nursing home beds. Curiously, the National Master Facility Inventory lists North Carolina as having 32,000 nursing home beds, about 10,000 more than are counted under the state's licensing law, according to Katherine McLeod. Before the moratorium began, there were 22,644 SNF and ICF beds officially recorded in the state, including beds in 15 hospitals and 220 freestanding facilities, she said.

While comparisons are difficult in beds-per-thousand because of different classification systems among states, these population comparisons provide some guideposts: North Carolina (6.0 million), Georgia (5.6 million), and Tennessee (4.7 million).

[18]"Long-term care industry develops alternatives to meet needs of elderly," *Modern Healthcare*, April 26, 1985, pp. 59-61.

[19]Most experts believe a Super SNF level of care could be opened without asking the General Assembly for permissive legislation. One way might be under the Medicaid waiver program. Few question that the Department of Human Resources could issue licenses under existing statutes.

[20]That's not as easy as it sounds, say reimbursement experts. The present reimbursement presumes a mix of heavy care, normal care, and even lighter care patients (who are getting ready to move to intermediate care or go home). Would the establishment of a "heavy care" rate mean that normal reimbursement should go down? Would two separate rates mean a huge new bureaucracy to make sure nursing homes weren't trying to claim a heavy care rate for patients who just needed a little more care?

[21]The Division of Social Services estimates there are 3,000 empty rest home beds, although no exact figures are available.

[22]The major responsibilities for the five divisions, regarding the long-term care system for older persons, are:

- *Social Services:* Lead agency at state level for long-term care screening program. Develops policy and guidelines for programs including adult day care, chore, homemaker, preparation and delivery of meals, housing and home improvement, transportation, and placement of adults in domiciliary and nursing care facilities. Responsible for standards for licensure of domiciliary care facilities. *County* departments of social services provide these services to the elderly to enable them to stay at home as long as possible, assist with placement in domiciliary and nursing care facilities, and determine eligibility for Medicaid.
- *Facility Services:* Writes state health plan, which spells out the state's need for long-term care services. Operates the certificate of need program. Licenses hospitals, nursing homes and other long term care services.
- *Medical Assistance:* Runs the state Medicaid program. Pays for health care for persons whose income is below a certain level or whose medical expenses reduce income to that level. Pays hospital and doctor bills, nursing home care, some home health care, and prescriptions.
- *Aging.* Operates the long-term care ombudsman program, nutrition services (including the home delivered and congregate meals programs, senior center services, and technical assistance for a variety of programs for the elderly.
- *Health Services.* Monitors home health care and provides financial assistance to home health agencies for patients unable to pay for essential home health services. Works on health promotion and disease prevention.

[23]For more on the single portal of entry concept, see "Mental Health Policy Questions Under Debate" by Roger Manus and Michael Matros, *North Carolina Insight,* Vol. 7, No. 1, page 48.

Selected Resources

compiled by Cynthia Lambert

Many valuable resources appear in the footnotes to the articles in this issue of North Carolina Insight. *Other background references include the books, reports, pamphlets, and organizations listed below.*

General Resources

The Aging, A Guide to Public Policy by Bennett M. Rich and Martha Baum, University of Pittsburgh Press, 1984. Describes and analyzes federal programs, including the aging network, financial and retirement issues, medical programs, aging veterans, and the elderly worker. Extensive footnotes.

Aging America, Trends and Projections, prepared by the U.S. Senate Special Committee on Aging in conjunction with the American Association of Retired Persons, 1983. Indispensable on demographics, employment, health, family, housing, and education trends.

Demographic and Socioeconomic Aspects of Aging in the United States, U.S. Bureau of the Census, Current Population Reports, Series P-23. No. 138, August 1984. An essential resource for primary data, with chapters on health, size and age structure, sex and race, geographic distribution, social aspects, and economic characteristics.

Getting Even with Getting Old by Julia Braun Kessler, Nelson-Hall, Chicago, 1980. Overview of social and historic issues—family role, purposes of elderly organizations, Social Security, Medicare, and other areas.

"Health Care for the Elderly: A New Agenda," a special issue of *Frontiers of Health Services Management* magazine, Vol. 1, No. 2, Nov. 1984.

Housing Assistance for Older Americans: The Reagan Prescription by James P. Zais et al., The Urban Institute Press, Washington, D.C., 1982. Good overview of subject, 125 pages. Part of this press's "Changing Domestic Priorities" series.

The Law and the Elderly in North Carolina by Lucy Strickland and Mason P. Thomas Jr., Institute of Government, University of North Carolina at Chapel Hill, 1978. While somewhat dated, this is still a good background resource on North Carolina law, with sections on income programs, health, nursing homes, mental health and protective services, and other topics.

LIFE: Health Promotion for Older Adults, revised edition, N.C. Division of Aging, 1984. LIFE, an acronym for Living Independently for Elders, is a manual for use by local communities to encourage education and motivation among older persons about health, recreation, stress management, nutrition, and community involvement.

"Long-term Care in North Carolina: Planning for the Continuing Care Needs of Our Elderly and Disabled Population," N.C. Department of Human Resources, June 1984. Report by an interagency task force, the Long-term Care Advisory Committee, on ways to improve the long-term care system in the state (includes shortened executive summary version).

