ON THE SIDELINES: HISPANIC ELDERLY AND THE CONTINUUM OF CARE

SELF-SUFFICIENT ELDERLY

Preventive Services
Transportation
Employment Services
Volunteer Opportunities
Senior Center Programs
Congregate Meals
Escort Services
Telephone Reassurance
Information & Referral

FRAIL/TEMPORARY ILL ELDERLY

Restorative Services
Respite
Home-delivered Meals
Home-health Services
Homemaker/Chore Services
Case Management
Legal Assistance
Protective Services

DEPENDENT ELDERLY

In-Home Services
Institutional Care
Pre-Admission Screening
Adult Day Care
Ombudsman Services
THE NATIONAL COUNCIL OF LA RAZA (NCLR)

The National Council of La Raza (NCLR), the largest constituency-based national Hispanic organization, exists to improve life opportunities for the more than 20 million Americans of Hispanic descent. In addition to its Washington, D.C. headquarters, the Council maintains field offices in Los Angeles, California; Phoenix, Arizona; McAllen, Texas; and Chicago, Illinois. The Council has four missions: applied research, policy analysis and advocacy on behalf of the entire Hispanic community; capacity-building assistance to support and strengthen Hispanic community-based organizations; public information activities designed to provide accurate information and positive images of Hispanics; and special innovative, catalytic, and international projects. NCLR acts as an umbrella for 130 affiliated Hispanic community-based organizations which together serve 32 states and the District of Columbia and reach more than one million Hispanics annually.

THE ANCIANOS NETWORK PROJECT

The NCLR Ancianos Network Project has established a long-term commitment to issues affecting Hispanic elderly within the National Council of La Raza’s policy analysis and advocacy agenda. The Project brings together NCLR affiliates and other Hispanic and non-Hispanic groups which share a commitment to addressing the needs and concerns of older Hispanics into an information- and skill-sharing network. Major program activities include applied research and policy analysis focusing on the socioeconomic status and program needs of low-income Hispanic elderly; dissemination of information and materials to increase awareness of the status and needs of Hispanic elderly; and training and technical assistance to help network members assess elderly needs in their communities and design and improve programs to address these needs.
ON THE SIDELINES:
HISPANIC ELDERLY AND THE CONTINUUM OF CARE

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EXECUTIVE SUMMARY

The elderly population in the U.S is growing more rapidly than the rest of the population. The 65 and older population has almost doubled in less than 30 years, from 16.7 million in 1960 to 31.5 million in 1989, and is projected to more than double again in the next 40 years. In 1989, the 60 and over population (those eligible for Older Americans Act programs) totaled 41.8 million; of these, 37.4 million, or 89.5% were White; 3.6 million, or 8.6%, Black; and 1.6 million, or 3.8%, Hispanic.

Today older Americans as a group are living longer, healthier, and more financially secure lives than decades ago. They are the beneficiaries of successful federal programs which have helped to improve their economic condition: Social Security, Medicare/Medicaid, Supplemental Security Income (SSI), Older Americans Act programs, housing and energy assistance, Food Stamps, employment and training, and other programs. The elderly have also benefited from better health care, increases in real wages, the expansion of private pensions, and improved working conditions, sanitation, safety, and nutrition. As a result, there is a growing perception that senior citizens in the U.S. lead a privileged lifestyle. While it is true that middle- and upper-class elderly have substantial resources, a significant portion of older persons, primarily minority elderly, have practically none. These vulnerable elderly live on the edge of economic survival. A very large proportion of the Hispanic elderly fall into this "at-risk" group.

A. Demographic Overview of the Hispanic Elderly

Hispanics overall are a young population. In 1989, they had a median age of 25.9 years, compared to 32.5 for the total U.S. population. Hispanics 65 and older accounted for 5.2% of the total Hispanic population. Cubans were the oldest Hispanic subgroup with a median age of 41.4, compared to 23.6 for Mexican Americans, 26.8 for Puerto Ricans, and 28.4 for Central and South Americans. Thus among the Hispanic subgroups, only Cubans had a percentage of elderly (17%) similar to that of the overall population (12%). Although Mexican Americans were younger, and had the lowest percentage of elderly in 1989 (3.8% of the Mexican American population were 65 and older), nearly half of all Hispanic elderly were Mexican American. As of March 1989, 47.6% of the Hispanic elderly were Mexican American, 10.9% Puerto Rican, 18.1% Cuban American, 8.4% Central and South American, and 15.0% other Hispanic.

The Hispanic elderly population is growing at a faster rate than the non-Hispanic elderly population. The Hispanic 65 and over population is projected to almost double from 3.6% of the total elderly population in 1990 to 6.3% in 2010, and to 11.7% in 2050. In comparison, the White non-Hispanic elderly population is projected to decrease from 86.9% of all elderly in 1990 to 81.8% in 2010 and 68.9% in 2050. The Black elderly population will experience a slight increase, from 8.1% in 1990 to 9.1% in 2010 and to 13.7% in 2050.
Hispanic elderly are geographically concentrated in the Southern and Western regions of the United States, particularly California and Texas. According to 1980 Census data, seven out of 10 Hispanic elderly lived in four states -- California (25.3%), Texas (21.2%), Florida (13.5%), and New York (10.9%) -- much like the entire Hispanic population. By comparison, the same proportion of non-Hispanic elderly, seven out of 10, were dispersed in 17 different states.

More than four out of 10 Hispanic elderly are foreign-born. While more than 70% of all Hispanics were born in the U.S. (including Puerto Rico) according to 1980 Census figures, only 58% of Hispanic elderly were native-born Americans. Conversely, about 88% of the total elderly population were native born. Mexico is the country of origin for the largest group of foreign-born Hispanic elderly, followed by Cuba. A large proportion of the Mexican American elderly come from families who have lived in the Southwest for generations; however, the majority of elderly Cubans came to the U.S. in adulthood, as political refugees.

Hispanics are the least educated elderly subgroup. According to 1988 Census data, only about one in five Hispanics 65 and over had graduated from high school, and more than one in three had less than five years of schooling, compared to one in 20 of the total elderly population. In addition to limited access to education and the need to leave school to work, limited English proficiency can often contribute to low Hispanic educational levels. As of 1989, approximately four in 10 elderly Hispanics did not speak English at all.

B. Socioeconomic Status

The median income for elderly Hispanics is about two-thirds that of Whites, and the poverty rate for Hispanic elderly is more than twice the rate for Whites. In 1989, the median income for elderly Hispanics was $6,642, slightly above the poverty threshold ($5,947) for an individual 65 years and over, compared to $10,048 for White elderly and $6,069 for Black elderly. In 1989, the poverty rate for Hispanic elderly was 20.6%, more than twice the rate for White elderly (9.6%), but below the rate for Black elderly (30.8%). Because most elderly Hispanics have worked at low-paying jobs, or are forced to leave the workforce before retirement age for health reasons, they are likely to receive minimum or near-minimum Social Security or pension benefits when they retire. This results in high rates of poverty and near poverty.

Although they have worked hard throughout their lives, most Hispanic elderly cannot count on a financially secure retirement. Hispanic elderly are less likely than Whites or Blacks to receive public pensions or veterans’ benefits, partly due to the fact that Hispanics have traditionally been underrepresented as government employees. Hispanic elderly are also less likely than Whites to receive private pensions or to have incomes from interest and other assets, and less likely than either Blacks or Whites to receive Social Security. As of 1988, only 77% of Hispanic elderly received Social Security, compared to 93% of White elderly and 89% of Black elderly. Only 19% of Hispanic elderly received a
private pension, compared to 31% of White elderly and 17% of Black elderly. Hispanics who do receive Social Security tend to depend on it more than all elderly. In 1988, Social Security provided more than 64% of the total income for half of all elderly Hispanics, while it represented 48% of total support received by half of all White elderly.

Due to low incomes and limited participation in Social Security and other retirement plans, Hispanic elderly are more likely than non-Hispanics to depend on earnings and public assistance to survive. In 1988, elderly Hispanics were three times as likely as the total aged population to collect Supplemental Security Income (SSI); 21% of Hispanic elderly received SSI benefits, compared to 7% of all elderly. In 1986, SSI accounted for 6.4% of the Hispanic elderly’s total income, compared to 0.9% of the income of all elderly. Despite high need, Hispanic elderly are less likely to receive SSI than the rest of the eligible population; it has been estimated that only 44% of eligible Hispanics receive SSI. Moreover, while the labor force participation rate for elderly Hispanics is similar to that of Black and White elderly, Hispanics are far more likely than Whites to be unemployed.

Older Hispanics are in poorer health than the general elderly population. A 1989 report by the House Select Committee on Aging found that in 1986, 41.2% of elderly Hispanics perceived themselves to be in poor or fair health, compared with 29.9% of all elderly. Older Hispanics were also found to have high rates of disability. Some 31.5% of elderly Hispanics had been bedridden for one to 30 days during 1986, compared to 21.9% of elderly Whites and 26.9% of elderly Blacks. Elderly Hispanics had an average of 37.0 "restricted activity days", compared to 31 days for Whites and 43 days for Blacks. Moreover, Hispanic elderly averaged fewer doctor visits despite the needed attention, 8.0 doctor visits, compared to 9.1 visits for Whites, and 9.0 visits for Blacks.

While Hispanic elderly are likely to be in worse health and functional status than others their age, they have lower rates of health insurance coverage. According to a 1989 Commonwealth Fund report, Hispanics were more likely not to have any health insurance (8%) than the overall elderly population (1%) and less likely to have Medicare and supplemental Medicare coverage than all elderly. Only 82% of Hispanic elderly were covered by Medicare, compared with 96% of all elderly. Only 21% of older Hispanics were covered by both Medicare and private insurance, compared to 69% of all elderly. As a result, older Hispanics are especially vulnerable to costly medical expenses.

While these statistics reflect the economic vulnerability of the Hispanic elderly population, they do not adequately reflect its strengths. Hispanic culture places a high value on the family, which is clearly reflected in the living conditions of older Hispanics. Elderly Hispanics are more likely to live in the community and in multigenerational families than other U.S. elderly and are less likely to live in homes for the aged. As of 1989, more than three-fourths (76.6%) of Hispanic elderly lived with family members, compared to two-thirds (67.5%) of White elderly and three-fifths (63.1%) of Black elderly. Of the 1.5 million elderly living in nursing homes in 1985, only 2.7% were Hispanic, 92.2% were White, and 7.8% were Black.
There is a misconception that because Hispanic families take care of their elderly, older Hispanics have little need for external services and programs. The high rate of poverty within the overall Hispanic community, however, makes the cost of such care a serious financial burden for Hispanic families. In addition, some elderly Hispanics do not have families, particularly if they came to the U.S. as refugees or immigrants. As the growth of the elderly Hispanic population outpaces the growth of younger generations, families face greater difficulties in meeting elderly needs. Social services and programs which can supplement family care and thus ease the burden of caregiving are critical for Hispanics.

Current trends indicate that in the 21st century Hispanic elderly will be living longer, and that they will continue to be economically disadvantaged, and to live in the community rather than in institutions. This presents significant challenges for American society, particularly for the "aging network," in providing for the health, income, social services, and housing needs of this growing population.

C. Hispanic Elderly and the Continuum of Care

The Older Americans Act (OAA) is the basis for the organization and delivery of community-based social services for the aging. The Act lays the foundation for a service delivery network -- the aging network -- with the Administration on Aging (AoA) at the federal level, 57 State Units on Aging, 670 Area Agencies on Aging, and more than 40,000 service providers at the state and local levels. While the federal government is responsible for assuring that federal dollars equitably serve all elderly, program funding and implementation decisions are made at the state and local levels. It is therefore crucial to monitor programs and assess how effectively they are serving older Hispanics.

Over the last decade, the aging network has not fully met one of the fundamental missions of the OAA, to provide services to "older persons with the greatest economic or social need, with particular attention to low-income minority individuals". Data from AoA reveal that Hispanic participation in OAA nutrition programs declined by 14.9% from Fiscal Year (FY) 1981 to FY 1986, and then remained stable between 1986 and 1988. Hispanic participation in supportive services declined by 35.4% between FY 1980 and FY 1988. According to AoA, the apparent decreases are due to changes in target group definitions or criteria of inclusion that were less liberal after 1981, and the states' increasing ability to report less duplicated participant counts.

It appears that lack of participation in OAA programs is due in part to such factors as a lack of bilingual/bicultural staff; location of meal sites and programs outside minority communities, making them inaccessible or difficult to reach due to lack of transportation; and a perception by many minority elderly that they are not welcome in the programs. In addition, the Hispanic elderly's low educational attainment and limited English proficiency make the traditional written outreach strategies employed by mainstream agencies largely ineffective.
A history of high concentration in service sector and farm labor jobs, work that until recently was not covered by Social Security or pension plans, is one of the major factors accounting for the low level of Social Security coverage among the Hispanic elderly. Other reasons include lack of knowledge of eligibility criteria or how to apply for benefits, fear of government agencies, and not working long enough to qualify for benefits—many Hispanics are forced to leave the work force before retirement age for health reasons.

Despite high need, most older Hispanics do not appear to be participating in entitlement programs in proportion to their need. Common barriers to enrollment in these programs appear to be lack of knowledge about eligibility criteria due to scarce or ineffective publicity and outreach efforts; and the complexity of the application process, especially in view of the lack of bilingual assistance in most public agencies.

Lack of decent, affordable housing is a major problem in the Hispanic elderly community. As the Hispanic family’s living arrangements begin to shift away from the traditional multigenerational model, many Hispanic elderly will be looking for housing which will allow them to stay in their communities and maintain an independent living status, while receiving necessary support services. The long waiting lists for existing agency-sponsored Section 202 housing—the chief federal program financing the construction of subsidized housing for the elderly and handicapped—are evidence of the high level of need for this type of facility. In addition, the federal government’s involvement in housing for the low-income elderly, particularly in the production of new units, has been falling off since 1981.

For the elderly, services are useful only to the extent that transportation can make them accessible. Transportation, the vital link between home and community, can support an individual’s capacity for independent living and thus reduce or eliminate the need for institutional care. The age and economic need of the client population make accessibility and affordability of transportation major issues. Current transportation programs do not begin to meet the great demand. Busses run infrequently, routes do not serve Hispanic communities, or facilities do not meet the needs of frail or disabled elderly. Language problems may also limit Hispanic elderly’s use of public or private transportation systems.

D. Analysis and Recommendations

Improving opportunities and services for Hispanic elderly requires a comprehensive approach at the national, state, and local levels. Policy making at all levels should reflect an understanding of the needs and status of Hispanic elderly. If OAA and other publicly funded social service programs are going to equitably serve Hispanics, immediate policy interventions are needed.

Participation by older Hispanics in OAA and in needs-tested programs should reflect the high proportion of needy Hispanic elderly. According to current standards, minority elderly should be served in at least the same proportion that the population of minority elderly bears to the total elderly population in the area. However, this standard
ignores the fact that minority elderly "participate in poverty" at a greater rate than non-minority individuals. They should also participate in these programs at greater rates than their proportion of the elderly population, preferably at a level reflecting their percentage of the local low-income elderly population.

The social service needs of the Hispanic elderly cannot be met without increased enforcement of AoA targeting requirements and greater funding of programs based in Hispanic neighborhoods. Because Hispanics tend to rely on their own community for accessible and appropriate services and assistance, Hispanic community-based organizations are an essential mechanism for reaching and serving Hispanics. Such organizations should be encouraged and funded to develop programs to meet the needs of older Hispanics.

Mainstream public and private agencies should carry out more -- and more effective -- outreach about available services and eligibility requirements. In addition, mainstream social service agencies serving communities with a large number of older Hispanics should be required to have bilingual and bicultural staff. These agencies should also develop strong coordination with Hispanic service providers in order to successfully reach the Hispanic elderly population.

Because income security programs are critical in alleviating the plight of elderly Hispanics, policy changes in these programs are essential. Of special concern is the need for greater equity in the Social Security system. Consideration should be given to adding a variable age formula which would take into account not only recipient age but also the number of years worked. For example, workers could be eligible for full benefits at an earlier age, or increased benefits if they have worked a greater number of years. Targeting outreach efforts toward the Hispanic community, particularly the limited-English-proficient, could help bring many more eligible into entitlement programs.

Federal guidelines for programs such as SSI, housing assistance, and other cash and non-cash benefits should be changed so that they do not separate or penalize multigenerational families. It is generally both less expensive and more socially desirable for elderly people to be cared for at home than for them to be institutionalized, but this places the burden of caring for the elderly on the community and the family. Tax and other benefits should be investigated for families that care for their elderly at home.

Both health and mental health services should be expanded, made affordable, and placed in locations which are accessible to the Hispanic elderly. Bilingual outreach for Medicare, Medicaid, and other health resources must also be improved.

All federal, state, and local agencies should be required to collect and report data on eligibility, access, and participation by race/ethnic characteristics. Data on Hispanic eligibility rates and participation in elderly programs are essential to measure program effectiveness and ensure equitable provision of services.
Two current demographic trends -- the increase in the elderly population in this country and the rapid growth of the Hispanic elderly population -- promise a profound impact on America's present and future. Both of these demographic factors have the potential to further depress the already severe social, economic, and health conditions of the elderly Hispanic population. Greater public awareness of the status and needs of Hispanic elderly is needed in order to develop appropriate policy and programmatic responses.
I. ELDERLY SERVICES AND PROGRAMS

Today older Americans as a group are living longer, healthier, and more financially secure lives than decades ago. They are the beneficiaries of successful federal programs which have helped to improve their economic condition. Some, such as Social Security, Medicare, and Older Americans Act programs, are specifically targeted to the elderly, while others, such as Supplemental Security Income, Medicaid, and Food Stamps, are designed to have a greater reach. The elderly have also benefited from better health care, increases in real wages, the expansion of private pensions, and improved working conditions, sanitation, safety, and nutrition. As a result, there is a growing perception that senior citizens in the U.S. lead a privileged lifestyle. While middle- and upper-class elderly have substantial resources, many elderly have almost none. A very large proportion of the Hispanic elderly are part of this vulnerable population.

