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OLDER AMERICANS ACT

Eldercare Partnerships Generate Few Additional Funds for Public Services

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Dear Mr. Chairman and Members of the Committee:

Good morning. It is my pleasure to appear before the Subcommittee to present our recently completed work on public-private partnerships established between area agencies on aging and private corporations. These arrangements have been encouraged by the Administration on Aging (AOA) as a potential source of additional funding for aging services. Accordingly, my testimony today focuses on the partnerships' nature, extent, and financial results.

Before detailing our findings, I will sketch the organization of aging services under the Older Americans Act and the context for the effort to pursue funding via public-private partnerships. The Older Americans Act, or OAA, was first passed in 1965. As you know, the act was intended to provide grants to states for the development of new or improved programs specifically designed to meet the special needs of persons aged 60 and over. Today, the programs under the act provide the major vehicle and only national network for the organization and delivery of social, nutritional, and other supportive services to older persons. This "aging network" consists of the Administration on Aging, or AOA, and its 10 regional offices; 57 state and territorial units on aging; 670 area agencies on aging; and nearly 25,000 local service providers.

Since the initial passage of the Older Americans Act in 1965, the mission and constituency of the aging network have expanded considerably, due partly to growth in the number and proportion of Americans over age 60 and partly to legislative expansion of the objectives of the Older Americans Act. Between 1965 and 1990, the number of Americans in the 60-plus age group grew by 16.3 million, increasing from 13 to 17 percent of the population. This expansion of the aging network's target population has been accompanied by the addition or articulation of goals for the aging network so that the OAA now includes separate authorizations for supportive services; nutrition services; in-home services for the frail elderly; health education and promotion services; elder abuse prevention; long-term care ombudsmen; and outreach activities to persons eligible for assistance under the Supplemental Security Income, Medicaid, and Food Stamp programs.

However, even putting aside the recent expansion of the aging network's target population and legislated mission, its funding has never been sufficient, especially over the last decade, to serve the entire elderly population as intended by the Older Americans Act. In particular, our previous work has documented the fact that the resources required to carry out AOA's mission have not kept pace with recent changes in the agency's functions.

One result of this combination of shrinking resources and growing demands has been a search by the aging network for

additional sources of funding. This has led to attempts, encouraged by AOA, to attract private funding for aging services by marketing particular eldercare services to private corporations as potential employee benefits. Such arrangements are embodied in contractual relationships, called public-private partnerships, between private corporations and area agencies on aging, also known as AAAs. In these partnership agreements, AAAs provide certain eldercare services to private employers or vendors, who in turn offer this assistance to corporate employees with caregiving responsibilities for elderly dependents. Although the Administration on Aging promoted the establishment of public-private partnerships for eldercare services between AAAs and private corporations, the actual agreements were made by the affected parties.

Some persons have criticized these partnerships on the grounds that they detract from one of the main purposes of the OAA; that is, that in the provision of services, preference should be given to serving older individuals with the greatest economic and social needs, with particular attention given to low-income minority individuals. For example, in planning and providing comprehensive programs in such areas as in-home services and transportation, AOA is mandated to give special consideration to elderly people who are poor or have special needs. However, proponents of these partnerships point out that the partnerships generate income for the AAAs that can then be used to provide additional services to the most disadvantaged elderly persons. At issue, then, is whether public-private partnerships do provide resources to the AAAs, and whether the AAAs use these resources to reduce the gap between shrinking funds and the growing demand for AAAs' services. To help resolve these questions, you asked us to describe both the extent and nature of these partnerships as well as the degree to which they have resulted in either additional funds for public services or other advantages for the aging network.

To meet these objectives, we reviewed the limited literature on public-private partnerships, administered a survey of area agencies on aging, visited sites in New York City and Los Angeles, and interviewed aging-network officials and experts. Based on discussions with your staff, we narrowed the scope of our study to those AAAs using a public-private partnership to provide either enhanced information and referral or case management services, or both. We chose to focus on these services because they require more intensive activity on a continuing basis than other eldercare services, because they were typically thought to generate revenues, and because they comprised the bulk of eldercare services offered through such arrangements.

Our survey of AAAs was conducted between March and December 1992 using a combination of our own surveys and results from a

recent survey performed by the National Association of Area Agencies on Aging (NAAAA). By combining the surveys, we obtained questionnaire responses from 97 percent of the 655 AAAs in the United States indicating whether they provided any of these eldercare services through a public-private partnership and, for those that did so, specific information about their partnerships.