Medicaid in the Reagan Era: Federal Policy and State Choices by Randall R. Bovbjerg and John Holahan, The Urban Institute Press, Washington, D.C., 1982. Examines Medicaid from the view of the 1981 changes, before and after. Part of this press's "Changing Domestic Priorities" series.

Older Americans in the Reagan Era: Impacts of Federal Policy Changes by James R. Storey, The Urban Institute Press, Washington, D.C., 1983. A review of major changes by program area, with fiscal year 1984 budget proposals. Part of this press's "Changing Domestic Priorities" series.

"Older, Wiser, Stronger: Southern Elders," a special issue of *Southern Exposure* magazine, Vol. XIII, No. 2-3, March-June, 1985. Issues facing older persons in the South, with oral histories and first-person accounts.

Southern Growth Policies Board (SGPB), Box 12293, Research Triangle Park, N.C. 27709. See "The Elderly: Our Oldest Human Resource "(an "SGPB Alert") and "Moving South: The Impact of Elderly Migration."

State Policies and the Aging: Sources, Trends, and Options by William W. Lammers and David Klingman, Lexington Books, 1984. Has chapters on health and long-term care, social services, income maintenance, regulatory protection, and sources of state policy. Good bibliography.

U.S. House of Representatives, Select Committee on Aging, 712 House Annex One, Washington, D.C., 20515. Excellent resource.

U.S. Senate Special Committee on Aging, G-233 Senate Office Building, Washington, D.C. 20510. Excellent resource, with many valuable publications.

Voices of Experience: 1500 Retired People Talk about Retirement by Mario A. Melletti, Teachers Insurance and Annuity Association, College Retirement Equities Fund, New York, 1984. These first-person accounts are divided by subject (adapting, freedom, activities, working, health, etc.).

You and the Senior Boom: New Challenges and Opportunities for All by Louise Minter Odell and Charles Edward Odell Sr., Exposition Press, New York, 1980. Examines how older persons can use and develop their skills and considers options for those interested in working with older persons.

State Legislative Reports

"Aging, Report to the 1985 General Assembly of North Carolina," Legislative Research Commission, February 5, 1985. Findings and recommendations on liability insurance for Nursing Home Advisory Committees, property tax exemption, licensure of adult day care programs, regulation of life care retirement communities, income tax exemption of pensions, senior centers, and continuation of long-term care ombudsmen.

"Aging, Report to the 1983 General Assembly of North

Carolina," Legislative Research Commission, January 12, 1983. Findings and recommendations including hospital nursing home beds within the Nursing Home Patients' Bill of Rights, eliminating the 70 year-old mandatory retirement age, income tax deductions for maintaining parents, liability of the Nursing Home Advisory Committees, appointing older persons to state boards, allowing elderly groups to use school buses, update the Governor's Advisory Council on Aging, and amend the Domiciliary Home Residents' Bill of Rights.

"Aging, Report to the 1981 General Assembly of North Carolina," Legislative Research Commission," 1981. Findings and recommendations on technical inconsistency in "jury service" bill, the Nursing Home Advisory Board, increases in the property tax exemption, and filing tax exemptions only one time.

"Aging, Report to the 1979 General Assembly of North Carolina," Legislative Research Commission, 1979. Findings and recommendations on raising mandatory retirement age, increase in state appropriations for in-home services, appropriate monies for a geriatric medicine program at the University of North Carolina at Chapel Hill, tax exemptions for sale of residence, establish coordinated homemaker-home health aide system in each county, and allow county departments of social services to charge fees.

Selected Private Organizations

American Association of Retired Persons (AARP), James A. Ballard, state director, Rt. 3, Box 214-A, Sylva, N.C. 28779, (704) 586-6169.

The Greater Carolinas' Association of Non-Profit Homes for the Aging, 100 Leonard Ave., Newton, N.C. 28658, (704) 464-8260. An association of mostly church-affiliated nursing homes.

Hospice of North Carolina, Judy Lund, director, 800 St. Mary's St., Suite 401, Raleigh, N.C. 27605, (919) 829-9588.

North Carolina Adult Day Care Association, Suzie Kennedy, president, Life Enrichment Center, 610 Charles Rd., Shelby, N.C. 28150, (704) 484-0405.

North Carolina Association on Aging, Sue Koch, president, Bolens Creek, Burnsville, N.C. 28714, (704) 682-6331.

North Carolina Association of Area Agencies on Aging, Diane Padgett, president, Isothermal Planning and Economic Development Commission, Box 841, Rutherfordton, N.C. 28139, (704) 287-2281.

North Carolina Association for Home Care, Gary Bowers, director, 1037 Dresser Court, Raleigh, N.C. 27609, (919) 878-0500.

North Carolina Association of Long-term Care Facilities, Steve Pierce, president, 1200 Front St., Suite 111, Raleigh, N.C. 27609, (919) 828-4570.

North Carolina Health Care Facilities Association, Craig Souza, director, 5109 Bur Oak Circle, Raleigh, N.C. 27612, (919) 782-3827. The largest trade group for nursing homes in the state.

North Carolina Senior Citizens Association, P.O. Box 34, Fayetteville, N.C. 28302, (919) 323-3641.