A. Towards a National Aging Policy

Attempts at developing a national policy on aging can be traced back to the early 1900s, when activists began advocating for a comprehensive social insurance system covering industrial accidents, sickness, old age, disability, death, and unemployment. The economic devastation of the Great Depression, the growing unemployment among the aged, and the poverty and despair in which so many elderly found themselves when no longer able to work led to the enactment of the Social Security Act in 1935. Although Social Security was originally intended to provide protection to the retired worker, it was modified to include Old Age Survivors Insurance (OASI) before the first benefit payments were made in 1940. Over the years, coverage has been expanded and benefits increased. In 1972 the Supplemental Security Income (SSI) program was authorized under Title XVI of the Social Security Act. Two years later, the SSI program began providing a nationally uniform minimum income to the needy aged, blind, or disabled who did not qualify for Social Security or whose Social Security benefits were not sufficient to meet their basic needs.

A series of legislative initiatives of importance to the elderly were signed into law as part of President Lyndon B. Johnson’s Great Society programs. The Food Stamp Act of 1964 was designed to improve nutrition among low-income households through a cooperative federal-state program of food assistance. A medical care system for the elderly and poor was established in 1965. Through its main component, Medicare, the federal government assumed a substantial responsibility for the health-care costs of older Americans. Under Medicaid, the federal and state governments were to provide health care to those who qualified for public assistance; this was designed to help the elderly poor pay for services not covered by Medicare. Concern for the large percentage of needy elderly, and the belief that greater federal involvement beyond health and income transfer programs was needed, led to the enactment of the Older Americans Act (OAA) of 1965. The Act marked the beginning of social service programs specifically designed to meet the needs of older persons. The box which follows summarizes major events in the development of a national policy on aging.
HISTORICAL HIGHLIGHTS

1913  I.M. Rubinow's promotion of a comprehensive social insurance system in his book "Social Insurance"

1920  Civil Service Retirement Act passed

1927  American Association of Old Age Security established

1935  Social Security Act passed

1937  Railroad Retirement Act passed

1949  Comprehensive National Health Program recommended by President Truman

1950  First National Conference on Aging

1956  Special Staff on Aging assigned within Office of the Secretary, Department of Health Education and Welfare

1961  First White House Conference on Aging

1964  Food Stamp Act passed

1965  Older Americans Act passed
       Medicare enacted
       Grants to States for Medical Assistance established (Title XIX Social Security Act)

1967  Age Discrimination Act of 1967 passed

1971  Second White House Conference on Aging

1972  Nutrition program for the elderly started
       SSI Program established

1974  National Institute on Aging established

1975  Age Discrimination Act of 1975 passed

1978  OAA amendments emphasizing serving low-income minorities

1981  Third White House Conference on Aging

1983  Social Security amendments increasing retirement age to 67 and making a portion of the benefits taxable

B. Meeting the Challenges of an Aging Society

1. The Older Americans Act

Although the aged can receive services under a number of federal programs, since its enactment in 1965, the Older Americans Act (OAA) has become the cornerstone for the organization and delivery of community-based social services to the elderly. Signed into law during the Johnson Administration, the Act was designed to address the needs of all older Americans and provide support to those who cared for and worked with the elderly.

The Act outlined the structure through which services would be delivered to older persons. The Administration on Aging (AoA) was established within the Department of Health, Education, and Welfare (HEW) as the national focal point in the field of aging and the agency in charge of overseeing the process of building effective systems of services for the elderly throughout the country (Title II). Based on the premise that decentralization of authority and local control over policy and programmatic decisions would create a more
responsive service system at the community level, State Units on Aging (SUAs) were established to administer the program (Title III). Other major provisions included grants to the states for community planning, services, and training (Titles III and IV).

Over the past 25 years, the OAA has been amended to reflect an ever-increasing focus on Title III services (nutrition, supportive, and in-home services) and targeting services. For example, a national nutrition program for older Americans was created in 1972, and later incorporated into the OAA under the 1973 amendments. In 1973 the age of eligibility was lowered from 65 to 60 years, and the Area Agencies on Aging (AAAs) were established under an expanded Title III. A three-tiered administrative structure was created with a national Administration on Aging, SUAs to plan and administer programs, and AAAs as the primary implementors of the programs. In 1974 a special transportation program was added under Title III model projects. Priority services (transportation, home care, legal services, and home renovation/repair) were mandated for the first time in 1975. The 1978 amendments consolidated social services, multipurpose centers, and nutrition services (Titles III, V, and VII, respectively) into one Title III, and emphasized certain priority services, such as access, in-home, and legal services. The foundation for establishing an "aging network" under Title III programs was laid out.

**THE OLDER AMERICANS ACT**

<table>
<thead>
<tr>
<th>Year</th>
<th>Amendment Details</th>
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<tbody>
<tr>
<td>1965</td>
<td>The Older Americans Act established AoA within HEW; grants to states for community planning services and training; and State Units on Aging to administer the program</td>
</tr>
<tr>
<td>1967</td>
<td>Reauthorization; no major changes</td>
</tr>
<tr>
<td>1969</td>
<td>Amendments authorized Title III funds for areawide model projects</td>
</tr>
<tr>
<td>1973</td>
<td>Amendments established Area Agencies on Aging and authorized grants for model projects, senior centers, multidisciplinary centers of gerontology, and nutrition projects</td>
</tr>
<tr>
<td>1974</td>
<td>Amendments added a special transportation program under Title III</td>
</tr>
<tr>
<td>1975</td>
<td>Amendments authorized Title III grants to Indian Tribal Organizations, and mandated priority services (home care, transportation, legal services, and home renovation/repair)</td>
</tr>
<tr>
<td>1978</td>
<td>Amendments consolidated Title III, V, and VII (social services, multipurpose centers, and nutrition) into Title III, redesignated the previous Title IX (Community Service Employment Act) as Title V, and added a new Title VI (Grants for Indian Tribes)</td>
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<tr>
<td>1981</td>
<td>Amendments authorized new initiatives focusing on low-income minorities, and required AAAs to enforce the states' emphasis on serving low-income minorities</td>
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<td>1984</td>
<td>Amendments emphasized targeting of minorities, required AAAs to include minorities in advisory councils, and added a new Title VII (Older Americans Personal Health Education and Training Program)</td>
</tr>
<tr>
<td>1987</td>
<td>Amendments authorized Commissioner on Aging to report directly to Secretary of HHS; states were required to specify in their plans the percentage of funds spent on each program, and to document how local providers were meeting low-income minority needs</td>
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From its enactment in 1965 until 1978, the OAA stressed a decentralized approach, universal eligibility of clientele, and emphasis on planning and coordination of services. In 1978, it was suggested that service agencies give priority to poor and minority elderly, initiating the present debate over targeting services to specified populations. The 1981 amendments authorized several new initiatives focusing on the low-income minority elderly. At the local level, the AAAs were to enforce the states’ emphasis on serving the elderly with the greatest economic or social needs. Particular attention was to be given to the non-English-speaking elderly. The 1984 amendments further emphasized the targeting of services to the needy and minorities, and required AAAs to include minority individuals on their advisory councils.

THE OLDER AMERICANS ACT
(Following the 1987 Amendments)

**Title I** -- States objectives and policy goals

**Title II** -- Describes the role and function of AoA, and establishes the Federal Council on Aging

**Title III** -- Establishes the State Units on Aging and the Area Agencies on Aging; authorizes grants to States which in turn award funds to area agencies for community planning, advocacy, and service development and coordination; and outlines how the funds are to be administered

- **Part B** grants funds for access, in-home, and community and neighborhood services
- **Part C** grants funds for nutrition services
- **Part D** grants funds for in-home services for frail elderly
- **Part E** grants funds for additional assistance for special needs of the elderly
- **Part F** grants funds to develop health education and training programs for older individuals
- **Part G** grants funds for prevention of abuse, neglect, and exploitation of older persons

**Title IV** -- Establishes grants for education, training, and demonstration activities in the aging field

**Title V** -- Administered by the Department of Labor; provides funds for community service employment programs for adults 55 years and over

**Title VI** -- Establishes grants for tribal organizations for development of social and nutritional programs, and for outreach to older American Indians

The Older Americans Act amendments of 1987 elevated the AoA by authorizing the Commissioner on Aging to report directly to the Secretary of Health and Human Services (HHS) rather than to the Office of Human Development Services. The amendments also instituted measures to improve minority participation in OAA programs. States were required to specify in their plans a certain percentage of funds to be spent on each service/program,
and to document how service providers were meeting the needs of low-income minority elderly. AoA became responsible for gathering, through the AAAs, data regarding the services funded, the individuals served, and the local needs. The objective was, and remains, to serve low-income minority elderly in proportion to the population they represent in an area.

2. The Aging Network

The extent and reach of the national aging network is remarkable. At the federal level, the Administration on Aging advises the Secretary of Health and Human Services, and provides information to other federal agencies and to Congress on elderly matters. The Federal Council on the Aging (FCoA), created by the 1973 OAA amendments as a successor to the Advisory Council on Older Americans, advises the President on aging matters. The FCoA meets every quarter and is composed of 15 members, five each appointed by the President, House of Representatives, and Senate. FCoA membership is supposed to represent a cross-section of rural and urban older Americans, national organizations with an interest in aging, business and labor, and the general public. At least nine of the members must be older persons. As of December 1990 there were no Hispanics serving on the Council and only one minority member, a Black female.

The Administration on Aging advocates for older persons and oversees the development of responsive systems of service at the national level. Through its 10 regional offices, AoA assists states in developing comprehensive and coordinated services. The Regional Office Director is the official federal representative dealing with state and local governments. AoA regional offices not only monitor state compliance with federal laws and regulations governing OAA, but also provide technical assistance and leadership to assist states in the development of systems of services.

Fifty-seven State and Territorial Units on Aging -- 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands -- are charged with protecting the rights and promoting the continued independence of older persons; and developing a comprehensive, coordinated system of social and health services for the elderly. The State Unit on Aging (SUA), the agency responsible for carrying out OAA programs within each state, can be an independent agency reporting directly to the governor or a component of a larger human service agency in the state. Although no longer required by law, a State Advisory Council often advises the SUA in developing and implementing the state plan. The SUA is required to divide the state into planning and service areas (PSAs) and to designate for each PSA an Area Agency on Aging. Because of their small size or population, 15 states/territories have designated their entire geographic area as a single PSA with the SUA performing the AAA functions.

While the SUAs identify needs and priorities within a state and manage and direct the activities of the state aging network, it is the AAAs who are responsible at the point of delivery. Currently there are some 670 AAAs, they may be single-purpose agencies or
Figure 1

THE AGING NETWORK

SERVICE PROVIDERS

Nutrition Services
Legal Assistance
Health Services
Access Services
In-Home Services
Community-Based Services
Institutional Services
Senior Centers
Voluntary Organizations
Social Agencies
Churches/Religious Organizations

CONSUMERS
organizations with the sole responsibility of administering programs for the elderly or multipurpose agencies administering a wide range of human service programs. In most cases, AAAs do not provide direct services, but subcontract with local service providers. In addition to developing comprehensive and coordinated systems for service delivery, AAAs direct additional private or public resources to local elderly programs and provide technical assistance to private/public agencies serving older persons. An area advisory council assists AAAs in developing and administering the areawide plan on aging.

The service delivery network also includes approximately 27,000 nutrition and supportive service providers, some 15,000 community-based organizations which provide supportive social services to the elderly, and federal, state, and local government agencies which are not directly under the control of AoA, but carry out programs that serve the elderly. In addition, although not involved in direct service provision, numerous national and regional advocacy and/or public policy organizations as well as professional, educational, and research institutions are a part of the national network on aging. The chart (Figure 1) on the opposite page outlines the roles and relationships within the aging network.

C. The Continuum of Care

The range of available services for the elderly can be looked at as a "continuum of care" with all steps or sequences linked to and dependent upon each other. The continuum of care includes all health and social service programs administered by the AAAs and local service providers, but the continuum is much broader in scope. It also includes services provided by federal agencies not under AoA, hospitals, advocacy groups, and other organizations. Services can also be provided informally through the family and friends. Services include preventive care and programs to help the elderly stay healthy and maintain independent living; services to those who are recovering from an illness and need temporary care, or who are frail but can continue to live in the community with adequate support; assistance in obtaining appropriate services for those who need institutional care; and support services for caregivers. The programs and services along the continuum reflect the level of support or care necessary to address the needs of the individual and his or her family.

While there are numerous programs designed to meet the social and human needs of elderly Americans, not all older persons have access to them. Service capacity is limited. Language and educational barriers prevent many elderly from learning about services. Ineffective outreach strategies, the complex application process of some programs, and lack of transportation keep many vulnerable elderly -- Hispanic and non-Hispanic -- from benefiting from available income support, health, and social service programs. Because all services in the "continuum" are necessary and important, a service gap in any part of this continuum weakens the viability of the system of care. A "continuum of care" does not exist, in practice, for many older persons. Hispanics face special barriers -- cultural, educational, language -- which keep them from benefiting from all available services.
Most services and programs targeting the elderly can be classified as those funded under the Older Americans Act, income support or entitlement programs, employment and volunteer opportunities, or other programs providing supportive services.

1. Older American Act Services and Programs

A large portion of the services and programs targeting the elderly are funded under Title III of the Older Americans Act. These include access, in-home and community-based services, and services to residents of care-providing facilities. The chart on the opposite page highlights the continuum of services available to the elderly under the Older Americans Act.

a. Access Services

Linking older persons with services appropriate to their needs is a major function of the area agencies and local service providers. Programs which fall under the category of Access Services assure this. They include: transportation services, information and referral, outreach, case management, and escort services.

- Transportation programs provide funds for travel vouchers or vehicles to transport the elderly to medical and other appointments, shopping, and senior center activities.

- Information and Referral programs assure that the elderly have information about government or private agency programs and refer clients who wish to participate.

- Outreach, usually through media announcements and door-to-door canvassing, assesses the needs of isolated elderly and links them with needed services and benefits.

- Case Management, or coordination of medical and/or supportive services, provides a single point in the community where a person can enter the service system. The case manager assesses the client’s needs, develops a service plan, and, after the services are initiated, follows up to assure the services are being provided.

- Escort Services -- accompanying clients to appointments -- enable those with limited mobility or language barriers to obtain services.

b. Home-Based Services

To help frail or homebound elderly remain in their homes as long as possible, a variety of in-home services provide assistance with activities of daily living to individuals who are physically unable to perform certain tasks and who have no one to assist them nor the means to pay for assistance.
Homemaker services provide assistance with shopping, meal preparation, light housekeeping, and laundry.

Chore Service includes assistance with heavy cleaning, minor repairs, or yard work.

Home Delivered Meals, also known as "meals-on-wheels," are delivered five days per week to the homes of sick, elderly, and handicapped persons who cannot prepare their own meals or come to local meal sites.

Home Health Care provides an alternative to institutionalization for disabled or convalescent persons who do not need round-the-clock professional supervision but do require assistance. Skilled Care -- nursing care, therapy, medical equipment and supplies, laboratory services -- is given under the direction of a physician and provided by licensed health care professionals. Supportive Services, or help with personal needs and chores, are provided by homemaker/home health aides as a complement to skilled care.

Companionship programs such as Friendly Visitors and Telephone Reassurance provide regular personal or telephone contact for elderly who are homebound or live alone. These services may have different names in various communities and are usually provided by volunteers. Activities may include letter writing, reading, or just plain conversation. In addition to providing companionship, the volunteer can identify needs the elderly may have and inform those who can help.

c. Community-Based Services

A variety of social services and programs are available to the elderly through either community-based organizations or local government agencies. Probably the most well known are those provided through the numerous multipurpose senior citizen centers. The centers commonly serve as sites for the Congregate Meal Program, which provides the elderly with nutritional hot meals daily, and offer recreational and social activities -- games, field trips, arts and crafts, exercises -- which can give elderly a sense of belonging and the opportunity to socialize with friends. Centers may also provide educational and health-related programs such as English-as-a-Second-Language (ESL) and nutrition classes. Other community-based elderly services or programs which can be provided with Title III or other federal and/or local government funds, and are often coordinated through community-based organizations and senior centers, include housing, energy and emergency assistance, legal assistance, and a variety of health care services.
Housing Services include housing counseling and information and referral, landlord-tenant dispute resolution, carpentry, minor electrical and plumbing repairs, and low-cost weatherization.

Residential Repair and Renovation programs provide assistance with home insulation and roof and plumbing repairs.

Energy Assistance programs provide low-income elderly with funds to help pay heating and other utility bills.

Legal assistance is most commonly sought in matters relating to entitlement programs (Social Security, Medicare, Medicaid, SSI, Food Stamps), consumer complaints, nursing home resident rights, wills, and guardianships/conservatorships. The Adult Protective Service (APS) in each community investigates reported cases of elder abuse and provides victims with protective services. APS agencies along with other agencies involved in elderly abuse protective programs -- law enforcement agencies, hospitals and medical clinics, AAAs, and mental health agencies -- hold programs to increase awareness of elder abuse problems. Many communities also have crime prevention and victim assistance programs to reduce the elderly's vulnerability.

Legal Assistance programs provide counseling, information, or representation by licensed attorneys or trained paralegals to elderly persons experiencing legal problems.

Adult Protective Services investigate cases of physical and emotional abuse or neglect by a caretaker and intervene (through counseling, information and referral, liaison with the court system) in cases of individuals who are incapacitated to the point where they cannot manage their personal and financial affairs and who have no one to assist them.

Crime Prevention programs provide information on effective crime prevention strategies.

Victim Assistance programs counsel elderly crime victims, help them replace lost identification, and provide emergency financial assistance.

Health Care programs in community-based settings encompass a wide range of services: screening for cancer, high blood pressure, diabetes, dental, vision, and hearing problems; educational programs about good health and nutrition habits; physical fitness or
exercise programs; monitoring of chronic physical conditions; and mental health services. Physical and mental health care and diagnostic services may be obtained through private means or through community health clinics, hospitals, and social service agencies.

Caring for the impaired elderly can exact a great physical and emotional toll on caregivers. Many caregivers themselves suffer from health problems; most struggle to balance other family and work obligations with their caregiving responsibilities. Allowing caregivers time off helps maintain their health and well-being, and may prevent or delay the premature institutionalization of elderly persons which frequently takes place when caregiving becomes a severe burden. To assist family and friends in coping with caregiving obligations, several community-based support mechanisms such as adult day care, respite, and hospice care are available.

- **Respite**, short-term relief to families caring for frail elderly, may vary in time from part of a day to several weeks, and may be provided in-home by family, friends, community-based groups, and/or health agencies, or may encompass temporary placement in a care-providing facility.

