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ELDERLY AMERICANS

Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor

Statement of
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Mr. Chairman and Members of the Committee:

It is my pleasure to be here today to present our work on the elderly population. My statement is based upon our report entitled Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor, which is being issued today. You requested that we address a series of questions about poor and near-poor elderly persons involving the issues of health, housing, and nutrition.[1] In response, we will present information on (1) the size and characteristics of the poor and near-poor elderly population and (2) the relationship between poverty and various aspects of health care, housing, and nutrition. We will also present data on the extent to which poor elderly persons receive services from the principal federal programs covering these areas.

Because of the limited time available to answer your questions, we had to rely on extant data sources to address issues of demographics, health, housing, and nutrition. However, we have used the most recently published national surveys. In addition, because all of our data are from national surveys, our findings can be generalized to the elderly population of the United States. To the extent possible, we have categorized our data on the elderly population by sex, race/ethnicity, and age. It is important to underscore the fact that this testimony focuses on the problems of the 19 percent of elderly persons who were poor or near poor in 1990.

THE NUMBER AND CHARACTERISTICS OF POOR AND NEAR-POOR ELDERLY PERSONS

The economic condition of the nation's elderly population improved tremendously during the 1960s and early 1970s. As shown in figure 1, over 35 percent of the elderly population was poor in 1959. At that time, the elderly were twice as likely as other adults, and somewhat more likely than children, to be impoverished. Today, the gap between the poverty rates for elderly and nonelderly persons has greatly narrowed, primarily as a result of the expansion of Social Security benefits.

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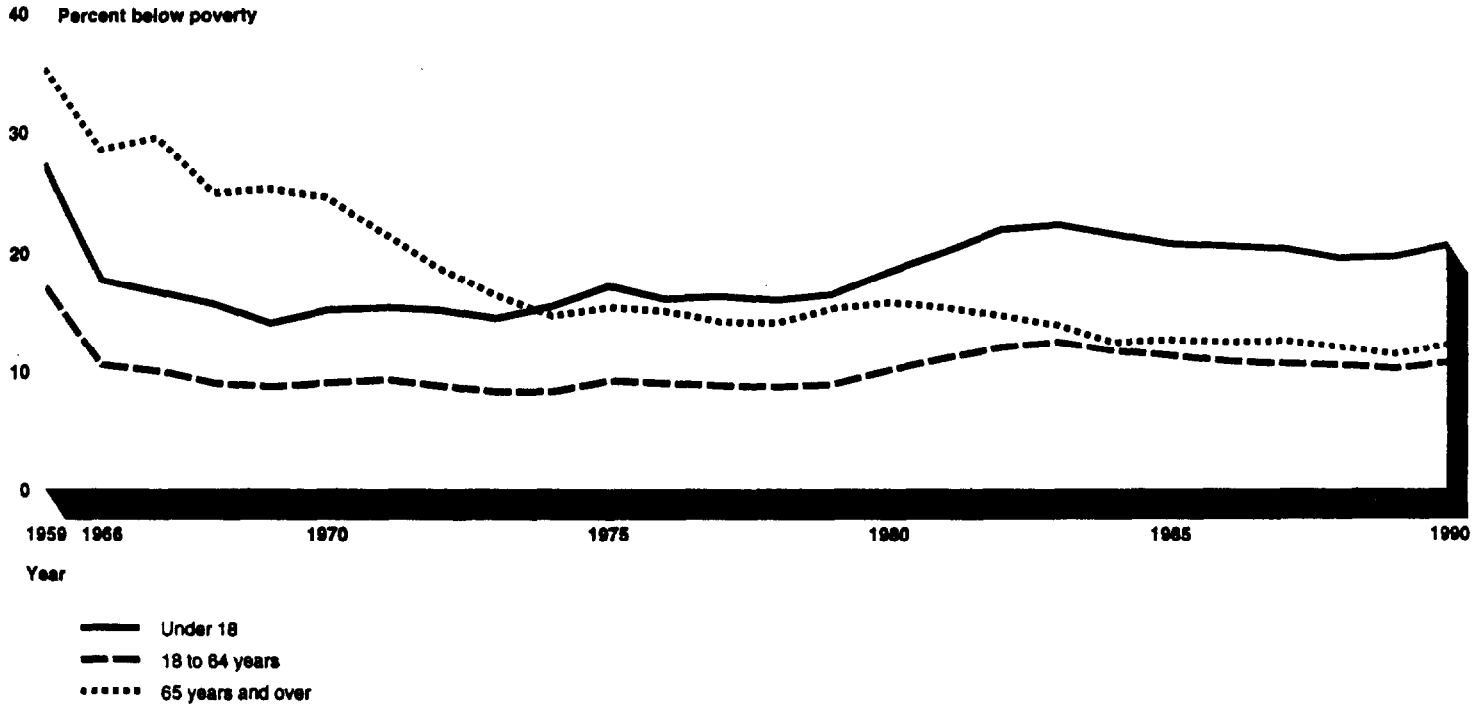
[1]In this testimony, the term "poor" refers to persons with incomes at or below the federal poverty level. "Near poor" refers to those with incomes between 100 and 125 percent of the federal poverty level. "Nonpoor" refers to persons with incomes above the federal poverty level. In addition, "elderly" refers to persons who are 65 years of age or over, except in reference to federally subsidized housing programs. In such programs, persons over the age of 62 are considered to be elderly.