North Carolina Senior Citizens Federation, P.O. Drawer 1455, 111-113 West Montgomery, Henderson, N.C. 27536, (919) 492-6031.

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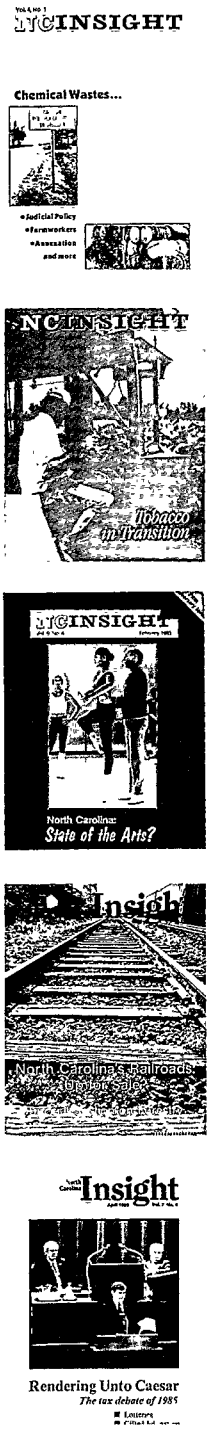


With this column, North Carolina Insight *launches a new regular feature designed to examine policymaking by the judicial branch of state government. Each issue will highlight a recent and significant opinion handed down by the state's courts. This initial effort takes a close look at the court's recent decision in* Larry Delconte v. State of North Carolina, *which upheld the right of parents to teach their children at home in lieu of attending public or conventional private schools. In the future, this column will examine other decisions by the N.C. Supreme Court or the N.C. Court of Appeals.*

When is a school a school?

by Katherine White

Larry and Michele Delconte's legal battle against the state to educate their two children at home ended on May 7, 1985. The N.C. Supreme Court ruled that state law allows home instruction, so long as the home meets certain standards.[1]

The decision focused on a narrow interpretation of state statutes, but at the same time raised fundamental questions about constitutional rights—including freedom of religion and whether that freedom outweighs the state's responsibility to guarantee each child an education. The decision even raised the basic question of what precisely constitutes a school.

The Delconte's home instruction program, called the "Hallelujah School," gained Supreme Court approval because the Harnett County couple met statutory guidelines for private schools, according to the unanimous Court decision written by Associate Justice James Exum.

In 1969 and again in 1979, the N.C. Attorney General had held in two separate formal opinions that the state's compulsory school attendance laws prohibited home instruction[2] and required that public and nonpublic education be conducted in an institutional setting.[3] The Supreme Court's *Delconte* ruling nullified these opinions.

"We find nothing in the evolution of our compulsory school attendance laws to support a conclusion that the word 'school,' when used by the legislature in statutes bearing on compulsory attendance, evidences a legislative purpose to refer to a particular kind of instructional setting," ruled the Court. "Indeed, the evident purpose of ... recent statutes is to loosen, rather than tighten, the standards for nonpublic education in North Carolina."[4]

But the Court invited the General Assembly to reassess the statutes that allowed the Court to reach its conclusion that home instruction is permissible as long as certain academic criteria are met. "Whether home instruction ought to be permitted, and if so, the extent to which it should be regulated, are questions of public policy which are reasonably debatable. Our legislature may want to consider them and speak plainly about them," the Court said.

The legislature may choose to do just that. Even before the May 7 opinion, two state legislators—Sens. Helen Marvin (D-Gaston) and Dennis Winner (D-Buncombe) introduced a bill directing a study commission to evaluate the state's position on home instruction.[5] Winner explained, "Home education was at least worth looking at if you could ensure they (children) were getting a good education." Of the Court's ruling, Winner said he thought "the legislature never intended (to allow) home education."

The motivation for the study commission came from several of Winner's constituents, he said, including former public school teachers who complained that their children did not get an adequate education in public schools. Because of inadequate public instruction, he said, they wanted the option of teaching their children at home.

But until and unless the legislature takes formal action, the Court decision means that parents in North Carolina can teach their children as long as they meet certain criteria, including maintaining attendance records, immunizing against diseases, keeping a regular schedule, conducting safety and health inspections, administering annual tests and maintaining test scores, and providing information on operations to the appropriate state agencies.

Katherine White, a lawyer, covers the N.C. Supreme Court, the N.C. General Assembly, and other government institutions for The Charlotte Observer.

Beyond the Delcontes' argument that existing state statutes allow home instruction, the couple offered several constitutional reasons for justifying their position. The court did not have to rule on the constitutional questions in order to decide the *Delconte* case, but gave a strong signal that the justices would, in the right circumstances, lean toward the rights of individuals. The plaintiffs raised these constitutional points:

- The N.C. Constitution seems to permit children to be "educated by other means" than in public schools.[6] "It is clear that the North Carolina Constitution empowers the General Assembly to require that our children *be educated.* Whether the Constitution permits the General Assembly to prohibit their education at home is not clear," Exum wrote. The legislature historically has insisted only that the teaching setting, whatever it is, meet certain, objective standards, he added.
- The First Amendment to the U.S. Constitution, establishing freedom of religion, can take precedence over state compulsory schools laws.[7] Exum wrote that the U.S. Supreme Court "seems to consider the right of parents to guide both the religious future and the education generally of their children to be fundamental so as not to be interfered with in the absence of a compelling state interest."