- **Adult Day Care**, a lower-cost alternative to institutionalization for adults who cannot stay alone during the day, may operate as part of a senior center or in a specialized facility. Programs may provide a variety of health, therapeutic, and social services: counseling; health care monitoring; exercise sessions; recreational activities; physical, occupational, and speech therapy; medication administration; meals; and transportation to and from the facility.

- **Hospice Care** offers special care to terminally ill patients and their families. The objective is not to cure, but to improve the quality of life and relieve the pain for the patients and provide assistance to the caregiver. Hospice care may be home-based or through in-patient facilities, in either public agencies or private organizations.

d. Services to Residents of Care-Providing Facilities

In cases of acute illness or deteriorating functional ability, more intensive medical and/or skilled nursing services are necessary. **Pre-admission screening** of nursing home applicants to assure that nursing home placement is needed and appropriate is currently offered in many states. SUAs are required to operate **Long-Term Care Ombudsman Programs** to deal with nursing home regulations, abuse of residents, and access restrictions. State and local ombudspersons serve as advocates for the patients, investigate complaints, assist care facility staff to meet the needs of their patients, educate the elderly in the community about long-term care facilities to foster better understanding and use of care facilities, and advocate for improvements in legislation/policies affecting care in these facilities.
2. **Income Support Programs**

The concept of retirement -- ceasing work and having time to spend on activities one enjoys, while receiving an income that will allow maintenance of a pre-retirement standard of living -- has been part of American society for many years. Numerous Americans are able to enjoy this lifestyle because their Social Security income is supplemented by pension plans provided by many employers, unions, the U.S. armed forces, and federal, state, and local government, and by personal savings and assets. Nearly 67% of all wage and salary workers were covered by an employer-sponsored pension plan in 1984.¹ For many elderly, however, Social Security is the sole source of income during old age.

For most Hispanics, the traditional notion of retirement may not be applicable. Because they are more likely to hold lower-paying jobs during their working years, Hispanics have less opportunity to save money for retirement. Also, low-paying jobs -- particularly in the service, retail trade, and agricultural sectors, where Hispanics are overrepresented -- are the least likely to have pension programs. Consequently, social insurance and public assistance programs play an important role in the economic status of elderly Hispanics.

The majority of federal government expenditures for the elderly involve income support programs, primarily Social Security. In FY 1989, payments to Social Security beneficiaries totaled nearly $228 billion. Federal and State Supplement payments to SSI beneficiaries totaled $14.2 billion in FY 1989. The cost of the Food Stamp program was projected to be around $15 billion for FY 1990.²

a. **Social Security**

One of the most successful programs to come out of President Franklin Roosevelt's "New Deal," Social Security protects workers and their families against total loss of earnings due to retirement, disability, or death. By spreading the cost of supporting the aged and disabled across the working population, Social Security seeks to limit the burden on individual family members or on particular segments of society. In the more than 50 years since its enactment, Social Security has been expanded and substantially changed, although its basic purpose has remained unaltered. In 1950, the Social Security Act was amended to include aid to the permanently and totally disabled and to expand aid to dependent children. In 1956, women became eligible for early retirement (age 62) at a lower benefit level; men were included in this measure in 1961. The amendments of 1960 and 1961 eliminated age 50 as the minimum to qualify for disability benefits, liberalized the retirement test and the requirement for fully insured status, and increased benefits. The 1972 amendments raised benefits by 20% and provided for automatic benefit increases based on cost of living increases.

During the 1970s, the financial status of the Social Security trust funds deteriorated. Large benefit increases fueled by inflation, without concomitant increases in payroll tax revenues because of low real wage growth, and a rise in unemployment rates as a result of the 1974-75 recession resulted in lowering payroll tax income. Additionally, an error in "over
indexing" benefits for some new retirees contributed to the drain on trust fund reserves. In an effort to restore financial solvency to the trust funds, the 1977 amendments increased payroll taxes beginning in 1979. A high unemployment rate in the early 1980s, and no real wage increases in subsequent years, contributed to the continued depletion of funds.³

The amendments of 1983 brought about additional changes geared to raising reserves. Coverage was extended to all federal employees hired after 1984 and to current and future employees of private, nonprofit, tax-exempt organizations. Increases in cost of living adjustments (COLAs) were shifted to a calendar year and a failsafe (compensation) mechanism was set up so that when trust funds are lower than a fraction (20%) of the outgo (benefit payments) for the coming year, the COLA will automatically be calculated on the lesser wage or price index. Beneficiaries between 65 and 69 years of age became subject to a reduction in benefits when their income exceeds certain limits. The schedule of payroll tax increases was accelerated, and the tax rate for the self-employed was raised. Finally, an increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between 2000 and 2022.⁴

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**Eligibility Conditions for Social Security Retirement Benefits**

- **Retirement age:** 65 years for full benefits; those electing to start benefits at age 62 receive 20% lower benefits.

- **Quarters:** Generally, for those born in or before 1929, at least one quarter of covered employment for each year elapsed since 1950; for those born after 1929, at least one quarter per year since age 21, until an insurable event (death, retirement, disability). For those reaching retirement age after 1990, 40 quarters will provide eligibility.

- **Earned Credits:** For each $540 in covered earnings in 1991, a worker receives one quarter of credit; this amount is indexed yearly to keep up with the average wage and amount of taxable earnings. A maximum of four credits may be earned per year.

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Social Security taxes flow into two trust funds: the Old Age and Survivors Insurance Trust Fund (OAS) and the Disability Insurance Trust Fund (DI). Almost all revenues for the trust funds come from payroll taxes and interest earned by the trust funds. The annual tax rate in 1991 is 15.30%. Employers and their employees each pay an equal share (7.65%) of the taxable earnings; the self-employed pay the combined employer/employee rate. The maximum amount of earnings on which Social Security taxes are paid is $53,400 in 1991 (the wage cap is indexed annually to keep up with inflation). In 1991, monthly payments to retired workers average $602 or $7,224 annually; disabled workers receive an average of $587 per month.
Because the most basic function of Social Security is to provide a substitute for lost earnings, there is a limit on the income a person may earn and still receive benefits (the Social Security benefit itself does not count as earnings). In 1991 Social Security recipients aged 65-69 have their benefits reduced by $1 for every $3 earned above $9,720. For beneficiaries between 62 and 65, $1 is withheld for every $2 earned above $7,080. The exempt amounts are adjusted yearly to reflect average wages. The income test does not apply to those 70 and over.

Several factors account for Social Security’s lasting popularity. First, because of its universality, the great majority of workers are eligible for coverage and all employment counts. Employees may change jobs, occupation, or residence and still continue to build their eligibility and credits wherever they work. Second, it protects against adverse selection (selective coverage of those who cost least to insure -- the young) that is common in many private pension plans. Because costs for pension coverage progressively increase as a person ages, due to greater risk of illness, retirement, or death, the young tend to benefit from the most advantageous plans. Social Security does not discriminate based on age-associated costs of insurance coverage. Third, because it is an earned right, the beneficiary maintains his/her self-respect. Finally, the absence of a means test encourages savings to supplement program benefits.

b. Supplemental Security Income

The SSI program was established in 1972 to help the poor elderly, blind, and disabled. Authorized by Title XVI of the Social Security Act, the program was designed to supplement the income of those who did not qualify for Social Security or whose benefits were not adequate for subsistence, and to give recipients the opportunity for rehabilitation and encouragement to seek employment. It was expected that a national system would be more efficient than state-operated public assistance programs, and thus eliminate the great disparities in eligibility standards and benefit levels inherent in state programs. It was also hoped that having the program administered by the Social Security Administration would reduce the welfare stigma.

As a means-tested program, SSI requires applicants to satisfy two basic tests: income and assets. In determining eligibility, monthly income counted for SSI includes earnings, Social Security benefits, pensions, cash gifts, and in-kind items such as food and shelter. The value of social services provided by government programs such as Food Stamps, housing, and nutrition; medical care payments by a third party; and in-kind assistance provided by nonprofit organizations are excluded from the calculation. Assets include real estate, personal belongings, bank accounts, cash, and stocks. Assets not counted include a person’s home, car, burial plot, a maximum of $1,500 per person in burial funds, and the cash value of life insurance policies not exceeding $1,500. If a recipient is living in another person’s household and being supported by that person, the value of such in-kind assistance is assumed to equal one-third of the benefit standard. Consequently the individual is paid only two-thirds of the full SSI benefit. If the individual can prove that s/he contributes a pro rata share to the household expenses, the one-third reduction does not apply.
To be eligible for SSI, an individual must:

♦ Be 65 years or older; or

♦ Blind (vision no better than 20/200 or limited visual field of 20 degrees or less); or

♦ Disabled, suffering from a physical or mental impairment which prevents a person from working and is expected to last at least 12 months or result in death.

♦ Be a U.S. citizen, permanent resident, or legal alien.

♦ Reside in the U.S. or territories.

♦ Have a monthly income less than the benefit standard.

♦ Not have assets exceeding $2,000 for an individual or $3,000 for a couple, except for certain exempt assets.

In 1989, 4.6 million persons received assistance under the program; of these, 1.4 million were 65 or older. The standard monthly benefit in 1990 for an individual was $386, and for a couple $579. In most states eligibility for SSI automatically qualifies recipients for Medicaid and Food Stamps. Because state funds may be used to supplement SSI payments, persons living in states which choose to supplement SSI receive larger monthly payments. About 42% of SSI beneficiaries receive such supplementation, although the median monthly state supplement is just $36. Eight states provide no SSI supplement, and in only four states -- Alaska, California, Massachusetts and Connecticut -- is the supplement enough to bring benefits up to the poverty level.

c. Medicare/Medicaid

Before World War II and the discovery of antibiotics, not many people had access to complicated medical procedures; thus medical care accounted for a minor fraction of national expenditures. As medical care improved due to technological and scientific advances, health care costs rose. Unions pressed for medical care plans, and non-union firms began offering group health care to attract employees and discourage unionization. In the late 1940s, Congress legislated federal financial aid to states that chose to add health care to their welfare programs. Most states responded and began providing some medical services to the needy, with the states defining eligibility and level of benefits and administering the programs. Still, a large segment of the population did not have access to affordable care. Attempts during the early 1950s to establish a national health care system or national health insurance failed. Yet, advocates continued to press for a system of health
insurance for the elderly -- a group with evident medical needs, inadequate financial resources, and little access to employment-based group medical insurance or other private insurance because of retirement or high risk.

National health care became an issue during the 1960 presidential elections. Senator John F. Kennedy supported a Social Security-based system of health insurance, a non-needs-tested program financed by payroll taxes, for those 65 and over. Republicans and conservative Democrats proposed a needs-tested federal/state grant-in-aid program. The result was the Medical Assistance Act of 1960 (MAA), a federal aid-to-the-states program which depended on the states for enactment, definition of eligibility and benefits, and partial financing. The Act was neither effective nor adequate. Cost of health care was still not a major issue in the nation's health policy agenda; instead, the focus was on improvement of quality of care and expansion of access. As costs soared, the enactment of Medicare in 1965 (after much opposition from then Chairman of the Ways and Means Committee Wilbur Mills) was a partial answer to the most urgent medical-care needs of the elderly and disabled. Authorized under Title XVIII of the Social Security Act, Medicare was meant to assure wide access to medical care for acute illness and to prevent financial devastation as a result of health care costs.

Medicare, the most costly federal domestic program after Social Security, insured 33 million aged and three million disabled at an estimated cost of $86.9 billion in 1989. Medicare Part A, also known as Hospital Insurance (HI), reimburses providers for reasonable costs of hospitalization, most in-hospital services (excluding physician costs), in-hospital drugs, skilled nursing care, home health care, and hospice care. Part A is financed through a portion of the Social Security payroll tax. Medicare Part B, or Supplementary Medical Insurance (SMI), covers doctors' fees; in-hospital services by radiologists, anesthesiologists, and psychiatrists; and outpatient hospital services. It also covers supportive services such as ambulance transportation, therapy, medical equipment, and post-acute (temporary) home health care services. Home health care has been one of the most rapidly growing Medicare benefits. Participating care-providing agencies grew from 3,000 in 1981 to 5,700 in 1989. In 1988, 31.7 million persons were covered under Part B. Premiums and interest cover about 26% of program costs; the remainder is paid for by the federal government from general revenues.γ

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<th>Eligibility Conditions for Medicare</th>
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**Part A ...** All persons eligible for SS benefits and aged 65 or older. Those collecting Disability Insurance qualify after being on the disability rolls for 24 months.

**Part B ...** Persons 65 and over or disabled who elect coverage and pay a monthly premium ($29.90 in 1991).
Under the FY 1991 federal budget, the annual deductible for services under Medicare Part B will increase from $75 to $100. The deductible is not indexed for inflation; thus unless subsequent legislation raising the deductible is passed, it will remain at $100. The monthly premiums, for the next five years, will continue to equal 25% of the average yearly cost per beneficiary incurred in the Part B program. Premiums will increase from $28.50 per month in 1990 to $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994, and $46.10 in 1995.8

Medicare coverage of hospital costs for extended acute illnesses (more than 60 days) is limited. Also, until FY 1991, Medicare did not cover in-home personal or adult day care services for functionally limited or chronically ill persons; coverage was limited to skilled post-acute (temporary) care services for medically-related home health needs. Medicaid paid for such services only if the individual lived in a nursing home. The FY 1991 federal budget package provides $580 million over five years to allow states the option of covering home and community-based, long-term care services -- personal care, chores, and nursing services -- for "functionally disabled" elderly.

The FY 1991 federal budget includes other Medicare and Medicaid improvements which will benefit low-income elderly. For example, there are changes in reimbursement policies which provide incentives for low-income Medicare beneficiaries to use preventive and primary health care. Beneficiaries will not have to incur out-of-pocket costs for deductibles or co-payments for services at health care facilities that serve low-income individuals (i.e., community health centers). The near-poor are also protected from increases in out-of-pocket costs; over time, the out-of-pocket costs of the near-poor will also be reduced.

Authorized under Title XIX of the Social Security Act, Medicaid serves as a supplemental or "Medigap" policy by covering Medicare's cost-sharing, paying the Part B premiums, and providing additional benefits. Medicaid has also become the primary source of public funds for nursing home care. Each state designs and administers its own program and sets eligibility and coverage standards within broad federal guidelines. Currently, Medicaid pays the Medicare premiums, deductibles, and co-payments for beneficiaries with incomes below 90% of the poverty threshold. Under the new budget, Medicaid will begin in 1991 to pay all cost-sharing for Medicare beneficiaries with incomes up to 100% of the poverty level. In FY 1993 Medicaid will cover Medicare premiums for beneficiaries with incomes up to 110% of poverty and in FY 1995 for those with incomes up to 120% of poverty. In an effort to control current abuses with Medigap insurance, the new law prohibits the sale of more than one Medigap policy to each person, and forbids the sale of Medigap policies to low-income elderly already covered by Medicaid.

d. Food Stamps

Established in 1964, the Food Stamp Program was designed to reduce malnutrition and hunger among low-income Americans by increasing their food purchasing power. States were given the option of operating a Food Stamp Program in lieu of existing commodity donation projects. Food coupons issued by the U.S. Department of Agriculture
(USDA) are supposed to enable eligible households to purchase an adequate low-cost diet based on USDA’s Thrifty Food Plan. The program is available to households which meet certain assets and income tests or which already receive benefits under the Aid to Families with Dependent Children (AFDC) or SSI program.

To be eligible for Food Stamps, a household’s …

♦ monthly gross income must not exceed 130% of the Office of Management and Budget (OMB) poverty level.

♦ monthly income, after medical, shelter, utilities and work-related expenses, must be equal to or less than 100% of the OMB poverty level. (Special program rules for the elderly include more liberal treatment of shelter costs, medical expenses, and assets.)

♦ liquid assets cannot exceed $2,000, or $3,000 if the household includes an older or disabled person. (The value of a home, personal property and household belongings, business assets, a car, and burial plots is excluded from calculations.)

Eligible applicants receive Food Stamps in the amount determined by household size and income, to buy food at authorized grocery stores. The stamps are forwarded by the grocery stores to commercial banks for cash or credit. The stamps then flow through the banking system to the Federal Reserve Bank, where they are redeemed out of a special U.S. Treasury Department account. The USDA Food and Nutrition Service is responsible for the administration, supervision, and development of program policies and regulations. At state and local levels, the Food Stamp Program is administered by state welfare departments.

3. Employment and Training and Volunteer Opportunities

a. Employment and Training Programs

In an effort to promote the employment opportunities of older workers, the federal government provides funds for training disadvantaged and dislocated workers to make them more employable. Two of these programs are the Job Training Partnership Act (JTPA) and the Senior Community Service Employment Program (SCSEP) under Title V of the OAA.

The Job Training Partnership Act, enacted in 1982, supports a nationwide system of job training programs administered jointly by local governments and private-sector planning agencies. JTPA includes two major training programs: Title II for economically
disadvantaged youths and adults, with no upper age limit; and Title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to re-employment. Title II-A program funds are awarded to the states based on the following criteria: number of unemployed persons living in areas with unemployment rates of at least 6.5%; number of unemployed individuals in excess of 4.5% of the state’s civilian labor force; and the number of economically disadvantaged. Training can include on-the-job and classroom training, remedial education, employability development, and a limited amount of work experience. Under section 124 of JTPA, governors are required to set aside 3% of their Title II-A funds for the training and placement of economically disadvantaged workers 55 or older for jobs in private industry. These older worker programs are designed to be operated in conjunction with public agencies, private nonprofit organizations, and businesses. Title III programs are administered by the states and include job search assistance, job development, training in a job skill for which demand exceeds supply, and relocation assistance.

The purpose of the Senior Community Service Employment Program, established under Title IX of the 1973 OAA amendments and redesignated as Title V by the 1978 OAA amendments, is "to promote useful part-time opportunities in community service activities for unemployed low-income persons." The program, administered by the Department of Labor, not only provides employment opportunities to older workers, but also serves as a source of labor for various community service activities. Nearly half the enrollees are between the ages of 55 and 64, and more than a quarter are 70 or older. To be eligible for the SCSEP, an individual must be 55 years of age or older (priority is given to those 60 and over), unemployed, and have an income level not exceeding 125% of the poverty level. Participants work an average of 20-25 hours per week, and are paid the lesser of the federal or state minimum wage or the local prevailing wage for similar employment. In addition to a salary, participants receive physical examinations, personal and job-related counseling, and sometimes transportation to and from the job. SCSEP or Title V funds are awarded to nine national sponsoring organizations and to state agencies.

b. Older American Volunteer Programs (ACTION Programs)

Volunteer programs offer meaningful opportunities for older persons to participate in activities that provide the sense of identity, social contact, and usefulness that they once derived from work. These programs also offer poor elderly the chance to earn much-needed income. The best known of these programs are the Foster Grandparents Program (FGP), the Retired Senior Volunteer Program (RSVP), and the Senior Companion Program (SCP).