Our findings address four questions:

- What proportion of AAAs report engaging in public-private partnerships?
- What is the nature and scope of these arrangements?
- What are the financial results of such partnerships? and
- How are any profits from partnership services reportedly used?

According to our survey respondents, only 75 AAAs--less than 12 percent--have entered into public-private partnerships to provide enhanced information and referral or case management services. These AAAs with partnerships are geographically dispersed, with some clustering around the Great Lakes region. None of the partnerships began earlier than 1987.

Most of the AAAs with partnerships (66 of 75, or 88 percent) had an arrangement with a vendor. That is, the AAAs have provided their services to employers by using a vendor to act as a go-between and a referral source. All 66 partnerships involving vendors were associated with three firms: Work/Family Elder Directions, the Partnership Group, or Working Solutions. Only five AAAs had partnerships directly with employers, while four had partnerships with both vendors and employers.

During our review, we found that the nature of services provided to employers or vendors through these 75 partnerships was quite varied. AAAs were far more likely to provide enhanced information and referral services, which were offered by 93 percent of those with partnerships, than to provide case management, offered by less than 10 percent. Counseling was provided by 54 percent of the 75 partnerships. We also found that 37 percent of the AAAs with partnerships provided additional services through arrangements with insurance companies or other vendors. The primary service provided under these arrangements was client health assessment; that is, health assessments of older people were performed to assist insurance companies in determining client eligibility for long-term care insurance.

Overall, the operations of these partnerships were limited in scope and reflected a modest level of activity. Among the 68 AAAs with partnerships that provided referral data, the average number of reported referrals was only four per month. Of more importance, perhaps, is the fact that 79 percent of these AAAs reported using existing staff to provide the services, thus

diverting some staff resources from the primary goals described by OAA.

This modest level of activity generated relatively little income. For the 56 AAAs that had partnership contracts in 1991 and reported data on income, the median income generated was $660. Three out of every four received less than $2,700. The remaining 25 percent received revenues ranging from $2,700 to $155,000. Stated in terms of the experience of all AAAs that responded to our survey, about 2 percent (14 of 635) reported both engaging in a public-private partnership for the delivery of eldercare services and deriving more than $2,700 in income from the partnership.

As I stated earlier, proponents of public-private partnerships have suggested that they can generate profits that may then be used to supplement shrinking resources for public services. By 1991-92, among the 31 AAAs that reported income and expense data, over half had realized no net profit through their eldercare partnerships to support additional public services. For these 31 AAAs reporting both income and expenses associated with eldercare services provided through partnerships in fiscal or calendar year 1991, the median net profit was $0. Fifteen (15) of these reporting AAAs showed a net profit, 13 broke even, and 3 reported losses. The median net profit for the 15 AAAs reporting a net profit was $598. Although start-up expenses might mask the potential profitability of these partnerships, 63 percent of responding AAAs indicated that their first contract had been signed in 1989 or earlier. Thus, most of the reporting partnerships did not meet the goal of generating additional resources that could finance activities more central to the AAAs' mission.

Nevertheless, we asked those AAAs that generated net profits what use was made of the added funds. Of the 15 AAAs that reported income exceeding expenses, 11 responded, with 5 reporting that they used these funds for maintaining or increasing services for the public, 4 that they used them for general administrative purposes, and 2 that the funds were used to maintain or increase services targeting low-income minority elderly. Thus, even the few AAAs that generated profits indicated that the funds were usually used for purposes more general than enhancing or maintaining services targeted to the low-income minority elderly.

In summary, relatively few AAAs have entered into public-private partnerships for the provision of enhanced information and referral or case management. Among those that have done so, the scope of the partnerships is quite limited, with a reported average of 4 referrals per month. More often than not, they resulted in no additional income for AAAs that reported related receipts and expenses. The fact that most reporting partnerships

failed to generate additional financial resources is particularly important because the purpose of undertaking these additional activities was to increase financing for services more central to the AAAs' mission. However, most of the AAAs that engaged in these partnerships did not report deriving sufficient income from them to support additional services for the primary target populations covered by the Older Americans Act. Moreover, AAAs with public-private partnerships typically reported using existing staff to provide services to those referrals they received, thereby actually reducing the resources available for AAAs' primary mission.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you may have.

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