At the same time, the Court recognized "that the state has a compelling interest in seeing that children are educated and may, constitutionally, establish minimum educational requirements and standards for education."

The Delcontes did not limit their arguments to religious beliefs, citing what they called "socio-psychological" reasons as other, nonreligious reasons for teaching their children at home. Mr. Delconte also testified at a Superior Court hearing that his family could not afford to send the children to a private school. And, he declared, he objected to the school's use of corporal punishment.

Because of these nonreligious objections to compulsory public school attendance, the Delcontes do not present a clean case for a court's decision on whether an individual's freedom of religion outweighs the state's interest in requiring education.

State Rep. Frank D. Sizemore III (R-Guilford), who filed a friend of the court brief in the case for The Christian Legal Society, a national group of lawyers and judges, said that the balancing of the two constitutional interests "would inevitably get involved into considering what kinds of responses—short of closing (a home school)—were reasonable to accommodate the state's interest.... Where those two cross, the basic (individual) right would still prevail. But I don't think we've had to cross that threshold."

State courts generally have been divided on a parent's right to educate a child at home simply because the parent believes state schools are inadequate. One friend of the court brief, noting the fact that at last count, 39 states allow some form of home instruction, cited the example of the state of New Jersey. That state has developed a model approach, placing the burden on the school system to show non-attendance first; then the parents must show that their home teaching is of equal quality to that of the public school. Finally, the school system must prove that home teaching deprives the child of an education. "The balanced approach takes account of both the state's interest in education and the parents' freedom to choose. In addition, and perhaps most important, it permits a greater focus on the best interests of the individual child," write Tobak and Zirkel in *Home Instruction: An Analysis of the Statutes and Case Law.*[8]

Should North Carolina adopt this approach? That is a question of public policy that the legislature must tackle. Choosing between the sometimes-competing demands of individual freedoms and the state's responsibility to educate its citizens guarantees that the next session of the General Assembly will have to make decisions that the N.C. Supreme Court could not. And that includes defining exactly what constitutes a "school" in North Carolina. □

FOOTNOTES

[1] *Larry Delconte v. State of North Carolina,* No. 9PA84, dec. May 7, 1985, 313 N.C. 384 (1985); 329 S.E.2d 636 (1985).

[2] 40 Op. Attorney General 211 (1969); 49 Op. Attorney General 8 (1979), on compulsory attendance laws.

[3] The Court relied on the legislature's definition of qualified nonpublic schools. NCGS 115C-555 requires that a nonpublic school have one of four characteristics, including that "it receives no funding from the state of North Carolina." The Delcontes' home school received no public funding.

[4] *Delconte v. State,* pp. 20-21.

[5] Senate Joint Resolution 224, introduced April 11, 1985: "The Legislative Research Commission is authorized to study whether home study programs should satisfy the requirement of compulsory school attendance." The study was authorized in chapter 790 of the 1985 Session Laws (SB 636), section 1 (24).

[6] Article IX, Section 3, North Carolina Constitution: "The General Assembly shall provide that every child of appropriate age and of sufficient mental and physical ability shall attend the public schools, unless educated by other means." The Court commented, "Whether these 'other means' would include home instruction is a serious question which we need not ... now address."

[7] *Wisconsin v. Yoder,* 406 U.S. 205 (1972).

[8] Tobak & Zirkel, *Home Instruction: An Analysis of the Statutes and Case Law,* 8 U. Dayton Law Review. 1 (1982). pps. 59-60.

Letters to the Editor

Vol. 7, No. 3: Insurance

I want to thank you for the kind and generous article you did on me in your recent publication, but more importantly, I want to congratulate you on the outstanding job you did on the overwhelming topic of insurance.

As you probably know, we have used your publication in several ways in just the first few days, educating our lawmakers with your material as background, and even our own staff turns to *Insight* for a quick and detailed reference guide.

Much of the material is being used in speeches for some department spokespersons, and I have recommended to all members of this department to take time to read the material. I have had requests from as far away as Kansas for copies of this issue.

Thank you very much for all you are doing and continue to do to educate our citizens on their government.

James E. Long
Commissioner of Insurance
Raleigh

Your articles are unbalanced and misleading.

John Ingram
Former Commissioner of Insurance
Cary

Thank you very much for the copy of Volume 7, No. 3 of *North Carolina Insight*. I have purchased additional copies for people interested in the insurance industry and I know they will share my appreciation for the most informative presentation.

As a long-time member of the North Carolina Center for Public Policy Research, Inc., let me again commend you and your colleagues for the splendid contribution you make in so many areas. Your publications on many varied subjects have been of much benefit to me.

J. Melville Broughton, Jr.
Raleigh

Thanks for sending the copy of *Insight*. I particularly liked the article on regulating rates.

Finley Lee
Julian Price Professor
of Business Administration
University of North Carolina
Chapel Hill

Vol. 7, No. 4: Lotteries

In your April 1985 article on a lottery, I noted that the key argument against a lottery was missing: that it is not a generator of economic opportunity. In fact as a voluntary tax it carries a minus economic multiple per dollar wagered.