Once part of the Administration on Aging, the FGP and the RSVP came under ACTION when the agency was established in 1971 as part of a Presidential reorganization plan consolidating several existing volunteer programs. When the SCP was authorized in 1973, it was also included under ACTION, placing all domestic volunteer programs under this one agency. ACTION awards grants, which may be supplemented by state and local governments or the private sector, to local private nonprofit or public sponsoring agencies to recruit, place, and support older volunteers in a variety of community service activities.
- **Foster Grandparents Program** volunteers work with children or youth with special health, educational, or social needs. Foster grandparents are placed with nonprofit sponsors such as schools, hospitals, and other institutions.

- **Senior Companion Program** volunteers provide companionship to elders in their homes, senior centers, and other care-providing facilities.

- **The Retired Senior Volunteer Program** provides volunteer opportunities in schools, hospitals, libraries, and other community agencies.

Both Foster Grandparents and Senior Companion volunteers serve 20 hours per week and receive an hourly stipend, transportation assistance, an annual physical examination, insurance, and meals. To be eligible, an applicant must be 60 years old or older and his/her income must not exceed 125% of the poverty level. Although they do not receive hourly stipends as under the FGP and the SCP, RSVP volunteers are reimbursed for out-of-pocket expenses. There is no income limitation for RSVP eligibility.

4. **Housing**

The housing needs of older persons have been a concern to those in the aging field for a number of years. Although the Housing Act of 1937 set the stage for federal housing assistance to low-income people, not until 1959 did amendments to the Act authorize targeting the elderly for such housing assistance. In that year, construction of units for the elderly was encouraged, and the first housing program specifically designed for the elderly, **Section 202**, was enacted. In the mid-1970s, housing assistance to the elderly was expanded, the Section 202 program was reinstated after being phased out in 1969, and the **Section 8** housing assistance program was enacted.

The foremost federal financing vehicle for the construction of subsidized housing for elderly and handicapped persons is the **Section 202** program. Under the program, the Department of Housing and Urban Development (HUD) makes direct loans to private, nonprofit sponsors to develop housing designed specifically to meet the needs of low-income elderly and the handicapped. Funds are allocated geographically among the 10 HUD regions based on the number of elderly households in each region, the number of households lacking plumbing facilities, and the number of elderly households with incomes below the regionally adjusted poverty levels.

The **Section 8** program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Although it does not specifically target the elderly, Section 8 has become a major source of housing assistance for
those 65 and older. Under the program, HUD pays owners the difference between 30% of the eligible tenant’s income (the standard portion of income that should be spent on rent) and what HUD has determined to be the fair market rent for a unit in that jurisdiction.

The **Low Rent Public Housing Program**, initiated during the Depression as a means to aid the construction industry and provide families with low-rent housing, is the oldest of the federal housing programs. Although it does not specifically target the elderly, it is a source of affordable housing. Eligible tenants pay a rent equalling 30% of their net income.

An alternative to public housing or other federal programs is provided by the **voucher system**, which enables a family to rent housing in the private market, assisted by a government payment transmitted through a local public housing agency to a landlord. The voucher subsidizes the difference between 30% of the family’s income and the fair market rent of the dwelling. If a tenant finds a unit that is cheaper, s/he can keep some of the subsidy for other uses. Conversely, if a tenant rents a unit that is more costly than the HUD rent standard, s/he pays the difference. Another difference between the Section 8 and voucher programs is the duration of assistance, which is limited to five years under the voucher program, compared to 15 years for Section 8 programs.

### 5. Other Federal Programs Benefiting the Elderly

In addition to the previously listed federal programs which have the elderly either as their primary concern or as a considerable segment of their beneficiaries, a myriad of programs at the national, state, and local levels provide assistance to older Americans. These programs resemble a patchwork quilt of approaches and services. Government programs are so complex that it is difficult to get an actual number of the existing services which may potentially benefit the elderly; estimates range from 48 to 200 federal programs. The development of this patchwork of interventions has often been perceived as evidence of attempts to do too much with too little money and other resources. Sometimes it is explained by the fact that the nation’s aging policy tends to be problem-oriented rather than goal-directed. The Appendix includes a list of major federal programs which devote some portion of their budget to serving older Americans.

Although providing help to the elderly may be seen as the primary concern of most of the programs in the continuum, assistance to family caregivers is equally important. Thus, a continuum of care which simultaneously addresses the needs of those who need care and those who provide it is indispensable. Because of their socioeconomic characteristics, most elderly Hispanics and their families have a great need for services. However, few elderly Hispanics benefit from all these programs. A true continuum of care does not appear to exist for older Hispanics; they are *on the sidelines*. The next section attempts to provide a better understanding of the conditions under which Hispanic elderly live and the problems they face.
II. THE HISPANIC ELDERLY

There is a growing perception that senior citizens in the U.S. have a plethora of resources and are the most well-off age group in our society. While this is true for some elderly, an alarmingly large number of minority elderly have practically no resources. A very large proportion of the Hispanic elderly fall into this vulnerable group of "at-risk" people who live on the edge of economic survival. The vulnerability of Hispanic elderly has been intensified by the combination of demographic trends and social, economic, and health conditions.

A. Demographic Overview

The number of elderly persons in the U.S is growing more rapidly than the rest of the population. The 65 and over population was projected to almost double in less than 30 years, from 16.7 million in 1960 to 31.5 million in 1989, and is projected to more than double again in the next 40 years. As of July 1989, the 60 and older population represented 16.8% of the total U.S. population (248.8 million). In the same year, of the total 41.8 million older Americans, 37.4 million, or 89.5%, were White; 3.6 million, or 8.6%, Black, and 1.6 million, or 3.8%, Hispanic.

While currently a small proportion of the overall elderly population, Hispanics are the fastest growing segment of the 65-and-over population. Figure 3 shows the growth of the minority elderly populations relative to the White elderly population. The Hispanic 65-and-over population is projected to almost double from 3.6% of the total elderly

FIGURE 3

PROJECTED GROWTH OF THE ELDERLY POPULATION

<table>
<thead>
<tr>
<th>YEAR</th>
<th>1990</th>
<th>2010</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISPANIC</td>
<td>3.6</td>
<td>6.3</td>
<td>8.6</td>
<td>11.7</td>
</tr>
<tr>
<td>WHITE</td>
<td>86.9</td>
<td>81.8</td>
<td>76.4</td>
<td>69.9</td>
</tr>
<tr>
<td>BLACK</td>
<td>8.1</td>
<td>9.1</td>
<td>11.3</td>
<td>13.7</td>
</tr>
<tr>
<td>OTHER</td>
<td>1.6</td>
<td>3.2</td>
<td>4.1</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Source: Census Bureau, CPS, P-25, 1986, Table V; and calculated from Table V.
population in 1990 to 6.3% in 2010 and 11.7% in 2050. In comparison, the White non-Hispanic elderly population is projected to decrease from 86.9% of all elderly in 1990 to 81.8% in 2010 and to 68.9% in 2050; and the Black elderly population is expected to increase from 8.1% of total elderly in 1990 to 9.1% in 2010 and to 13.7% in 2050.3

Overall, Hispanics are a young population but are aging along with the rest of the U.S. population. While 13.3% of the White population were 65 or older, 8.3% of the Black population and 5.2% of the Hispanic population fell into this age category as of 1989.4 As Figure 4 shows, the median age for the total U.S. population increased from 29.4 years in 1960 to 32.5 in 1989 and is projected to further increase to 40.8 by 2030. In comparison, the median age for the Hispanic population increased from 19.4 in 1960 to 25.9 in 1989 and is projected to increase to 33.0 by 2030. The median age of all three population groups is projected to level off by the year 2080 -- 43.9 for Whites, 41.8 for Blacks, and 40.9 for Hispanics.5

FIGURE 4

<table>
<thead>
<tr>
<th>MEDIAN AGE OF U.S. POPULATION</th>
</tr>
</thead>
</table>

There is great variation in median age among Hispanic subgroups. In 1988, Cubans were the oldest Hispanic subgroup, with a median age of 41.4, compared to 23.6 for Mexican Americans, 26.8 for Puerto Ricans, and 28.4 for Central and South Americans. Thus among the Hispanic subgroups, only Cubans had a percentage of elderly (17%) similar to that of the overall population (12%). Although Mexican Americans were younger and had a small percentage of elderly (3.8% of the Mexican American population were 65 and older), half of all Hispanic elderly were Mexican American. As of March 1989, 47.6% of the Hispanic elderly were Mexican American, 10.9% Puerto Rican, 18.1% Cuban American, 8.4% Central and South American, and 15.0% other Hispanic (See Figure 5).6
Although the vast majority of Hispanics are native-born Americans, more than four out of ten Hispanic elderly are foreign-born. Data from the 1980 Census indicate that 70% of all Hispanics were born in the U.S. while only 58% of Hispanic elderly were born in the U.S. (including Puerto Rico). In comparison, about 88% of the general elderly population were native-born Americans. Mexico was the most frequently named country of origin for foreign-born Hispanic elderly, followed by Cuba. Similar results were found in a survey conducted by Westat, Inc. in 1988. More than six of every 10 Hispanic elderly (63%) were born outside the continental U.S. and about two out of five (37%) were born in the U.S. mainland: 26% were born in Mexico, 15% in Cuba, and 11% in Puerto Rico. A large proportion of Mexican American elderly came from families who have lived in the Southwestern region of the U.S. for generations, while the majority of elderly Cubans came to the U.S. in adulthood, as political refugees.

The majority of elderly Hispanics are female. In 1988, the Hispanic 65 and over male population totaled 426,000, or 41.6%; females totaled 596,000, or 58.4%. The gender gap for Hispanic elderly is greater than for Black or White elderly. In 1988 the gender ratio of males per 100 females age 65 and over was 71.4 for the Hispanic elderly, 68.5 for the White elderly, and 67.8 for the Black elderly. Because of the shorter life expectancy of male Hispanics, nearly three times the proportion of females were widowed (44%) as males (15%), and a higher proportion of males were married (73%) than females (40%). The same was true for the White and Black elderly populations: 48% of White females versus 13% of White males were widowed, and 78% of White males versus 42% of White females were married; among Black elderly 55% of females versus 21% of males were widowed, and 64% of males versus 34% of females were married.

Unlike the non-Hispanic elderly population, which tends to be widely dispersed, Hispanic elderly are geographically concentrated in the South and West regions of the United States, particularly in California and Texas. In 1987, some 39% of the Hispanic
elderly lived in the South, 34% lived in the West, 20% lived in the Northeast, and 7% lived in the Midwest. On the other hand, 35% of the non-Hispanic elderly population lived in the South, 17% lived in the West, 23% lived in the Northeast, and 26% lived in the Midwest. According to 1980 Census data, seven out of 10 Hispanic elderly were concentrated in four states -- California (25.3%), Texas (21.2%), Florida (13.5%), and New York (10.9%) -- much like the entire Hispanic population. By comparison, the same number of non-Hispanic elderly, seven out of 10, were dispersed in 17 different states. Figure 6 lists the states with the highest proportion of Hispanic and non-Hispanic elderly. Approximately 86.6% of all Hispanic elderly lived in 10 states while 54.7% of all non-Hispanic elderly lived in the same number of states.

An overwhelming majority of Hispanic elderly live in urban areas, more than any other elderly population group. In 1987, 91% of Hispanic elderly lived in urban areas, compared to 82.2% of Black elderly and 71.8% of White non-Hispanic elderly.

**FIGURE 6**

**TOP TEN STATES FOR HISPANIC AND NON-HISPANIC POPULATIONS: 1980**

<table>
<thead>
<tr>
<th></th>
<th>HISPANIC POPULATION</th>
<th>HISPANIC ELDERLY</th>
<th>NON-HISPANIC ELDERLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>%</td>
<td>State</td>
<td>%</td>
</tr>
<tr>
<td>1. CA</td>
<td>31.1</td>
<td>CA</td>
<td>25.3</td>
</tr>
<tr>
<td>2. TX</td>
<td>20.4</td>
<td>TX</td>
<td>21.2</td>
</tr>
<tr>
<td>3. NY</td>
<td>11.4</td>
<td>FL</td>
<td>13.5</td>
</tr>
<tr>
<td>4. FL</td>
<td>5.9</td>
<td>NY</td>
<td>10.9</td>
</tr>
<tr>
<td>5. IL</td>
<td>4.3</td>
<td>NM</td>
<td>4.2</td>
</tr>
<tr>
<td>6. NJ</td>
<td>3.4</td>
<td>AZ</td>
<td>2.9</td>
</tr>
<tr>
<td>7. NM</td>
<td>3.3</td>
<td>NJ</td>
<td>2.8</td>
</tr>
<tr>
<td>8. AZ</td>
<td>3.0</td>
<td>CO</td>
<td>2.4</td>
</tr>
<tr>
<td>9. CO</td>
<td>2.3</td>
<td>IL</td>
<td>2.3</td>
</tr>
<tr>
<td>10. PA</td>
<td>1.1</td>
<td>PA</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: Census Bureau, PC80-1-S1, calculated from Table 67.

**B. Living Arrangements**

Hispanic elderly are more likely to live in the community and less likely to be institutionalized than White elderly. The 1985 National Nursing Home Survey conducted by the National Center of Health Statistics (NCHS) found that out of a total of 1.5 million elderly cared for in nursing homes, 2.7% were Hispanic, 92.2% were White, and 7.8% were Black. Furthermore, 1980 Census data indicate that Hispanic elderly were less likely to live in homes for the aged than White and Black elderly. For example, the proportion of White females 75 and over (12.4%) cared for in nursing homes was more than twice as great as the proportion of Hispanic females the same age (5.4%) (see Figure 7).
FIGURE 7
ELDERLY LIVING IN HOMES FOR THE AGED: 1980

<table>
<thead>
<tr>
<th>AGE 65-75</th>
<th>WHITE</th>
<th>BLACK</th>
<th>HISPANIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.3</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Female</td>
<td>1.7</td>
<td>1.5</td>
<td>0.9</td>
</tr>
<tr>
<td>AGE 75+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6.8</td>
<td>4.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Female</td>
<td>12.4</td>
<td>6.7</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Source: Cubillos, H. et. al., 1987, Figure 5.

Hispanics are less likely to live alone and more likely to live with family members than White and Black elderly. According to 1989 Census data, over three-fourths (76.6%) of Hispanic elderly lived with family, compared with two-thirds (67.5%) of White elderly and six out of 10 Black elderly (63.1%). About two out of 10 elderly Hispanics (22.0%) lived alone, compared to three out of 10 White elderly (30.6%), and one-third Black elderly (33.4%). Fewer Hispanic elderly lived with others (1.5%) than White (1.9%) and Black (3.5%) elderly (See Figure 8).17

Hispanic elderly are more likely than other elderly to live in a multigenerational family where the child is the householder. In 1989, Hispanic elderly were less likely to be householders (60.2%) than White (70.7%) and Black (68.1%) elderly. Also, a larger percentage of elderly Hispanics (38.7%) were non-householders living with family members than White (30.7%) or Black (27.5%) elderly (See Figure 8).18

FIGURE 8
LIVING ARRANGEMENT OF POPULATION 65 AND OVER: MARCH 1989

<table>
<thead>
<tr>
<th></th>
<th>WHITE</th>
<th>BLACK</th>
<th>HISPANIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOUSEHOLDER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>38.8</td>
<td>35.6</td>
<td>37.9</td>
</tr>
<tr>
<td>Alone</td>
<td>30.6</td>
<td>33.4</td>
<td>22.0</td>
</tr>
<tr>
<td>Others</td>
<td>0.7</td>
<td>1.7</td>
<td>0.4</td>
</tr>
<tr>
<td>NON-HOUSEHOLDER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>30.7</td>
<td>27.5</td>
<td>38.7</td>
</tr>
<tr>
<td>Others</td>
<td>1.2</td>
<td>1.8</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Source: Census Bureau, CPS, P-20, 1990, Table 7.
Hispanic elderly are less likely than other senior citizens to own their home. In 1987, three out of four senior citizens owned their homes, but a disproportionate percentage of homeowners were White. Figure 9 shows that more than three-fourths of White non-Hispanic elderly owned homes (77%), while a little more than half of Hispanic elderly (56%) and more than three-fifths of Black elderly (62%) were homeowners. Furthermore, a 1988 survey by Westat Inc. found that 22.4% of elderly Hispanics lived alone, 48.7% lived with their spouse, and 28.9% lived with others. Respondents living with their spouse were more likely to own homes (65%) than those living alone (44%) or with others (34%). Respondents living alone were most likely to rent (52%), compared to those living with a spouse (31%) or with others (40%). A comparison of housing occupied by Hispanic elderly shows that those living with their spouse were more likely to live in a house (75%) than those living with others (71%), or living alone (48%). Hispanic elderly living alone were most likely to live in an apartment (48%), compared to those living with a spouse (22%) or those living with others (28%).

C. Education

Hispanics are the least educated elderly group. As of 1988, elderly Hispanics had the lowest median number of school years completed, just 7.5 years, compared with 12.2 years for elderly Whites and 8.4 years for elderly Blacks (See Figure 10). In 1988 three out of 10 Hispanic elderly (29.3) had less than five years of formal education, compared with one in 20 of the total elderly population (5.7%). Hispanic elderly also have the lowest percent of high school graduates. Just 22.4% of elderly Hispanics had graduated from high school as of 1988, compared to 56.7% of elderly Whites and 23.5% of elderly Blacks. Hispanic elderly also have a lower percentage of college graduates (4.1%) than Whites (11.1%) or Blacks (4.7%).
FIGURE 10

YEARS OF SCHOOL COMPLETED
AGE 65 AND OVER: 1988


FIGURE 11

ENGLISH PROFICIENCY AMONG ELDERLY HISPANICS: 1989

<table>
<thead>
<tr>
<th>ENGLISH PROFICIENCY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Well/fairly</td>
<td>85.8%</td>
</tr>
<tr>
<td>Poor</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NO ENGLISH PROFICIENCY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexican</td>
<td>31.8%</td>
</tr>
<tr>
<td>Cuban</td>
<td>57.3%</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>37.4%</td>
</tr>
<tr>
<td>Other Hispanic</td>
<td>63.3%</td>
</tr>
</tbody>
</table>

Source: Westat, 1989, Table 2-1.