In contrast pari-mutuel wagering, but not bookmaking or off track betting, carries about the highest economic multiple—both secondary and tertiary—of any industry that you can name. This is because of the triple tier horse and farm development—breeding, training, and racing—as well as the tourism development for which racing serves as the incentive and catalyst.

The Carolina Sports Association has an economic program for the development of the horse industry in this state. Our consultants are Killingsworth and Associates, and other prominent men in this field. With in-depth research we have prepared a program that I feel is well worth studying. Too, for some it is a really viable economic alternative to a lottery.

Randall B. Terry, Jr.
Carolina Sports Association
High Point

Boards and Commissions

Thank you for providing us a copy of your report on boards and commissions. You and your staff have obviously devoted a great deal of time and effort to this project and the final product reflects an outstanding job.

From our perspective, your report will serve as a valuable reference in conducting our audits. From the point of view of concerned citizens, we hope those charged with the responsibility for taking corrective actions will follow through on your recommendations.

Edward Renfrow
State Auditor
Raleigh

My congratulations to the Center on a very thorough report on Boards, Commissions, and Councils. It has been and will continue to be a useful reference in our office regarding these groups and their functions. I expect many of your recommendations will be acted on by the Governor or the General Assembly.

The council has acted to respond to your suggestion and moved from the Department of Administration. We have also brought your recommendations regarding the seven secondary vocational education program area advisory committees to the attention of the Department of Public Instruction.

I look forward to the Center's continued examination of North Carolina government.

E. Michael Latta
Executive Director
State Advisory Council
on Education
Raleigh

Vol. 6, No. 4: Utility Regulation

We thought that the Center did a very good job reporting on the problems in regulating utility companies when they diversify. *(North Carolina Insight, January 1984)*

The improper subsidization of an unregulated propane gas subsidiary by a regulated natural gas utility is a problem we believe is far from a solution.

Another relevant issue I believe you will find interesting is the conflict of interests which exists when the men who determine where to run natural gas lines also offer the easiest substitute fuel, propane, through their unregulated subsidiary company. There are countless situations where someone has to decide between extending the natural gas line to a customer or referring him to another fuel supplier. Who makes this decision and what are his interests? We believe that in some cases, the representative from the gas utility simply says, "We'll take care of it," to the prospective customer.

Bruce E. Byers
North State Gas Service
Forest City

FROM THE CENTER OUT

Quick now—what's more than 1-1/4 inches thick, weighs more than 3-1/4 pounds and runs 637 pages? The Manhattan Yellow Pages? Gibbons' *Decline and Fall of the Roman Empire?* The North Carolina General Assembly's biennial pork barrel appropriations bill?

Nope. It's the Center's newest major publication, *Grantseeking in North Carolina: A Guide to Foundation and Corporate Giving.* The fruit of 2-1/2 years of research, the guide is the state's first comprehensive handbook to foundation and corporate giving programs. Released July 1, 1985, the book has already been reviewed by a number of newspapers.

The Asheville Citizen-Times noted editorially that "North Carolina is fortunate to have these good neighbors (foundations and corporations). Their presence is comforting to non-profit organizations that serve a legitimate purpose in providing services to deserving people.

The Durham Morning Herald echoed that sentiment in an editorial entitled "The Big-Hearted State," and the editor of The Fayetteville Times called the guide "a grand book about a very favorite subject, and while I don't expect to see it on every home library shelf, I suspect the copies that are sold will quickly become dog-eared with use." He went on to call the guide "a veritable Santa Claus goody-bag for grown folks."

Praise for the guide has rolled in from other quarters. An officer of the Council on Foundations in Washington, D.C., called the guide "about the most complete statewide guide I have seen, and I hope other publishers of such guides learn from it." And Samuel M. Stone, director of development for the N.C. School of the Arts, commented, "I have been anticipating the arrival of the volume, and in an action which I cannot explain to myself I read it cover-to-cover in one sitting last night. Only a hustler of the worst sort would do such a thing. The scope of the project as much as the details on the individual foundations is to be complimented."

The book, compiled under the direction of Anita Gunn Shirley under a special grant from the Z. Smith Reynolds Foundation of Winston-Salem, turned up some startling facts on foundations in North Carolina. Among the findings:

- There are 589 foundations in North Carolina, plus at least 81 corporate giving programs.
- The foundations collectively give away $95.7 million a year, and the corporate giving programs donate another $78.2 million to various organizations, individuals, causes, and institutions. The total: $174 million a year.
- North Carolina ranks 14th in the nation in the number of foundations, and there is at least one foundation in 67 of the state's 100 counties. Only 17 of the biggest foundations employ paid staff members, and 21 foundations issue an annual report, brochure or other publication about their programs.
- While the state is not generally known as a wealthy one, North Carolina's foundations give nearly twice as much as any other state in the South, and more than the combined totals of six other states—Alabama, Kentucky, Mississippi, South Carolina, Tennessee, and Virginia.

Ran Coble, executive director of the Center, explains three principal reasons why the Center took on the project. "First, as a public service, we wanted to provide all non-profit organizations in North Carolina with information on potential funding sources. Second, the guide contains details on what foundations and corporations give money for, so grantseekers don't waste time applying to people who may have no interest in their projects. And third, it should help foundations and corporations see what their peers are doing."

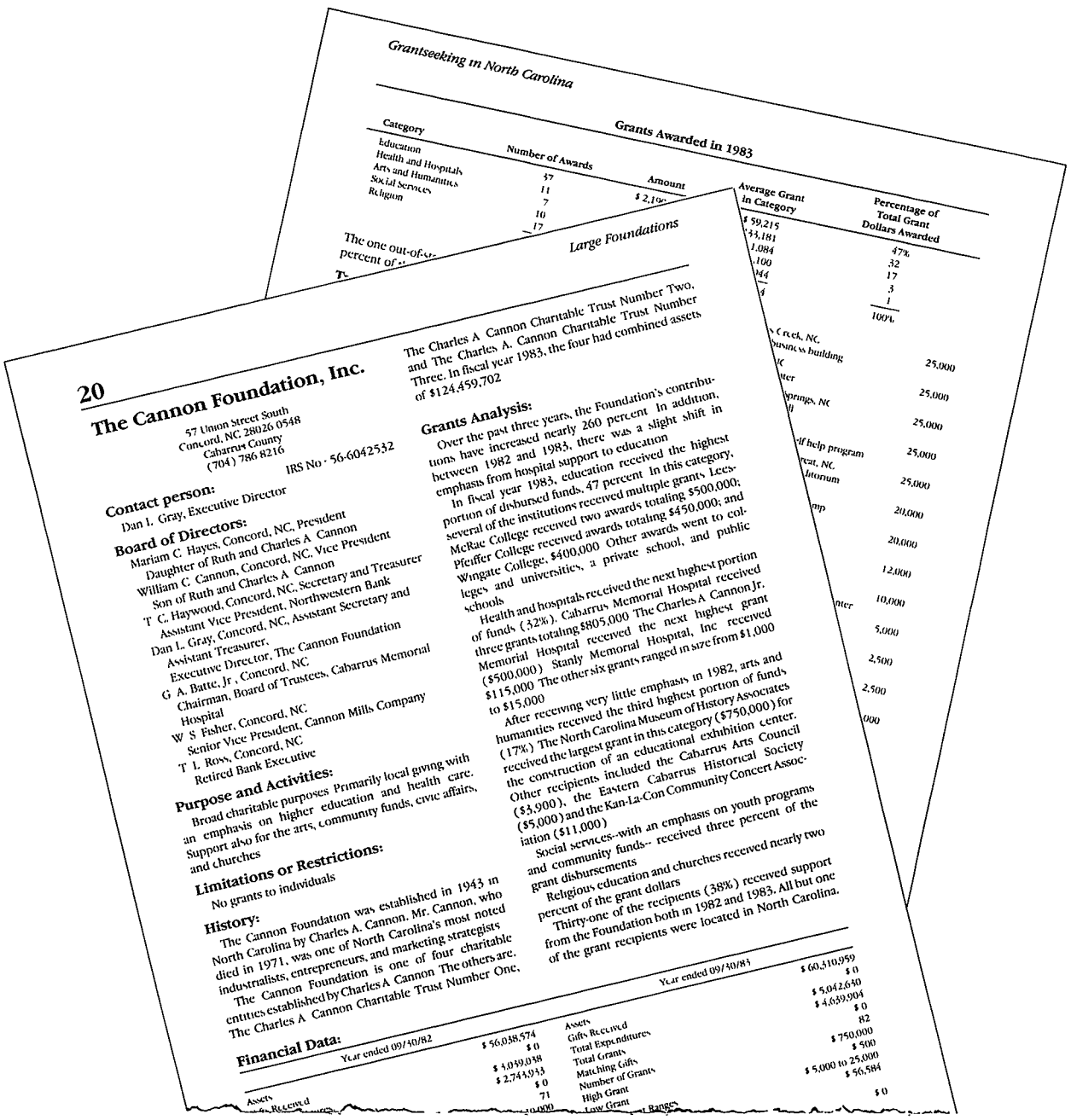
The guide functions as far more than a list of foundations and how much they give each year. In addition to such basic information as the name and address of foundations and their individual purpose, the guide also reports, for example, the foundation's board of directors, its history and limitations on giving, the types of projects funded and certain financial data including assets, normal grant ranges, and number of grants awarded.

The guide also helps fundraisers by giving

good advice on how to go about seeking money from foundations and from corporate giving programs. It includes a chapter on writing a grant proposal and a light-hearted but absolutely practical admonition entitled "The Eleven Commandments of Corporate Fundraising" written by John Bacon, a corporate official with R. J. Reynolds Industries, Inc. For instance, Bacon warns, "Thou shalt not call today and expect shekels tommorrow."

The Guide, available from the Center for $35 plus $2.50 for shipping and handling, found a wide variety of giving programs among the foundations and corporations. The top five foundations in terms of giving in 1982 were the Duke Foundation, Charlotte ($36.1 million); the Z. Smith Reynolds Foundation, Winston-Salem ($5.3 million); the Cannon Foundation, Concord ($4.6 million); the Smith Richardson Foundation, Greensboro ($4.1 million); and the Winston-Salem Foundation, Winston-Salem ($3.4 million).

The book includes information on 81 corporate giving programs in North Carolina. Among the largest programs are those of R.J. Reynolds Industries, Burlington Industries, IBM, Duke Power Company, and The Wachovia Corporation.