It is often suggested that limited English proficiency contributes to low Hispanic educational levels. As of 1989, approximately four in 10 elderly Hispanics did not speak English. Of those who did speak English, 85.8% spoke it well to fairly well. A breakdown by Hispanic subgroups (see Figure 11) indicated that 31.8% of Mexican American elderly, 37.4% of Puerto Rican elderly, and 57.3% of Cuban elderly did not speak English; in which case, Cuban elderly were most likely not to speak English, while Mexican Americans were the most likely to speak English. 22
D. Economic Status

The median income for elderly Hispanics is barely above the poverty level. In 1989 the poverty threshold for individuals 65 years and over was $5,947. The median income for elderly Hispanics was $6,642. In the same year, the median income for Black elderly was $6,069, while the White elderly had a median income of $10,048. The median income of all elderly 75 and over was lower than of those age 65 to 74 (See Figure 12).

**FIGURE 12**

<table>
<thead>
<tr>
<th>MEDIAN INCOME OF PERSONS 65 AND OVER: 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ (in thousands)</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>10</td>
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<td>4</td>
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<td>2</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>65-74</th>
<th>75+</th>
<th>65+</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Census Bureau, CPS, 1990, unpublished data.

**FIGURE 13**

<table>
<thead>
<tr>
<th>POVERTY RATES FOR PERSONS 65 OR OLDER BY SEX, RACE, AND HISPANIC ORIGIN: 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>65-74</th>
<th>75+</th>
<th>65+</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Census Bureau, CPS, P-63, 1990, and Census Bureau, unpublished data 1990

Hispanic elderly, particularly those 75 and over, have high rates of poverty. In 1989, the poverty rate for Hispanic elderly was 20.6%, more than twice the rate for White elderly (9.6%), but below the rate for Black elderly (30.8%). Figure 13 provides a comparison of elderly poverty rate by age, gender, and race. The poverty rate among those 75 and over far exceeded the poverty rate of those age 65 to 74 for Hispanic, White, and Black elderly. The poverty rate was higher for Hispanic (26.3%) and Black (37.0%) elderly than for White elderly (13.5%) 75 and over.

Elderly females are poorer than elderly males, especially among minorities. As Figures 12 and 13 show, all races had a significantly higher percentage of elderly females with incomes below the poverty rate than elderly males. In 1989, the median income for elderly Hispanic females was $5,543, compared to $8,486 for their
male counterparts; the median income for elderly Black females was $5,259 versus $7,517 for males; and for White females $8,125 versus $13,711 for males. The median incomes of both Hispanic and Black elderly females place them far below the poverty threshold. Hispanic elderly females were twice as likely to be poor (22.4%) as White elderly females (11.8%), but less likely than Black elderly females (36.7%).

Hispanic elderly are less likely than Whites to receive private pensions and to have income from interest or other assets. As of 1988, only 19% of Hispanic elderly received a private pension, compared to 31% of White elderly and 17% of the Black elderly. Hispanic elderly were half as likely to obtain income from assets (including interest, dividends, rents, and estates) as White elderly (37% versus 72%) (See Figure 14).

Hispanic elderly are more likely than other elderly to receive no Social Security benefits; nearly one in four Hispanic elderly receive no Social Security. In 1988, only 77% of elderly Hispanics received Social Security compared to 93% of White and 89% of Black elderly (See Figure 14).

---

**FIGURE 14**
INCOME OF THE ELDERLY FROM SPECIFIED SOURCES: 1988

<table>
<thead>
<tr>
<th>65 OR OLDER SOURCE OF INCOME</th>
<th>WHITE % of 65+ With Income From</th>
<th>BLACK % of 65+ With Income From</th>
<th>HISPANIC % of 65+ With Income From</th>
</tr>
</thead>
<tbody>
<tr>
<td>EARNINGS</td>
<td>22</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>PRIVATE PENSION</td>
<td>31</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>ASSETS</td>
<td>72</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Interest</td>
<td>70</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Dividends, Rent, Estates, etc.</td>
<td>28</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>SOCIAL SECURITY</td>
<td>93</td>
<td>89</td>
<td>77</td>
</tr>
<tr>
<td>SUPPL. SECURITY INCOME</td>
<td>5</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>


Hispanics who do receive Social Security tend to depend on it more than the general elderly population. In 1988, elderly Hispanics received a median income from Social Security of $5,437, 21% less than White elderly, who received $6,863, and slightly more than Black elderly, who received $4,899. In the same year, Social Security provided 64% or more of the total income for half of elderly Hispanics, while it provided 48% or more of the total income for half of elderly Whites.
Due to extremely low incomes and limited participation in Social Security and other retirement plans, Hispanic elderly are more likely than other older Americans to depend on public assistance to survive. In 1988, 21% of Hispanic elderly received Supplementary Security Income (SSI) benefits, compared to 7% of the total elderly population. 31 In 1986, SSI accounted for 6.4% of the Hispanic elderly's total income, compared to 0.9% of the income of all elderly. 32 Despite high need, Hispanic elderly are less likely to receive SSI than the rest of the eligible population. A 1988 survey found that only an estimated 44% of eligible elderly Hispanics received SSI, compared to about half the total eligible elderly population. 33

The labor force participation rate for elderly Hispanics is similar to that of Black and White elderly, but elderly Hispanics and Blacks are more likely to be unemployed than Whites. In 1989, about 11.4% of Hispanic elderly, 11.6% of White elderly and 10.8% of Black elderly were in the labor force. However, 5.3% of the Hispanic elderly were unemployed, compared to 2.3% of White elderly. Black elderly had the highest unemployment rate, 6.9%. 34

Employed Hispanic elderly are most likely to be working in service-related occupations. As Figure 15 shows, in 1989 both Hispanic and Black elderly were mainly employed in service occupations, while White elderly were mainly employed in technician, sales, and administrative/supervisory occupations. Most older Hispanics were employed in three occupation categories: Technician, Sales, and Administration/Supervisor; Service Occupations; and Machine Operator and Manufacturing Labor. 35

FIGURE 15
OCCUPATION OF EMPLOYED PERSONS 65 OR OLDER: DECEMBER 1989

<table>
<thead>
<tr>
<th>OCCUPATION</th>
<th>WHITE %</th>
<th>BLACK %</th>
<th>HISPANIC %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial &amp; Professional Specialty</td>
<td>27.7</td>
<td>10.6</td>
<td>15.8</td>
</tr>
<tr>
<td>Technician, Sales, &amp; Admin/Supervisor</td>
<td>32.3</td>
<td>11.7</td>
<td>24.6</td>
</tr>
<tr>
<td>Service Occupation</td>
<td>15.0</td>
<td>50.2</td>
<td>25.4</td>
</tr>
<tr>
<td>Precision, Professional, Craft, &amp; Repair</td>
<td>6.8</td>
<td>6.0</td>
<td>9.6</td>
</tr>
<tr>
<td>Machine Operator &amp; Manufacturing Labor</td>
<td>9.1</td>
<td>16.2</td>
<td>17.5</td>
</tr>
<tr>
<td>Transportation &amp; Material Moving</td>
<td>3.2</td>
<td>6.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Construction, Equip. Handler &amp; Cleaner, &amp; Other Laborer</td>
<td>2.3</td>
<td>5.7</td>
<td>4.4</td>
</tr>
<tr>
<td>Farming, Forestry, &amp; Fishing</td>
<td>9.2</td>
<td>5.7</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Source: Labor Bureau, 1990 unpublished data, Base Table 21.
E. Health Status

While Americans in general are living longer, life expectancy remains lower for minorities. Life expectancy at birth for the general American population increased from 69.7 years in 1960 to 74.9 years in 1988, and is projected to increase to 77.0 years in 2000, according to Census data. Although data are collected by race and ethnic categories, the National Center for Health Statistics (NCHS) (viz: Vital Statistics of the United States, 1987) does not publish life expectancy tables for Hispanics or Hispanic subgroup populations. Nonetheless, 1987 data indicate that life expectancy for minority groups (71.3 years) is less than for all races (75.0 years). For example, the life expectancy for Blacks (69.4 years) is 6.2 years less than for Whites (75.6 years).

Hispanics are less likely than non-Hispanics to reach the age of 85 or over. According to data presented in the recent case of *Meek v. Martinez* (which found Florida's Interstate Funding Formula discriminated against minorities), "minority groups [including Hispanics] have a shorter life expectancy than non-minorities, which means that they make up a smaller percentage of the over 75 elderly population than they do of the elderly over 60 years of age." Figure 16 provides a breakdown of persons age 55 and over as of 1989. A higher percentage of Hispanics fall in the 55 to 64 age category (53.7%) than non-Hispanics (43.5%). Yet, a smaller percent of Hispanics reach the 85 and over age group (2.8%) than non-Hispanics (4.3%).

**FIGURE 16**

Older Hispanics are generally in poorer health than others their age. The *Meek v. Martinez* case also revealed evidence that indicates minorities experience chronic disability at an earlier age than non-minorities. In addition, a 1989 report by the House Select Committee on Aging found that in 1986, 41.2% of elderly Hispanics perceived themselves to be in poor or fair health, compared with 29.9% of all elderly. Elderly Hispanics were also found to have high rates of disability. Some 31.5% of elderly Hispanics had been bedridden for one to 30 days in 1986, compared to 21.9% of elderly Whites and 26.9% of elderly Blacks. Elderly Hispanics had an average of 37.0 "restricted activity days" during 1986, compared to 31 days for Whites and 43 days for Blacks. However, Hispanic elderly averaged slightly fewer doctor visits in 1986 despite the need for attention, 8.0 visits compared to 9.1 visits for White elderly, and 9.0 for Black elderly.
Although Hispanic elderly often suffer disproportionately from illnesses or disability, they have lower rates of health insurance coverage than all elderly. Hispanic elderly are more likely to depend on Medicaid supplements to cover health expenses, while the general elderly population are more likely to have a private source of health insurance. Figure 17 shows the findings of a 1989 report by the Commonwealth Fund on Elderly People Living Alone which revealed that only 82% of Hispanic elderly were covered by Medicare, compared to 96% of all elderly. While only 1% of all elderly lacked health insurance, 8% of Hispanic elderly had no health insurance coverage. Hispanic elderly were less likely to have a private source of insurance; just 21% of Hispanic elderly were covered by Medicare and private insurance, compared to 69% of all elderly. Hispanic elderly depended more on Medicaid to supplement Medicare for health expenses than the general elderly population: 33% of Hispanic elderly were covered by both Medicare and Medicaid, while only 8% of all elderly had both Medicare and Medicaid coverage.

A higher percentage of Hispanic elderly have difficulties with personal care activities and tasks of household management than the overall elderly population. Another indicator of poor health is the need for assistance with Activities of Daily Living (ADL) (see Figure 18). The U.S. Bureau of Census collected data to determine whether individuals not living in nursing homes or institutions required help
from another person for ADLs because of health conditions that lasted or were expected to last more than three months. Their findings indicate that, in 1986, 19.2% of Hispanic elderly needed help with one or more ADLs, a higher percentage than White elderly (15.4%), but less than Black elderly (22.7%). ADLs included: (1) personal care, (2) getting around outside, (3) preparing meals, (4) doing housework, and (5) keeping track of bills and/or money. Both Hispanic and Black elderly had the greatest need in doing housework, whereas White elderly had the greatest need in getting around outside.⁴⁴

According to the Commonwealth Fund, 40% of Hispanic elderly have problems with one or more ADLs, compared with 23% of all elderly. In this study, ADLs were defined to include eating, toileting, dressing, bathing, and transferring (to bed or chair). The most troublesome activity for Hispanics was transferring. Furthermore, 54% of Hispanic elderly had problems with one or more "Instrumental Activities of Daily Living" (IADL), compared with 27% of all elderly. IADLs included managing money, using the telephone, preparing meals, light housework, shopping, and heavy housework. The most troublesome IADL for elderly Hispanics was heavy housework.⁴⁵

**Hispanic elderly rely on their families for assistance with ADLs and IADLs.** The Westat, Inc. survey of elderly Hispanics identified a spouse or a child as the main source of help for each ADL and IADL, more than other relatives and non-relatives. For example, among Hispanic elderly living with others more than half reported receiving help with ADLs from a child in the household and more than six out of 10 reported receiving help with IADLs from a child.⁴⁵ In the same survey, most Hispanic elderly, particularly those living alone and those living with others, reported not paying for help obtained for ADLs and IADLs. The report concluded that most Hispanic elderly live with others because they need assistance and lack funds to pay for that assistance.⁴⁶

**F. Hispanic Elderly Needs**

**Hispanic elderly are among the most vulnerable yet least visible segments of the Hispanic community.** Because Hispanics are a young population and the most undereducated Americans, the attention of the Hispanic community has tended to focus appropriately on its youth and young adults. The rapid growth of the Hispanic elderly population, however, has tremendous implications for the Hispanic community and for society in general, since this elderly population is among the neediest in the country.

Although they have worked hard throughout their lives, most Hispanic elderly cannot count on a financially secure retirement. The basis for the economic security of most elderly Americans is Social Security; however, as previously noted, Hispanics are less likely than White elderly to receive Social Security. Nearly one in four (23%) Hispanic elderly received no Social Security in 1988, compared to about one in eight Blacks (11%) and one in 12 Whites (7%). Hispanics are also less likely than Whites to receive private pensions and to have income from interest and other assets.
Because of low rates of participation in Social Security and other retirement plans and high rates of poverty, Hispanics are more likely to depend on earnings and public assistance to survive. As of 1988, elderly Hispanics were three times as likely as the total aged population to collect SSI; and SSI accounted for a much larger share of the Hispanic elderly's total income than for all elderly. Despite high need, Hispanic elderly are less likely to receive SSI than the rest of the eligible population. Low Hispanic participation in SSI is especially alarming since elderly Hispanics need SSI so badly, because they are less likely to be receiving Social Security, pensions, or earnings than other elderly.

Hispanic elderly face serious economic problems. Because most elderly Hispanics have worked at low-paying jobs, or are forced to leave the workforce before retirement age for health reasons, they are likely to receive minimum or near minimum benefits when they retire. This results in high rates of poverty and near poverty. As already noted, the median income for Hispanic elderly is only slightly above the poverty threshold for an individual 65 and over; older Hispanics are more than twice as likely to be poor as White elderly. Although the poverty rate for Hispanic elderly decreased from 30.8% in 1980 to 20.6% in 1989, the total number of Hispanics 65 and over in poverty has steadily increased, from about 179,000 in 1980 to approximately 211,000 in 1989. Many elderly Hispanics have incomes so low that they cannot survive without assistance from families and friends.

Hispanic families place great priority on caring for their elderly, which puts special responsibilities on the family. Hispanic elderly are more likely to rely on their families for care and assistance than other elderly. According to 1989 Census data, over three-fourths of Hispanic elderly lived with family compared with about two-thirds of White elderly and Black elderly. Hispanic elderly are also less likely to be institutionalized than both White and Black elderly. This places great responsibilities on the Hispanic family, which already faces difficult economic challenges; one-fourth of Hispanic families are poor.

Health care is a serious problem for Hispanic elderly. Many Hispanics start working at a very early age, and are often employed in hard labor (e.g., farmwork or manufacturing), which leaves them with a variety of illnesses or disabilities. Without adequate transportation services, many Hispanic elderly have difficulty getting to clinics, hospitals, or doctors' offices. When they do get there, they seldom find bilingual staff to assist them. Thus health status and access to care both represent significant difficulties for elderly Hispanics.

Hispanic elderly have low rates of health insurance coverage. Most of the jobs Hispanic elderly have had are unlikely to include health benefits; thus access to health care is limited even for employed Hispanics -- about one-third of Hispanics of all ages have no health insurance coverage. Hispanic elderly have a much lower rate of Medicare coverage than non-Hispanic elderly (probably a reflection of the lower rate of receipt of Social Security), as a result older Hispanics are more dependent on Medicaid. In addition, Hispanics are more likely not to have any health insurance than the general elderly population. Private supplemental insurance (Medigap coverage) is also less common among elderly Hispanics.
than among all elderly. A lack of supplemental insurance leaves elderly not covered by Medicaid vulnerable to costly medical expenses: premiums, deductibles, cost-sharing requirements, and services not paid for by Medicare.

Hispanic elderly not only have greater unmet acute medical care needs, but appear to have greater long-term care needs as well. A higher percentage of Hispanic elderly have difficulties with self-care activities and household management tasks than White elderly. Unable to care for themselves or manage their affairs, these elderly are dependent on others for assistance. As Hispanic elderly live longer, and Hispanic families need greater support in caring for their elderly, Hispanic community-based agencies are being called upon more frequently to provide services to home-bound Hispanic elderly.

Because of the age factor and economic need of the client population, accessibility and affordability of transportation have become a major issue. In an NCLR survey of selected community-based service providers and their elderly clients, transportation appeared to be a serious problem for older Hispanics. Even the agencies which were able to offer their own transportation services to clients could not begin to meet the demand -- transporting all the elderly who wished to participate in their programs. Where agencies did not have their own vans or buses to transport clients, the elderly were forced to rely on public transportation, transportation provided by other private sources (e.g., the local "Dial-A-Ride" service, where one existed), or on family members. Most staff and elderly described their public transportation systems, when they were available at all, as very inadequate. Local buses ran infrequently, were not convenient to places of residence, or did not accommodate the needs of elderly who were especially frail. "Dial-A-Ride" systems, which require the elderly client to call in advance to reserve a ride, often have neither bilingual staff people to handle calls from Spanish-speaking elderly nor bilingual drivers to understand them once on the bus or van; many have inflexible schedules.48

Decent affordable housing is a major need for the Hispanic elderly, particularly as the living arrangements of the Hispanic family shift away from the traditional multigenerational model. Hispanic elderly will need housing which will allow them to stay in their communities, and maintain an independent living status, while receiving necessary support services. Families who want to have their elderly members continue to live with them will need housing assistance -- now available only if the elderly members live in their own apartments.