Grantseeking in North Carolina

Grants Awarded in 1983

Category	Number of Awards	Amount	Average Grant in Category	Percentage of Total Grant Dollars Awarded
Education	57	$ 2,10-	$ 59,215	47%
Health and Hospitals	11		33,181	32
Arts and Humanities	7		1,084	17
Social Services	10		100	3
Religion	17		44	1
				100%

The one out-of-s... percent of ...

Large Foundations

20

The Cannon Foundation, Inc.

57 Union Street South
Concord, NC 28026 0548
Cabarrus County
(704) 786 8216
IRS No - 56-6042532

Contact person:
Dan L. Gray, Executive Director

Board of Directors:
Mariam C. Hayes, Concord, NC, President
Daughter of Ruth and Charles A. Cannon
William C. Cannon, Concord, NC, Vice President
Son of Ruth and Charles A. Cannon
T. C. Haywood, Concord, NC, Secretary and Treasurer
Assistant Vice President, Northwestern Bank
Dan L. Gray, Concord, NC, Assistant Secretary and Assistant Treasurer,
Executive Director, The Cannon Foundation
G. A. Batte, Jr., Concord, NC
Chairman, Board of Trustees, Cabarrus Memorial Hospital
W. S. Fisher, Concord, NC
Senior Vice President, Cannon Mills Company
T. L. Ross, Concord, NC
Retired Bank Executive

Purpose and Activities:
Broad charitable purposes Primarily local giving with an emphasis on higher education and health care. Support also for the arts, community funds, civic affairs, and churches

Limitations or Restrictions:
No grants to individuals

History:
The Cannon Foundation was established in 1943 in North Carolina by Charles A. Cannon, Mr. Cannon, who died in 1971, was one of North Carolina's most noted industrialists, entrepreneurs, and marketing strategists The Cannon Foundation is one of four charitable entities established by Charles A Cannon The others are. The Charles A Cannon Charitable Trust Number One, The Charles A Cannon Charitable Trust Number Two, and The Charles A. Cannon Charitable Trust Number Three. In fiscal year 1983, the four had combined assets of $124,459,702

Grants Analysis:
Over the past three years, the Foundation's contributions have increased nearly 260 percent In addition, between 1982 and 1983, there was a slight shift in emphasis from hospital support to education In fiscal year 1983, education received the highest portion of disbursed funds, 47 percent In this category, several of the institutions received multiple grants, Lees-McRae College received two awards totaling $500,000; Pfeiffer College received awards totaling $450,000; and Wingate College, $400,000 Other awards went to colleges and universities, a private school, and public schools

Health and hospitals received the next highest portion of funds (32%). Cabarrus Memorial Hospital received three grants totaling $805,000 The Charles A Cannon Jr. Memorial Hospital received the next highest grant ($500,000) Stanly Memorial Hospital, Inc received $115,000 The other six grants ranged in size from $1,000 to $15,000

After receiving very little emphasis in 1982, arts and humanities received the third highest portion of funds (17%) The North Carolina Museum of History Associates received the largest grant in this category ($750,000) for the construction of an educational exhibition center. Other recipients included the Cabarrus Arts Council ($3,900), the Eastern Cabarrus Historical Society ($5,000) and the Kan-La-Con Community Concert Association ($11,000)

Social services--with an emphasis on youth programs and community funds-- received three percent of the grant disbursements

Religious education and churches received nearly two percent of the grant dollars

Thirty-one of the recipients (38%) received support from the Foundation both in 1982 and 1983. All but one of the grant recipients were located in North Carolina.

Financial Data:

	Year ended 09/30/82	Year ended 09/30/83
Assets	$ 56,038,574	$ 60,310,959
Gifts Received	$ 0	$ 0
Total Expenditures	$ 3,039,038	$ 5,042,640
Total Grants	$ 2,743,933	$ 4,639,904
Matching Gifts	$ 0	$ 0
Number of Grants	71	82
High Grant	10,000	$ 750,000
Low Grant		$ 500
Typical Range		$ 5,000 to 25,000
Average Grant		$ 56,584
Number of Employees		$ 0

Contributors to the N.C. Center for Public Policy Research

The North Carolina Center for Public Policy Research wishes to express appreciation to the foundations and corporations supporting the Center's efforts in 1985. Their help makes it possible for the Center to produce high-quality research on important public policy issues facing the state.

Major funding for the North Carolina Center is provided by:

THE MARY REYNOLDS BABCOCK FOUNDATION

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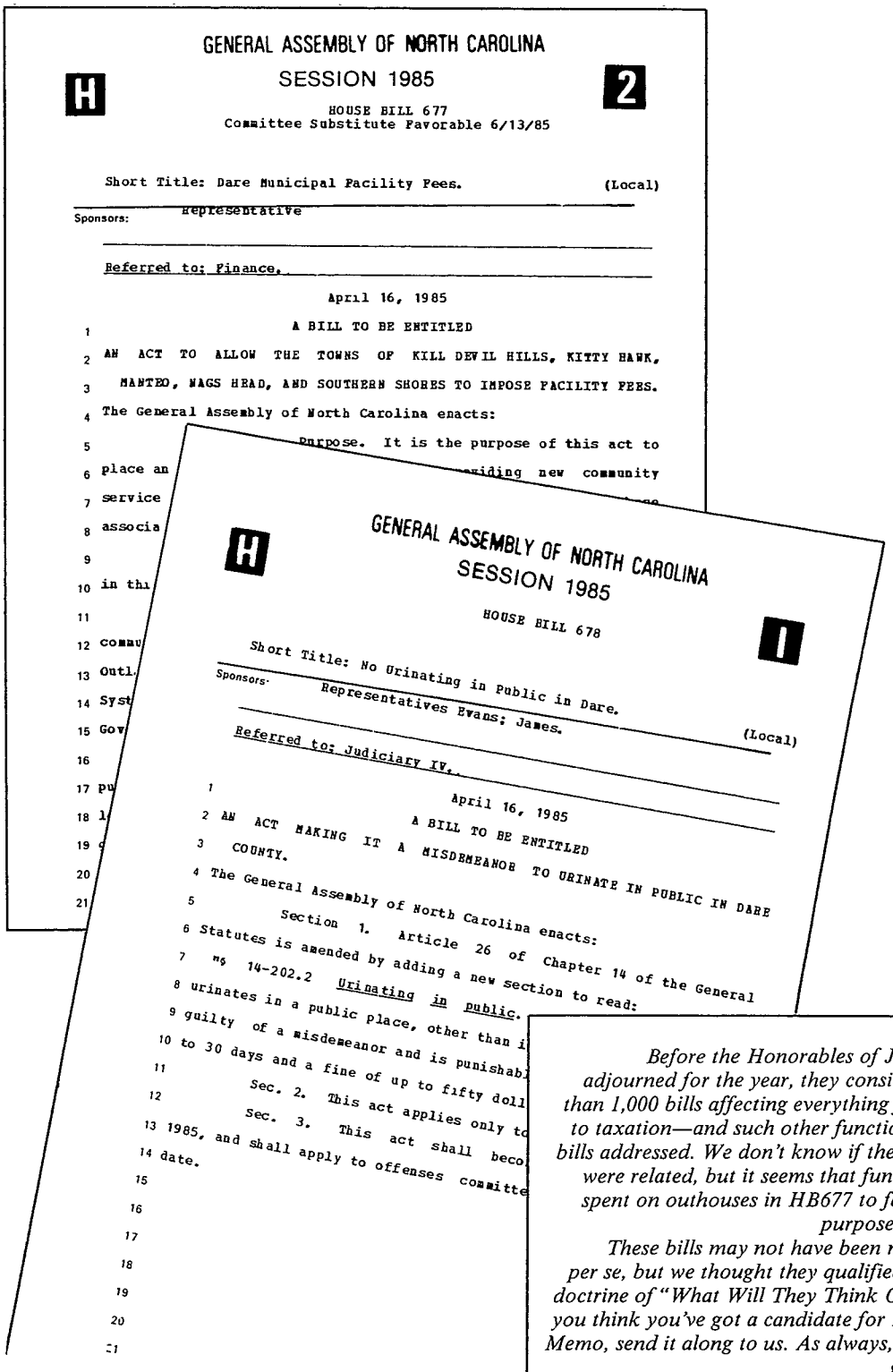
Index to Vol. 7

Below is a subject index to *North Carolina Insight,* Volume 7 (1984-85). Following the subject heading is the article title, the author(s), the number of the issue in Volume 7 in which it appeared, and the page number in the issue.

MEMORABLE MEMO



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1985

H 2

HOUSE BILL 677
Committee Substitute Favorable 6/13/85

Short Title: Dare Municipal Facility Fees. (Local)

Sponsors: Representative

Referred to: Finance.

April 16, 1985

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE TOWNS OF KILL DEVIL HILLS, KITTY HAWK, MANTEO, NAGS HEAD, AND SOUTHERN SHORES TO IMPOSE FACILITY FEES.

The General Assembly of North Carolina enacts:

Purpose. It is the purpose of this act to place an ...viding new community service ... associa... in thi... commu... Outl... Syst... Gov...

pu...

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1985

H 1

HOUSE BILL 678

Short Title: No Urinating in Public in Dare. (Local)

Sponsors: Representatives Evans; James.

Referred to: Judiciary IV.

April 16, 1985

A BILL TO BE ENTITLED

AN ACT MAKING IT A MISDEMEANOR TO URINATE IN PUBLIC IN DARE COUNTY.

The General Assembly of North Carolina enacts:

Section 1. Article 26 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"§ 14-202.2 Urinating in public.

... urinates in a public place, other than i...
... guilty of a misdemeanor and is punishab...
... to 30 days and a fine of up to fifty doll...

Sec. 2. This act applies only to...

Sec. 3. This act shall beco... 1985, and shall apply to offenses committe... date.

Before the Honorables of Jones Street adjourned for the year, they considered more than 1,000 bills affecting everything from death to taxation—and such other functions as these bills addressed. We don't know if these two bills were related, but it seems that funds could be spent on outhouses in HB677 to facilitate the purpose of HB678.

These bills may not have been memoranda per se, but we thought they qualified under the doctrine of "What Will They Think Of Next?" If you think you've got a candidate for Memorable Memo, send it along to us. As always, anonymity guaranteed.

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Raleigh, North Carolina 27602

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