There is a misconception that because Hispanic families take care of their elderly, older Hispanics have little need for services and programs. Caring for an elderly relative imposes a financial as well as an emotional strain on families, especially for those with limited resources. Furthermore, as the growth of the elderly Hispanic population outpaces the growth of younger generations, families face greater difficulties in meeting elderly needs. Social services and programs which can supplement family care and thus ease the burden of caregiving are critical for Hispanics.
III. ANALYSIS AND IMPLICATIONS

While government programs have helped to reduce poverty, poor health, and inadequate living conditions among the elderly overall, a substantial portion of older persons, primarily minority elderly, continue to experience serious socioeconomic difficulties. Although retirement typically brings about a significant decline in income, middle-class elderly can usually maintain a middle-class standard of living. Because economic well being during old age is based on the degree to which the elderly were able to meet their needs throughout their adult years and thus save and invest for old age, those who have been poor most of their lives continue to be poor during old age. Low educational attainment, limited job skills, and a history of high concentration in poorly paid service and farm labor jobs clearly contribute to the Hispanic elderly’s low socioeconomic status.

The Hispanic elderly population in this country is growing at a faster rate than the non-Hispanic elderly population. Current trends indicate that as the nation enters the 21st century, Hispanic elderly will be living longer, and will continue to be more likely to live in the community rather than in institutions, but will also continue to be disproportionately economically disadvantaged. This presents significant challenges for American society, particularly for the "aging network," in providing for the health, income, social services, and housing needs of this growing population.

A continuum of care that emphasizes preventive health care and services to help maintain and sustain independent living, and recognizes the importance of informal caregivers by offering services designed to support those that provide voluntary care at home is critical. Lack of access to such a continuum by all elderly creates a two-tiered system where the affluent few can afford to provide a continuum of care for themselves, and those without substantial financial resources lack alternatives. Low participation rates by Hispanic elderly in services under existing public and private programs is largely due to ineffective outreach strategies, and programs that may not be meeting the sociocultural needs of older Hispanics. As a result, a majority of the Hispanic elderly do not benefit from this continuum of care in proportion to their need; Hispanic elderly are on the sidelines.

A. Older Americans Act Programs

One of the primary missions of the Older Americans Act since the 1980s has been to provide services to older persons with the greatest economic and social needs, particularly low-income minorities; however, minority participation in OAA programs has declined. Data from AoA reveal that minority participation in OAA programs has declined from 22% of the clients in 1980 to about 16% in 1988.1 According to a recent survey by the Commonwealth Fund, only 16% of elderly Hispanics reported using any public social service (those using services tend to use more than one). The most commonly used services by Hispanic elderly were the senior centers and meal programs, with 13% of the
elderly surveyed reporting use of each of these services. Transportation services were used by 12% of elderly Hispanics; 9% used visiting nurses; 7% used homemaker services; 7% received home-delivered meals; and 5% used home health aide services.²

Although meal programs seem to be among the most commonly used services by Hispanic elderly, Hispanic participation in AoA-funded meal programs was lower in 1988 than in 1981. Hispanic participation in the nutrition programs (both congregate and in-home) declined from 166,276 elderly Hispanics served in FY 1981 to 141,429 in FY 1986, a decrease of 14.9%. Between 1986 and 1988, Hispanic participation rates in nutrition programs remained essentially stable. Elderly Hispanics represented 4.2% of all persons participating in congregate meals programs and 3.3% of those receiving home-delivered meals in FY 1986, 4.2% and 3.4% in FY 1987, and 4.9% and 3.9% in FY 1988, respectively³ (See Figure 19).

### FIGURE 19

**PERSONS SERVED BY TITLE III PROGRAMS**

<table>
<thead>
<tr>
<th>Title III-B Support Services</th>
<th>1986 Number</th>
<th>%</th>
<th>1987 Number</th>
<th>%</th>
<th>1988 Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Persons</td>
<td>8,976,112</td>
<td>8,556,025</td>
<td>8,221,663</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>3,843,795</td>
<td>3,614,581</td>
<td>3,366,030</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>1,460,603</td>
<td>1,307,441</td>
<td>1,331,061</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>43,318</td>
<td>39,344</td>
<td>42,976</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>116,530</td>
<td>101,644</td>
<td>108,615</td>
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<tr>
<td>Black</td>
<td>917,003</td>
<td>877,486</td>
<td>892,470</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>377,048</td>
<td>290,967</td>
<td>287,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title III-C1 Congregate Meals</td>
<td>2,853,953</td>
<td>2,780,101</td>
<td>2,748,885</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Poor</td>
<td>1,512,195</td>
<td>1,424,267</td>
<td>1,406,693</td>
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<tr>
<td>Minority</td>
<td>470,007</td>
<td>442,745</td>
<td>457,914</td>
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<tr>
<td>Indian</td>
<td>31,251</td>
<td>29,447</td>
<td>31,589</td>
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<tr>
<td>Asian</td>
<td>44,400</td>
<td>43,717</td>
<td>49,049</td>
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<tr>
<td>Black</td>
<td>275,147</td>
<td>253,319</td>
<td>242,495</td>
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<tr>
<td>Hispanic</td>
<td>119,227</td>
<td>116,261</td>
<td>134,799</td>
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</tr>
<tr>
<td>Title III-C2 In-Home Meals</td>
<td>671,496</td>
<td>715,891</td>
<td>745,097</td>
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</tr>
<tr>
<td>Poor</td>
<td>415,702</td>
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<td>435,521</td>
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</tr>
<tr>
<td>Minority</td>
<td>113,069</td>
<td>121,994</td>
<td>127,303</td>
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<td></td>
</tr>
<tr>
<td>Indian</td>
<td>6,643</td>
<td>7,997</td>
<td>7,813</td>
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<td>Asian</td>
<td>5,236</td>
<td>4,661</td>
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<tr>
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<td>85,615</td>
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</tr>
<tr>
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<td>22,202</td>
<td>24,182</td>
<td>29,243</td>
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<td></td>
</tr>
</tbody>
</table>


Hispanic participation in AoA-funded supportive services continues to decline. The number of older Hispanics participating in Title III-B supportive services dropped from 444,804 in FY 1980 to 287,000 in FY 1988, a reduction of 35.4%. Hispanics accounted for 377,048 or 4.2% of those receiving supportive services in FY 1986, 290,967 or 3.4% in FY 1987, and 287,000 or 3.5% in FY 1988⁴ (See Figure 19).
The reasons for fluctuation in the percentage of minorities served are a subject of controversy. According to AoA, the apparent decreases are due to changes in target group definitions or criteria of inclusion that were less liberal after 1981, and the states' increasing ability to report less duplicated participant counts, and do not entirely reflect actual decreases in program participation. However, a 1990 American Association of Retired Persons (AARP) report on minority participation in Title III services points out that most states still find it difficult to report an unduplicated count of participants -- the sole measure upon which minority participation is evaluated -- and that this problem is intensified in urban areas, where Hispanics are concentrated; thus the count of their participation is likely to be inflated.³

Data problems may actually understate the degree of decline and overstate the level of Hispanic participation in programs. According to AARP, the reliability and validity of existing data are further affected by the data collection system's inability to measure the intensity of services provided. A person who receives one unit of service (i.e., eats lunch once a year at a meal site) is equivalent, in the unduplicated count, to a person who is served five days a week. Consequently, some providers may inflate their minority participation by actively recruiting minorities for special events. Many service providers also lack the expertise to operate complex data collection systems, and lack of funds may preclude computerization that would facilitate more accurate reporting.⁴

Because Hispanics are concentrated in a few states, program fluctuations or changes in reporting procedures or definitions in those states can have a great impact on aggregated data. According to the AARP report, lack of consistent definitions of services and unclear mechanisms for classifying minority group members lead to wide disparities among states with respect to reporting of services (i.e., information and referral may include person-to-person contact in some states, while in others mass media announcements may be counted as information and referral). Since seven out of 10 Hispanic elderly live in just four states -- California, Texas, Florida, and New York -- inconsistent definitions of services, program fluctuations or changes in reporting in these states, or in Puerto Rico, may lead to inaccurate counts of minorities served.

Traditional forms of outreach alone are not likely to effectively increase Hispanic participation in elderly programs. According to a 1982 report by the United States Commission on Civil Rights, lack of participation in AoA-funded programs by ethnic minority elderly was largely due to a lack of bilingual/bicultural staff; location of nutrition sites and programs outside minority communities, making them inaccessible or difficult to reach due to lack of transportation; and a perception by many minority elderly that they were not welcome in the programs.⁷ Other factors may also exacerbate the problem of low Hispanic participation in these programs. For example, the Hispanic elderly's low educational attainment and limited English proficiency make the traditional written outreach strategies employed by mainstream agencies ineffective. Cost sharing, or charging those who can pay a fee for services, may also preclude many elderly from benefiting from supportive services.
A growing number of State and Area Agencies on Aging are charging clients for non-OAA funded supportive services. Although voluntary contributions are accepted, it is currently illegal to charge for services financed with OAA funds, but fees may be charged for support services provided with state social services and other funds. A 1989 GAO study of in-home services for the elderly found that 36 states and about one-third of the AAAs which responded to the survey charged some elderly clients fees for non-OAA-funded in-home services. Respondent agencies had a generally positive attitude towards cost sharing, whether currently engaged in the practice or not, because they saw it as a way to generate revenues to expand services and increase the numbers served. On the other hand, cost sharing may give service providers incentives to target more services to the affluent elderly. It may also deter use of services by the elderly because it would impose an income determination requirement, or because those exempt from fees would tend to view the services provided as welfare.

The rapid increase of the Hispanic elderly population in this country and sociocultural changes in Hispanic families indicate that the aging network, both public and private service delivery systems, will face a growing demand for services by Hispanics. As the growth of the elderly Hispanic population outpaces the growth of younger generations, families face greater difficulties in meeting their elderly's needs. Additionally, the effectiveness of the Hispanic family support system is declining due to reduced family size, increasing economic difficulties, and acculturation into mainstream American society. An increasing proportion of Hispanics, like other Americans, do not live in the same city as other family members. Moreover, recent immigrants often lack extended families because other members remained in the home country. As more Hispanic women join the work force, home care for frail elderly becomes much more difficult.

Although for years the language of the Older Americans Act has focused on targeting minority and poor elderly, in practice, minority elderly are not served in proportion to their need. Under section 306 (5)(A) of the OAA, local groups are required to provide services to minority individuals in at least the same proportion as the population of minority elderly bears to the total elderly population in the area served by such provider. According to this standard, Hispanic elderly are being adequately served by Title III programs. In 1988, Hispanics accounted for 3.6% of the total 60 and over population and 3.5% of those receiving support services, 4.9% of those participating in congregate nutrition programs, and 3.9% of those receiving home-delivered meals. However, in that same year Hispanics accounted for 6.5% of all elderly poor. In addition, 22% of Hispanic elderly were poor in 1988, compared to 10% of White elderly; and about 33% of older Hispanics had incomes below 125% of the poverty level in 1989, compared to only 18% of White elderly. A better standard, therefore, would be participation in the same proportion as the population of low-income minority elderly bears to the total low-income elderly population. In the absence of more strict minority targeting, it is likely that Hispanic participation will continue to decline.

Minority representation among State and Area Agency staff is, at best, proportional to the total minority elderly population. According to a 1985 National Association of State Units on Aging (NASUA) survey, 18% of SUA directors and 17.5% of
all SUA staff were minority in 1984; 57% of all minority staff were employed in professional or managerial positions. Results of a 1989 survey of Area Agencies on Aging, conducted by Dr. John Krout of New York State University at Fredonia, revealed that 13% of AAA directors were minority. However, when this figure is broken down by race/ethnicity, only 1.7% of the AAA directors were Hispanic, 7.8% were Black, 2.0% American Indian, 1.2% Asian, and 86.8% White. As of 1989, 3.9% of the 60 and over population was Hispanic, 8.6% Black, and about 2.3% were classified as other races. Success in outreach and service to a community depends largely on the degree to which staff of an agency understand the needs of and can relate to that particular community. Bilingual and bicultural staff are extremely important when dealing with language-minority populations. With such low Hispanic representation in state and area agencies, it is not difficult to see why outreach efforts targeting Hispanics are not always effective.

B. Income Security Programs

Hispanic elderly generally do not share the advantages and retirement benefits that many elderly enjoy in this country. Nearly one in four Hispanic elderly receives no Social Security, and only about one in five receives other pensions or annuities. Consequently, older Hispanics are more likely to depend on earnings and public assistance to survive. Hispanics who do receive Social Security tend to rely on it more than all elderly.

A history of high concentration in service sector and farm labor jobs is one of the major factors accounting for low level of Social Security and pension coverage among the Hispanic elderly. Because many retirement benefits are tied to employment, previous work history is an important factor in determining economic security during old age.

According to a 1989 Commonwealth Fund report, only 79% of elderly Hispanics surveyed reported having worked for pay, lower than the percentage among all elderly (86%). Among those who had worked for pay, two-thirds (66%) had worked at unskilled, service sector or farm sector jobs, compared with 40% of all elderly. These jobs offer lower pay and fewer benefits such as health insurance and pension plans than jobs in other sectors of the economy. Hispanic elderly are less likely than Whites or Blacks to receive public pensions, partly due to the fact that Hispanics have traditionally been underrepresented as government employees.

Although they have worked hard throughout their lives, many Hispanic elderly have not contributed to Social Security long enough to qualify for benefits. Until recently, farm work and domestic labor were not covered by Social Security or pension plans; as a result, many elderly Hispanics did not pay into the system long enough to derive benefits. In addition, because a large proportion of Hispanic elderly are immigrants, they may not have worked in this country long enough to qualify for Social Security benefits. Health reasons also force many Hispanics to leave the work force before retirement age; this results in low benefits, or no benefits if they have not worked the required number of quarters. Unlike private pension plans, Social Security does not take into account years in the
labor force. Other reasons for low Hispanic participation in Social Security may include lack of knowledge of eligibility criteria or how to apply for benefits, and fear of government agencies.

Income security programs are critical for Hispanics, yet there is a great lack of awareness about these programs due to scarce publicity and outreach efforts, and limited dissemination of literature about the programs, in English as well as other languages. What literature is available frequently is written at a reading comprehension level which exceeds that of most eligible persons, especially older Hispanics -- the least educated elderly group. The complexity of the application process, especially in light of the high functional illiteracy rates among elderly Hispanics in Spanish as well as in English, is also an obstacle.* A 1981 NCLR analysis, "Non-Participation of the Neediest in Income Assistance Programs," confirmed that for reasons such as education, language, and access problems, those most in need of income support or service programs typically were least likely to locate and successfully apply for benefits.

Present levels of bilingual staff in Social Security Administration (SSA) field offices are insufficient to meet the needs of non-English-speaking applicants and clients. A report by the Department of Health and Human Services Inspector General's Office (Serving the Non-English-Speaking Clients) found that many non-English-speaking clients do not receive the same level of service as others, and that SSA has not given sufficient priority to the needs of non-English-speaking clients. This is reflected in the fact that many non-English-speaking clients wait longer to be served, and that there are insufficient bilingual staff to meet the needs of these clients. At present, the workload reporting system does not capture data on non-English-speaking client activity, and data on bilingual employees are incomplete. The report also noted that most SSA field office managers (62%) believed there were not enough bilingual staff, and that past staff cuts coupled with lack of recruiting were major obstacles to providing good services to limited-English-proficient clients.13

Lack of sufficient staff, particularly bilingual staff, in SSA field offices translates into long waits for clients, little assistance, and sometimes uncivil or intimidating treatment because of time constraints. According to a GAO survey of 146 SSA district managers, 43% of the respondents who perceived a need for outreach to non-English speakers felt that SSA was not doing enough. The principal reason cited by the managers for not doing enough outreach was lack of staff. The number of field staff who perform outreach declined from 1,039 to 601 -- or 49% -- between FY 1985 and FY 1989 (See Figure 20). With the decline in field representatives, responsibility for outreach has shifted to other field office employees; thus, less time is spent on outreach. According to the GAO report, 80% of the district managers estimated that their staffs spent 20 hours or less each month conducting outreach (See Figure 21). In addition, national public information activities were reduced by 43% between 1985 and 1989.14

* For further information on illiteracy among Hispanics see 1988 NCLR analysis Literacy in the Hispanic Community.
The quality of service to the public has been further compromised by the establishment of a toll-free telephone system which routes calls to national teleservice centers, bypassing local Social Security offices. Callers frequently are unable to get through. In January of 1989, the busy signal rate was 43% nationally, and in several metropolitan areas, it was as high as 60% to 70%. In January 1990 three out of four callers were unable to get through. Callers do not reach the same person twice; thus when a problem requires more than one call, a lot of time and effort is wasted explaining the situation again. In addition, callers may be given incorrect information as a result of their call being handled out of state. For example, those inquiring about SSI rates may be given the rate for the state in which their call is being taken rather than the state in which it was made. Spanish speakers may be routed to teleservice centers in states that are unable to provide bilingual assistance. It appears that the toll-free line is incompatible with SSA’s mission to serve those who are highly vulnerable, who often need personal service to be fully responsive, and who are often intimidated by modern technology.

In view of the importance of Social Security for elderly Hispanics, proposals to reform the system must be carefully analyzed. For example, the 1983 amendments to the Social Security Act will gradually increase retirement age from 65 to 67 years, beginning in the year 2000. There is already concern that due to differences in life expectancy, minorities are not benefiting equitably from Social Security; an increase in eligibility age, therefore, would negatively affect Hispanics. Unlike private pensions, Social Security does not take into account the number of years in the workforce (after the required number of quarters have been worked). Hispanics tend to leave school earlier and as a result enter the workforce three to four years before Whites. Consequently, they begin contributing to Social Security earlier. Hispanics also die younger; thus, they either do not live to collect benefits or collect fewer benefits due to a shorter life span. As Hispanics continue to leave school and enter the workforce earlier, and experience lower life expectancy rates than Whites, the increase in eligibility age will continue to affect Hispanics negatively. Additionally, because of high
rates of poverty or near poverty among Hispanics, and because Social Security is the major source of income for Hispanics, across-the-board cutbacks in benefits or freezes of the cost-of-living-adjustment (COLA) tend to have disproportionate, negative impacts on older Hispanics.

Because income support and public assistance programs are critical in alleviating the plight of elderly Hispanics, policy changes in these programs are necessary in order to improve the economic status of the Hispanic elderly. The accuracy of the present definition of "poverty" as calculated by the U.S. Bureau of the Census has received considerable criticism. Much of this criticism is focused on the fact that consumption patterns have changed since the official poverty standard was adopted in 1969. At that time, food cost was the largest expenditure of a family’s budget, thus, the poverty definition was essentially based on food costs. Currently, food costs account for a smaller proportion of a family’s budget and housing and other costs represent a larger share of a family’s minimum expenditures than they were when the poverty definition was first developed. But the basis for poverty definition has not changed. In addition, when the poverty definition was created, the "threshold" at which the elderly were considered poor was set lower than that of younger people because it was assumed that the elderly needed less food. Consequently, the special needs of the elderly are not considered under the present definition of poverty.

Increasing the SSI standard to at least the poverty threshold for all elderly, regardless of living arrangement, is essential to alleviating poverty among elderly Hispanics, even though this would increase program costs. Currently, benefits are at about 75% of the poverty line for single people and 90% for couples. This disproportionately affects low-income minority women, because they are more likely to live alone rather than be married. The elderly represented 1.4 million of the 4.6 million SSI beneficiaries in 1989, at a cost of $3.25 billion (the federal share equaled $2.31 billion, and the state share $938 million). An increase in the benefit level to 100% of the poverty level would mean approximately $1 billion in additional payments to those already receiving benefits. Increasing the benefit standard to poverty level would extend program eligibility to more persons, and induce some nonparticipants to participate, which also translates into additional program costs. In 1983, the Urban Institute calculated that if the benefit level were raised to the poverty threshold, program participation for the elderly would increase by 27% in the short run and 48% in the long run. If these figures are used as a reference, the elderly share of the cost of the SSI program would probably increase by about $2.9 billion in the short run and $4.4 billion in the long run. Most of the cost would be carried by the federal government, about $2.5 billion and $3.8 billion, respectively.

Revision of the allowable cash income for SSI would represent a substantial improvement for poor elderly. The cash income "disregards" -- $20 of monthly income from any source and $65 of monthly earned income -- have not been updated to reflect inflation since they were first set in 1974. In its 1983 study, the Urban Institute calculated that had the "disregards" been indexed for price inflation, their 1983 value would have been $40 and $130, respectively. For most SSI beneficiaries, only the general cash income "disregard" is relevant; it affects more than 90% of elderly beneficiaries. According to the
Urban Institute, only 4% of the beneficiaries had earnings, 50% had Social Security benefits, and 12% had other unearned income. Increasing the income disregard to the inflation-adjusted 1983 level would extend program eligibility to more persons with other cash income, and induce some nonparticipants to participate. As a result, according to the Urban Institute 1983 simulation, the cost of the SSI program would increase by $343 million in the short run and $410 million in the long run. The bulk of the increased expenses would be shouldered by the federal government, $275 million and $292 million, respectively.14

Indexing the SSI assets test for inflation would have a positive impact on those elderly who are income-eligible, but whose assets, although modest, fall slightly above the current limit. Through the first decade of the SSI program (1974-1984), the assets limits were set at $1,500 for an individual and $2,250 for a couple. The Deficit Reduction Act of 1984, however, increased the limits by $100 annually for an individual and $150 annually for a couple through 1989; the asset limit currently stands at $2,000 for an individual and $3,000 for a couple. Still, this is thought to be too stringent by some. According to a 1988 study conducted by the Policy Center on Aging of Brandeis University for AARP, 34% of the income-eligible 65-69 age group and 45% of those 85 and older were ineligible because of assets. About 60,000 elderly persons had countable assets that fell within $750 of the 1984 assets test threshold. The assets that contributed to the ineligibility were for the most part interest-earning savings accounts and modest life insurance policies. The study concluded that many of the elderly were excluded from SSI not because they were well-off, but because the government had failed to take into account the effect of inflation on program eligibility criteria.19 For example, in 1984 (when the assets limit was set at $1,500 for an individual and $2,250 for a couple) the median value of interest-earning deposits for White elderly households was $9,716, compared to $1,821 for Hispanics and $954 for Blacks.30 While the median value of interest-earning deposits of older Hispanic households was meager, and considerably below that of White elderly, they were slightly above the SSI assets limit.

Among the SSI reforms that have been advocated to address this problem are: the elimination of the assets test, use of the less stringent Food Stamp assets test, and indexing of the assets test. Using 1984 costs, the Brandeis study estimated that elimination of the assets test would be the most expensive, because it would increase the eligible population by 42% and increase the cost of federal benefits between $800 million and $1.2 billion annually. The Food Stamp test would increase the eligible population by 15% and federal benefits by $300 to $400 million. Indexing for inflation would increase those eligible by 7% and increase federal costs by $100 to $200 million.31

C. Health Care

Although Hispanic elderly are more likely to be in poorer health than all other elderly and thus have a greater need of health care, they tend to underutilize many types of health care services. Hispanics suffer from a variety of chronic health problems during old age, due in large part to their work history, yet they average fewer physician contacts than all elderly. Hispanics also have greater difficulty with personal care and household management activities than all elderly, but they tend to use formal, long-term care
services less than other elderly, preferring to stay at home and rely on informal care from family and friends, and services from community-based organizations. This is evidenced by the lower level of spending on institutional care by Hispanics, compared to non-Hispanic Medicaid recipients. In a 1990 study, the National Coalition of Hispanic Health and Human Services Organizations (COSSHMO) reported that in the seven states with the largest Hispanic populations (Arizona, California, Florida, Illinois, New Jersey, New York, and Texas), the per capita spending for skilled nursing and intermediate care facilities (excluding mental health facilities) was 15 times greater for White non-Hispanic Medicaid recipients ($1,024 per capita) than for Hispanics ($69 per capita).22

The high poverty rate among Hispanic elderly, coupled with the high cost of health care, makes it is unlikely that they could afford to pay for long-term care. Poor health among elderly Hispanics not only threatens their independence but can be devastating for the poor and/or those without insurance coverage. Medicare does not cover in-home personal or adult day care services for functionally limited or chronically ill persons, it only covers temporary skilled post-acute care for medically-related home health needs. As Figure 22 indicates, most Medicare expenditures are for hospital and physician services; only 2% of the Medicare dollar was spent on home health care services in 1988. Private insurance coverage for home health care is not readily available for the elderly. Most of the private insurance spending on home care covers services to the non-elderly. Medicaid can provide assistance to the low-income impaired, but until now has focused on reimbursing costs for nursing home expenses rather than on community-based services. As Figure 23 indicates, while 37% of the Medicaid dollar went to pay for nursing homes in 1988, only 3% went for home health care services.

**FIGURE 22**

**FIGURE 23**

**MEDICARE EXPENDITURES 1988**

- Hospitals: 65%
- Physicians: 26%
- Home Health: 2%
- Nursing Homes: 1%
- Others: 4%

**MEDICARE DOLLAR 1988**

Source: Health Care Financing Review Vol. 11 No. 4 Summer 1990.

**MEDICAID EXPENDITURES 1988**

- Hospitals: 38%
- Home Health: 3%
- Physicians: 7%
- Others: 15%
- Nursing Homes: 37%

**MEDICAID DOLLAR 1988**

Source: Health Care Financing Review Vol. 11 No. 4 Summer 1990.
A large portion of Hispanic elderly either have no health insurance or depend solely on Medicare coverage; they lack adequate financial protection against the high cost of medical care. Medicare does not provide full protection against the burden of illness. Coverage of hospital costs for extended acute illnesses (more than 60 days) is limited. Medicare also does not protect beneficiaries against potentially large copayments or charges above the approved rate for physician services, nor does it cover prescription drugs or dental care. As a result, Hispanics are vulnerable to costly medical expenses if they have no supplemental coverage.

Out-of-pocket medical expenses are a substantial burden for poor elderly Hispanics. In a 1987 report on Medicare and poor elderly, the Commonwealth Fund estimated that in 1986, out-of-pocket medical care spending was greater than 10% of the poor elderly’s income. Out-of-pocket costs were substantially reduced for poor elderly people who had Medicaid coverage. Poor elderly people without Medicaid spent more than twice as much as poor elderly people with Medicaid ($815 compared to $388). Two-thirds of poor elderly people without Medicaid spent more than 15% of their income on out-of-pocket medical costs; on average they spent one-quarter of their total income on medical expenses. Out-of-pocket payments made up almost one quarter (24%) of personal health care expenditures in 1988 (See Figure 24). Concern over large out-of-pocket costs has led many older Americans to purchase supplemental private coverage (Medigap insurance), and has resulted in abuses by insurance companies trying to sell unnecessary coverage.

**FIGURE 24**

Elderly Hispanics depend on Medicaid to compensate for the inadequacies of Medicare. Hispanic elderly have a higher rate of Medicaid coverage (33%) than the overall elderly population (8%) due to higher rates of poverty among elderly Hispanics. Among those with incomes below poverty, 44% of poor elderly Hispanics are covered by Medicaid,
compared to 29% of all elderly poor. Because Medicaid serves as a Medigap policy, out-of-pocket payments for medical care are substantially reduced for poor elderly covered by Medicaid.

Despite the fact that Medicare and Medicaid are critical for older Hispanics, there is little assistance with the application process, particularly for monolingual Spanish speakers. According to the COSSMHO report, one-third (33%) of the surveyed Medicaid application sites in the seven states with the largest Hispanic populations indicated that they provided no special services to help their staff work with Hispanic and/or monolingual Spanish-speaking clients. The majority of the offices provided only Spanish-language printed information. Because of older Hispanics' low educational level and high illiteracy rates, even in Spanish, this material is often difficult for them to understand.

Lack of knowledge about eligibility criteria, the complexity of the application process, and lack of cross-cultural training for Medicaid personnel are clearly barriers to Medicaid enrollment for older Hispanics. According to COSSMHO, inadequate knowledge of Medicaid eligibility requirements was the reason most often cited (49%) by the surveyed offices for the low levels of Medicaid enrollment among eligible Hispanic populations. Some 31% of the surveyed offices linked the complicated application process and forms to low levels of Hispanic Medicaid enrollment; about 20% of the surveyed offices indicated insufficient documentation of income status as a problem.

Although Hispanics tend to rely on their own community for services and assistance, community-based agencies are seldom used for outreach to the Hispanic community. Hispanic community-based organizations are an essential mechanism for reaching and serving Hispanics. However, according to COSSMHO, the great majority (77%) of the surveyed Medicaid application sites responded that they did not use community-based organizations as alternative application sites.

D. Food Stamps

Hunger in America has recaptured public attention. Throughout the 1980s, at least 75 national or local studies of hunger in the U.S. were carried out by government agencies, academic institutions, and advocacy organizations. Findings suggest that despite economic growth, hunger remains rampant in the U.S. Children and the elderly appear to be the hardest hit, and they are likely to suffer the greatest harm when food is inadequate.

As the numbers of elderly climb and studies reveal how poorly millions of them eat, concern about malnutrition intensifies. According to medical experts, malnutrition may account for a greater share of illnesses among older Americans than has been generally assumed. A 1987 National Survey of Nutritional Risk Among the Elderly by the Food Research and Action Center (FRAC) found that almost one in five low-income elderly respondents (18%) said they did not have enough money to buy the food they needed, more than one in three (35%) frequently ate less than three meals per day, and 5.4% had been
without food for more than three days during the previous month. Nearly one-third of the sample seldom or never participated in congregate meal programs and only about one-fourth were enrolled in the Food Stamp program.28

Despite the need, most older Americans do not appear to be benefiting from the Food Stamp program. According to a 1988 report by the Congressional Budget Office, only 41% of eligible households and 51% of eligible individuals received Food Stamps in 1984; but households with elderly members had a lower participation rate, 34% to 44%. As of 1989, persons 60 and over made up only 8% of all Food Stamp recipients and received 8% of Food Stamp benefits (an average of $31 per month).29 In 1989, about 13% of all person under 125% of the poverty level (a criterion for Food Stamp eligibility) were 65 and older.30 According to 1988 Census data, of the 65 and over households receiving Food Stamps, 59.4% were White, 31.5% Black, and 9.1% Hispanic.31

Even for those who receive Food Stamps, having enough to eat is a problem. According to a 1989 report of the Senate Special Committee on Aging, 31% of the elderly who received Food Stamps received only the minimum benefit of $10 per month.32 A 1983 FRAC study found that Food Stamp recipients were the major users of emergency food programs, mostly because they ran out of stamps by the second or third week of the month.33

Lack of information about eligibility seems to be a key factor contributing to nonparticipation in the Food Stamp program. According to two reports released by GAO in July and October 1988, lack of participation was mainly due to lack of information about the program and problems with administrative practices -- complex application forms, limited office hours and interviewing schedules, and difficulties with the required documentation. GAO found that the likelihood of a household participating in the Food Stamp program decreased as the age of the head of household increased, or as the number of persons 65 and over in the household increased. Additional factors influencing program participation included physical access problems such as transportation or impairment of the applicant, and the relatively low benefit payment, which may provide little incentive to apply.34

E. Employment

Although many Americans are choosing to retire at or before age 65, many Hispanic elderly cannot count on a financially secure retirement and need to continue working during their later years to survive. However, numerous obstacles to older worker employment persist, including negative stereotypes about aging and productivity, job demands and schedule constraints that are incompatible with the skills and needs of older workers, and management policies which make it difficult to hire older job seekers. Despite the fact that the labor force participation rate for elderly Hispanics is similar to that of Black and White elderly, older Hispanics and Blacks are more likely to be unemployed than Whites.

Hispanics are underserved in proportion to their need by the Senior Community Service Employment Program (SCSEP). Because Hispanics are more likely to depend on earnings during their old age, employment and training and placement programs are very
important to older Hispanics. The elderly Hispanic participation rate for the Title V SCSEP is about twice as great at it is for Title III Supportive and Nutrition Programs. Older Hispanics accounted for 8.8% of all enrollees in SCSEP during the 1988 program year; in comparison, 23.3% of enrollees were Black and 63.3% were White. According to 1989 Census data, Hispanics accounted for 7.3% of all persons 55 and over with incomes under 125% of poverty (the criterion for eligibility to the program), Blacks represented 21.6% and Whites 76.1% of those eligible. Relative to other groups, Hispanics appear to be equitably served. Unlike other programs where Hispanics are underserved, the problem with SCSEP is that is so underfunded that it serves less than 1% of the eligible population (Hispanics, Blacks or Whites). The issue is not inequity in program administration, but unmet need. Furthermore, elderly Hispanics and Blacks appear to have a much greater need for employment and training programs than Whites. While 27.9% of Hispanics and 39.8% of Blacks 55 and older had incomes below 125% of the poverty level in 1989, only 14.3% of Whites had incomes below 125% of poverty. Also, as mentioned in Part II of this report, elderly Hispanics and Blacks are more likely to be unemployed than Whites.

Volunteer opportunities in some ACTION programs may also provide supplementary income for needy elderly. In FY 1989, Hispanics accounted for 9% of the participants in the Foster Grandparent Program (FGP), Blacks represented 31%, and Whites 56%. These figures, however, include program participation in Puerto Rico, where the FGP is especially popular. Participation rates were similar for the Senior Companion Program; Hispanics totaled 7% of the program participants, Blacks 31%, and Whites 57%. Hispanics seem to be greatly underserved by these programs compared to Blacks. While for both the FGP and SCP, participants' income must fall at or below 125% of poverty, there is no such requirement for RSVP volunteers. Hispanics accounted for 4% of RSVP participants, Blacks for 11% and Whites for 84%.

F. Other Programs

Lack of decent, affordable housing is a major problem in the Hispanic community. As Hispanic family living arrangements begin to shift away from the traditional multigenerational model, many Hispanic elderly will be looking for housing which will allow them to stay in their communities, and maintain an independent living status while receiving necessary support services. The long waiting lists for existing agency-sponsored Section 202 housing units indicate the high level of need for this type of facility. However, the federal government's involvement in the area of housing for the low-income elderly, particularly in the production of new units, has been falling off since 1981. Moreover, federal policy has seen a shift from an emphasis from long-term commitments, such as construction of new units and the rehabilitation and modernization of older housing stock, to shorter-term commitments focusing on the use of existing housing stock (vouchers).

For the elderly, services are useful only to the extent that transportation can make them accessible. Transportation, the vital link between home and community, can serve to support an individual's capacity for independent living and thus reduce or eliminate the need for institutional care. Because of the age factor and economic need of the client
population, accessibility and affordability of transportation become a major issue. Current transportation programs do not begin to meet the great demand. Buses run infrequently, routes do not serve Hispanic communities, or facilities do not meet the needs of frail or disabled elderly. Limited English proficiency may also limit Hispanic elderly’s use of public or private transportation systems.

G. Conclusions and Policy Implications

Data clearly indicates that Hispanic elderly face serious socioeconomic difficulties and are not receiving adequate attention or services. Although demand for services far exceeds the aging network’s capacity to provide them, Hispanics face special difficulties — limited English proficiency, poor health, limited incomes, and transportation problems — in accessing services.

The serious socioeconomic problems of the Hispanic elderly are compounded by a severe underutilization of existing services. Despite the need, most older Hispanics do not appear to be participating in social services programs. The most commonly used services by Hispanic elderly are the senior centers, congregate meal programs, and transportation services. However, a minority of elderly Hispanics benefit from these services. Lack of bilingual/bicultural staff; location of services outside minority communities, making them inaccessible or difficult to reach; and a perception by minority elderly that they are not welcome in programs are important factors contributing to Hispanic underutilization of elderly programs.

The principal reason for low participation in social services and entitlement programs appears to be lack of awareness of such programs due to scarce or ineffective publicity and outreach efforts. Dissemination of literature about services, in English as well as other languages, is limited, and available literature is usually at a reading comprehension level which exceeds that of most eligible persons, especially older Hispanics — the least educated elderly group. The complex application process of some entitlement programs, especially in light of the high functional illiteracy rates among elderly Hispanics in Spanish as well as in English, is also an obstacle.

Older Hispanics rely more heavily on informal sources of support — family, friends, and Hispanic organizations — than they do on organized "aging network" services. Yet, the effectiveness of the family support system is declining due to reduced family size, increasing economic difficulties, and acculturation to mainstream American society. Services and programs which can supplement family care and thus ease the burden of caregiving are critical for Hispanics.

Because Hispanics tend to rely on their families or their own communities for services and assistance, Hispanic community-based organizations represent an essential mechanism for assuring that the future needs of the Hispanic elderly are met. Such organizations have special skills in reaching out and working effectively with Hispanics, and addressing the needs and concerns of their particular communities. Despite their capacity to
effectively address many of the outreach, language, and cultural sensitivity problems associated with the mainstream network, Hispanic community-based organizations remain an underutilized resource.

Although a large proportion of Hispanic community-based organizations currently provide services and/or advocacy for the Hispanic elderly, a minority have specific funding for elderly services. Hispanic community-based organizations recognize the growing need to serve the elderly in their communities. However, most are family-oriented human service or youth-focused agencies and perhaps have not carved out niches for themselves in the aging network. Many feel shut out of the aging network by mainstream government agencies and service providers and ignored by private philanthropy. Where given the opportunity, Hispanic community-based organization have a proven capacity to effectively address the needs of their communities. (For more information on the needs of and services provided by Hispanic community-based organizations, and the special characteristics which helps these agencies to meet community needs, see NCLR’s analysis, The Hispanic Elderly and the Community’s Response.)

As the overall elderly population in the United States increases, both families and the service delivery system -- public and private -- face growing challenges. Older Hispanics do not seem to be benefiting equitably from programs in the "continuum of care"; they remain on the sidelines. While there is growing concern within the Hispanic community over meeting the needs of this growing and vulnerable population, little outside assistance is available. Existing services -- already inadequate -- cannot meet the burgeoning needs assured by the projected growth of the Hispanic elderly population. The service gap between minority and non-minority elderly will continue to widen in the future unless changes are made in public policies and programs.
IV. RECOMMENDATIONS

Improving opportunities and services for Hispanic elderly requires a comprehensive approach at the national, state, and local levels. Policy making at all levels should reflect an understanding of the needs and status of Hispanic elderly. The federal government is responsible for assuring that federal dollars equitably serve all elderly, yet program funding and implementation decisions are made at the state and local levels. It is therefore crucial to monitor federal, state, and local programs to assess how effectively they are serving older Hispanics. If OAA and other community and entitlement programs are going to equitably serve Hispanics, immediate policy intervention is needed to improve the services and delivery systems. The following recommendations address policy and program issues dealing with these needs, and suggest action for increasing Hispanic participation in services and entitlement programs.

Participation by older Hispanics in OAA and in needs-tested programs should reflect the high proportion of needy Hispanic elderly. According to current standards, minority elderly should be served in at least the same proportion that the population of minority elderly bears to the total elderly population in the area. However, this standard ignores the fact that minority elderly are disproportionately poor. They should participate in these programs at greater rates than their proportion of the elderly population, preferably at a level reflecting their percentage of the local low-income elderly population.

Hispanic community-based organizations should be encouraged and funded to develop programs to meet the needs of older Hispanics. As families face greater financial and other difficulties in caring for their elderly, Hispanic elderly will rely more on community-based agencies for support. These agencies are designed to address the needs and concerns of their particular communities. Located primarily in Hispanic neighborhoods and governed and staffed largely by Hispanics, they have special skills in reaching out to and working effectively with the Hispanic community. Yet many such agencies receive no AoA funding, and few receive support from private foundations and corporations which fund mainstream elderly programs.

Recognizing, however, that mainstream organizations will continue to deliver the bulk of services, these organizations must be better prepared to address the needs of elderly Hispanics. For example, mainstream social service agencies serving large numbers of older Hispanics should be required to have bilingual and bicultural staff. Translation and interpretation services are important for elderly Hispanics, many of whom speak little or no English. Bilingual staff are needed to assist the elderly in their interaction with various bureaucracies. Staff also need to be sensitive to cultural practices such as holidays, ethnic meals, and the planning of recreational activities.

Mainstream public and private agencies should do more outreach about available services and eligibility requirements. This includes but should not be limited to translation of existing materials into Spanish, and hiring more bilingual/bicultural staff. More
extensive use of radio and other "street-level" approaches such as town hall meetings and flyers should be pursued. The provision of information about social services must be coupled with a comprehensive education program to facilitate clients' use of services. For example, many Hispanic elderly may be aware of existing services, but they may not be able to relate them to their own needs or link up with appropriate service providers.

Mainstream social service and government agencies should develop strong coordination with Hispanic service providers in order to successfully reach the Hispanic elderly population. Informal support systems -- families, friends, and Hispanic community-based organizations -- can serve as a linking mechanism and referral source to formally organized "aging network" services. Therefore, information and education efforts should also be targeted to these intermediaries. Coordination may result not only in improved services to Hispanic elderly, but also in more efficient use of existing resources.

More extensive and more accurate collection, tabulation, analysis, and reporting of data by public agencies and recipients of public funding for elderly services are critically needed. Data on Hispanic participation and eligibility rates in elderly programs are essential to measure program effectiveness; problems and needs must be well documented before action to solve them can be successfully initiated. Presently, collection and dissemination of data on Hispanics are inadequate. Hispanics are not sufficiently sampled in national surveys to provide reliable, valid data on Hispanic subgroups or even Hispanics as a whole. Data from the 1980 Decennial Census were incompletely analyzed or not published. Sample sizes of Hispanics should be sufficiently large to provide valid estimates needed for informed policy making. All federal, state, and local agencies should be required to include Hispanic information in their data collections and reports. Better "counting" of aging service program clients is also essential, including reporting mechanisms which reflect the level of services provided.

Eligibility for and levels of Social Security benefits should take into account the number of years worked as well as age. Public and private pensions are generally based not only on the age of the worker, but on the number of years worked. Yet, once the required number of quarters have been worked, Social Security ignores the number of years in the labor force. This disproportionately affects Hispanics, who enter the workforce earlier, and because of poor health frequently leave earlier or do not live long enough to collect benefits. With such a variable age formula, workers could be eligible for full benefits at an earlier age depending on the number of years worked, or could collect increased benefits if they have worked a greater number of years. A variable age formula is particularly important now that the retirement age is being increased to 67 years.

Policy changes in income support and public assistance programs are critically needed to improve the economic status of the Hispanic elderly. The SSI standard should be increased to at least the poverty threshold for all elderly. The present definition of "poverty" is outdated. Consumption patterns have changed since the official poverty standard was adopted in 1969, but the basis for the poverty definition -- food costs -- has not changed. Special needs of the elderly such as rising housing and health care costs are not taken into
consideration under the present definition of poverty. Although no immediate changes to the official poverty definition have been proposed, issues such as these should be examined when attempting to define and address the needs of the elderly.

The SSI benefit should be standard for all elderly, regardless of living arrangement. The current benefit level -- 75% of the poverty line for single people and 90% for couples -- disproportionately affects low-income minority women, who are more likely than others to live alone rather than with a spouse. Raising the SSI standard to the poverty level would probably mean an additional cost of about $3 to $4 billion per year. This could be paid for by increasing the federal benefit guarantee, by requiring all states to provide a supplement that will bring recipients to the poverty level, or by a combination of both approaches.

The existing provision which reduces SSI benefits by one-third under some housing arrangements should be repealed or improved. It is precisely the very poor elderly, forced to live with others to make ends meet, who are penalized. This provision has a disproportionate impact on Hispanic elderly, who are more likely than other elderly to live with family. Although the one-third reduction does not apply if the beneficiary can prove that s/he contributes pro rata to the household expenses, the burden of proof falls on the elderly person, who often has educational and language limitations which make it difficult to document his/her case. Additionally, many elderly may be embarrassed to reveal that family are unable to help them. The one-third reduction is also a disincentive for poor households who could benefit from additional income to take in elderly relatives.

The monthly cash income "disregard" and the assets limit for the SSI program should be indexed to protect benefits from inflationary erosion. Although updating the allowable cash income would tend to benefit those elderly whose income is already supplemented, it would prevent Social Security COLAs from resulting in loss of SSI benefits. Likewise, indexing the asset limit for inflation would have a relatively small effect on SSI program costs and would benefit the elderly poor.

The resources required to cover the costs of these recommendations, while substantial, are well within this country's capacity. One alternative could be to leverage funds through full taxation of Social Security benefits. In addition, the savings generated if more elderly were cared for at home rather than in institutions could partially offset the cost for these proposals. Increased SSI benefits regardless of living arrangement would provide an incentive for low-income families to take care of older relatives since the benefits would supplement their household income.

Employment programs which assist Hispanic elderly who are both able and eager to work, either part-time or full-time, should be expanded and better targeted to the needs of low-income minority elderly. Because Hispanics are more likely than non-Hispanic elderly to depend on earnings during their old age, these programs are extremely important to older Hispanics. This is evidenced in their relatively high rate of participation in such programs -- the Hispanic participation rate for the Title V SCSEP is about twice as great.
at it is for Title III Supportive and Nutrition Programs. In spite of this, compared to their proportion of the eligible population, Hispanics are seriously underserved by SCSEP. Thus, the need for additional employment opportunities for Hispanic elderly remains high.

Both health and mental health services should be expanded, made affordable, and placed in locations which are accessible to the Hispanic elderly. Health care and health care costs are critical problems for the Hispanic community, particularly for the aged. Bilingual outreach for Medicare, Medicaid, and other health resources must be improved.

Guidelines for social services, housing, and long-term care should be revised to help maintain rather than separate multigenerational families. It is generally both less expensive and more socially desirable for elderly people to be cared for at home than for them to be institutionalized, but this places the burden of caring for the elderly on the community and the family. Tax benefits should be investigated for families that care for their elderly at home. Guidelines for elderly housing assistance and other benefit programs should be revised to encourage and support multigenerational families. The "family" should be defined to include close, live-in relatives including grandparents for federal housing allowances, new construction and rehabilitation, and mortgage insurance programs. This would provide families the option to maintain a multigenerational living arrangement and reduce the costs of social and health services.

The need for decent affordable housing for the elderly is a growing priority which must be addressed. As Hispanic family living arrangements begin to shift away from the traditional multigenerational model, the need for more subsidized housing for the elderly becomes a growing priority. The long waiting lists for existing Section 202 housing units indicate the high level of need for this type of housing. Many Hispanic elderly will be looking to the public sector and community-based groups for housing which will allow them to stay in their communities and maintain an independent living status, while receiving necessary support services.

Existing transportation services should be expanded and better coordinated. Lack of transportation to service facilities often prevents Hispanics from participating in OAA services, particularly at sites located outside their neighborhoods, and from accessing health care and other services. Both the 1971 and 1981 White House Conferences on Aging stressed the importance of transportation to assure access to services, but little action has been taken to address this issue.

The implementation of these recommendations requires the reallocation of existing funds to better target those who are most in need, emphasis on community-based services rather than institutionalization, and support for multigenerational families rather than segregation of the elderly. The provision of these services will reduce the cost burden borne by frequently impoverished intergenerational families, and will thus prevent services to the elderly from negatively affecting disproportionately poor Hispanic children. Unless appropriate changes are made in public policies and programs, the problem of inadequate resources and services can only become more serious as the Hispanic population grows.
ENDNOTES

PART I


PART II


18. Ibid.
20. A Survey of Elderly Hispanics, op. cit., Table 2-6.
22. A Survey of Elderly Hispanics, op. cit., Table 2-1.
26. Ibid.
27. Ibid.
29. Ibid.
31. Ibid, Tables 1 and 4.
32. Demographic Characteristics of the Older Hispanic Population, op. cit., p. 4.


35. *Ibid,* Table 21.


44. *Poverty and Poor Health Among Elderly Hispanic Americans,* op. cit., pp. 40-43.


46. *Ibid,* Tables 2-30 and 2-34.


PART III


2. *Poverty and Poor Health Among Elderly Hispanic Americans, op. cit.*, p. 47.


12. *Poverty and Poor Health Among Elderly Hispanic Americans, op. cit.*, p. 27.


24. *Poverty and Poor Health Among Elderly Hispanic Americans, op. cit.*, p. 27.

25. *... And Access For All: Medicaid and Hispanics, op. cit.*, p. 39.

27. Ibid, p. 39.


33. Ibid, p. 145.


37. Ibid.

REFERENCES

NCLR PUBLICATIONS

The National Council of La Raza publishes an extensive amount of research material on the conditions of Hispanics in the United States, as well as manuals to assist Hispanic and non-Hispanic organization in reaching out to the Hispanic community. Please contact our publications coordinator for a list of our publications and for further information on how to obtain our publications. The following are useful resources published by NCLR about the Hispanic elderly and the general Hispanic population.


OTHER PUBLICATIONS

The following are useful references that provide information on the Hispanic elderly and other elderly-related issues.


APPENDIX

Other Programs Benefiting the Elderly

A. Energy Assistance and Weatherization

Because older persons are particularly susceptible to hypothermia and heat stress, it is important that they maintain their dwellings at appropriate temperatures. Thus the high cost of energy is a special problem for the low-income elderly. According to Department of Energy data, although the elderly consume relatively less energy than other households, they spend a larger portion of their disposable income on fuel. The Low-Income Home Energy Assistance (LIHEAP) and the Weatherization Assistance Program are two federal programs designed to ease the energy cost burden for low-income individuals.

Under LIHEAP, authorized by the Low-Income Home Energy Assistance Act of 1980, block grants are made to the states, the District of Columbia, Indian tribes, and U.S. territories to provide assistance for home heating and cooling costs and low-cost weatherization to eligible households. Assistance may be given directly to the household, through vouchers, or direct payments may be made to the vendor or landlord. States establish their own benefit structure and eligibility criteria within federal guidelines. Eligible households include those receiving other forms of public assistance such as SSI, Food Stamps, or Aid to Families with Dependent Children (AFDC), and households with incomes ranging from the federal maximum standard of less than 150% of the federal poverty level or 60% of the state’s median income, whichever is greater, to stricter state standards of 110% of the poverty level. In 1989, LIHEAP provided heating and energy crisis assistance to an estimated 5.9 million low-income households. According to the 1988 CPS, an estimated 24.8 million households had incomes under the federal maximum standard and some 17.9 million households had incomes under the stricter state standards. The elderly constitute the single largest group of beneficiaries. In FY 1988 the elderly accounted for 35% of households receiving heating assistance, 61% of those receiving cooling assistance, and 32% of those receiving weatherization aid.

The Department of Energy Weatherization Assistance Program, authorized under the Energy Conservation and Production Act of 1976, is designed to reduce the heating and cooling costs of low-income households by increasing their energy efficiency through insulation and repairs. Although its authorization expired at the end of FY 1985, Congress has continued to appropriate funds for the program. Funding is given to the states, which in turn award funds to nonprofit organizations for purchasing and installing low-cost insulation, storm windows, and doors. The maximum expenditure allowed is $1,600 per household. To be eligible for assistance households must have incomes at or below 125% of the federal poverty level (states may raise the eligibility criterion to 150% of the poverty level, but may
not set it below 125%). Also eligible are households with persons receiving AFDC, SSI, or local cash assistance payments. Priority is given to households with elderly individuals (60 or over) or handicapped persons.

B. Transportation

The federal government's role in providing transportation services to the elderly has focused on capital and operating costs for transit systems, reimbursement for transportation costs, and fare reduction. The major federal programs providing transportation assistance to the elderly and handicapped are administered by the Department of Transportation (DOT) and the Department of Health and Human Services (HHS).

DOT programs have been instrumental in developing mass transit services nationwide and in providing basic funding for primary transportation services for the elderly. The passage of the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 marked the beginning of special efforts to plan, design, and set aside funds for transportation facilities and equipment for the elderly and handicapped. The National Mass Transportation Assistance Act of 1974 amended UMTA to provide mass transit funding for urban and non-urban areas nationwide through block grants, and required that fares for the elderly and handicapped be reduced by 50% during offpeak hours. The Surface Transportation Assistance Act (STAA) of 1978 provided federal funding to support public transportation program costs for non-urban areas.

Under HHS a number of programs provide transportation services for the elderly, including Title III of the OAA, the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG), and in some cases Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Because of the overlap in funding and services by HHS and DOT, an interdepartmental Coordinating Council on Human Services Transportation was established in 1986 to increase coordination between the two Departments.

C. Education

While strong arguments exist for providing formal and informal educational opportunities for older persons, the needs of the elderly have traditionally had low priority in education policy making. Public and private resources have primarily been directed at establishing and maintaining programs for the young. The majority of federal and state efforts in developing educational opportunities for older persons fall under the Adult Education Act (AEA), which authorizes the Department of Education to provide funds for educational programs and support services benefitting all adults. These include federally sponsored adult literacy programs and special classes and programs geared to older adults within structured adult education programs. For example, through workplace literacy partnership grants, businesses, labor organizations, and private industry councils, in conjunction with state or local educational agencies, institutions of higher education or
schools provide adult literacy and training skills to enhance the productivity of the workforce. English literacy grants provide assistance to programs for adults with limited English proficiency.

Private literacy efforts include programs operated by numerous groups including churches, businesses, labor unions, civic and ethnic groups, and community and neighborhood associations. In addition, two national groups, the Laubach Literacy Action and Literacy Volunteers of America, provide voluntary tutors and instructional materials for literacy programs. Institutions of higher education offer a variety of continuing education programs, and some recognize work or life experience as credit hours.

The 1987 OAA amendments include a new provision requiring Area Agencies on Aging to conduct a survey on the availability of tuition-free postsecondary education in their localities and to disseminate this information. It is expected that this information will increase the enrollment of older persons in higher education programs. Additionally, the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 require that the Secretaries of Education, Labor, and Health and Human Services conduct a joint study of federal funding sources and services currently available for adult education programs.

D. Legal Services

Between 1964 and 1974, legal services were a program of the Office of Economic Opportunity. Legislation creating the Legal Services Corporation (LSC) was enacted in 1974, in an effort to insulate the program from political pressures due to the often controversial issues legal services attorneys address. LSC does not provide direct services; it funds local legal aid projects. Legal services provided through LSC funds are available only in civil matters and to individuals with an income not exceeding 125% of the poverty level. Cases include family-related disputes such as divorce, child custody and support, and adoption; housing problems including landlord-tenant disputes; consumer and finance problems; individual rights; and employment and health cases. Most of the cases involving the elderly deal with government benefit programs such as Social Security and Medicare. Funds for legal aid programs are also available through the Social Services Block Grant, which allocates federal funds to states to provide services either directly or by contracting with public and nonprofit social service agencies.

E. Block Grants

The major source of federal funding for social services programs in the states is Title XX of the Social Security Act, the Social Services Block Grant (SSBG) Program. Social services which can be provided under SSBG include, but are not limited to: adult day care, adult foster care, protective services, health-related services, homemaker and chore services, housing and home maintenance services, transportation, preparation and delivery of meals, senior centers, and other services that assist older persons to remain in their own homes or in community living.
The Community Development Block Grants (CDBG), HUD's major source of funds to cities and urban counties for community development activities, can be used for assistance to senior centers, including improvement of facilities, for housing rehabilitation and weatherization services for elderly homeowners and renters, and for general improvement of public facilities.
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