Figure 1: Poverty Rates, by Age, 1959-90

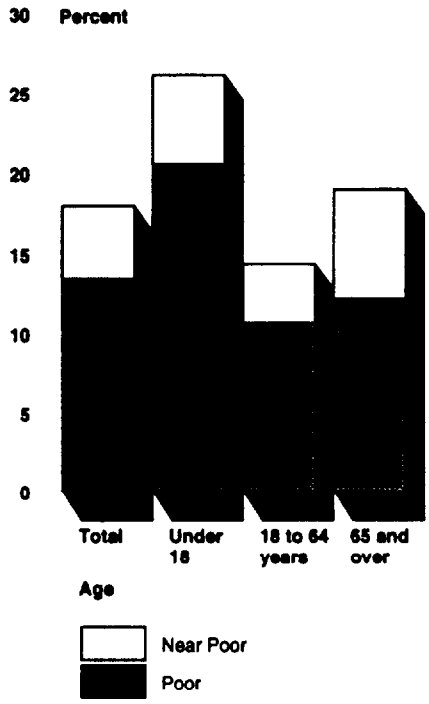


Note: No data are available for adults from 1960 through 1965.

Source: U.S. Bureau of the Census, Poverty in the United States: 1990, Current Population Reports, Series P-60, No. 175 (Washington, D.C.: U.S. Government Printing Office, 1991), p. 18.

The rise in the economic well-being of the elderly population overall should not mask the economic difficulties still experienced by a sizeable number of elderly Americans. Some 19 percent of the elderly population--over 5.7 million elderly persons--were poor or near poor in 1990 according to the Census Bureau's Current Population Survey. In this regard, the elderly were more fortunate than children (26.1 percent of whom were poor or near poor) but less fortunate than other adults (14.4 percent of whom were poor or near poor). See figure 2.

Figure 2: Poor and Near-Poor Persons, by Age, 1990

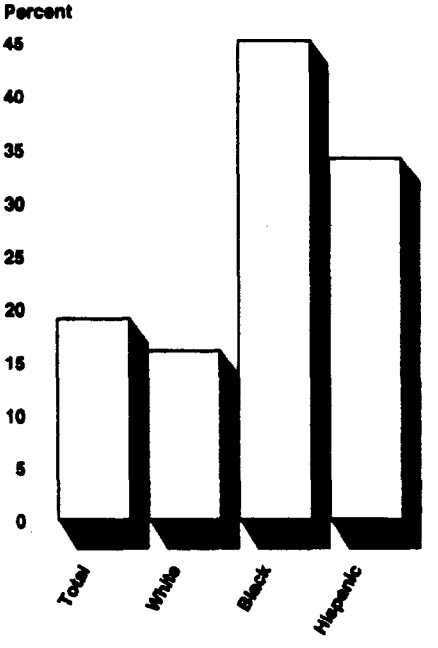


Source: U.S. Bureau of the Census, Poverty in the United States: 1990, Current Population Reports, Series P-60, No. 175 (Washington, D.C.: U.S. Government Printing Office, 1991), p. 30.

It is important to underscore that this figure may underestimate the magnitude of poverty and near poverty in the elderly population because (1) it does not include the homeless elderly population and (2) it is based on the official poverty thresholds of the U.S. Bureau of the Census, which some argue are artificially low.

We found that certain groups of the elderly were especially vulnerable to economic problems. Elderly women were nearly twice as likely as elderly men to be poor or near poor (23.4 versus 12.8 percent, respectively). In addition, as shown in figure 3, elderly minorities were 2 to 3 times as likely as elderly nonminorities to be poor or near poor (Hispanics 33.5 and blacks 45.1 percent versus 16.4 percent for whites). Similarly, persons over the age of 75 were almost twice as likely as persons between 65 and 74 to be poor or near poor (15.1 versus 24.9 percent, respectively). In fact, across all racial and ethnic groups, persons over the age of 75 were more likely than any other group of adults to be poor or near poor. The additive effect of sex, race, and age was dramatic: More than half of all black women over the age of 75 were poor or near poor in 1990. Such figures are disturbing and clearly demonstrate that some groups of older Americans have not enjoyed the general income improvements experienced by the elderly population as a whole.

Figure 3: Percent of Poor and Near-Poor Elderly Persons, by Race/Ethnicity, 1990



Note: Hispanics may be of any race.

Source: U.S. Bureau of the Census, Poverty in the United States: 1990, Current Population Reports, Series P-60, No. 175 (Washington, D.C.: U.S. Government Printing Office, 1991), pp. 30-33.

In contrast to their nonpoor counterparts, poor elderly persons have only limited access to wages, pensions, and asset income. Instead, they rely largely on Social Security benefits for their income. However, since nearly all poor elderly households received Social Security benefits in 1990, it is obvious that these benefits do not ensure elderly persons--even those with extensive work histories--incomes above the poverty level.

We also reviewed the literature to examine how elderly people become impoverished. We found that widowhood and retirement are among the most critical antecedents of poverty among the elderly. For instance, one longitudinal survey over a 10-year period of time found that elderly widows were twice as likely as elderly couples to become impoverished (20 versus 10 percent, respectively). One reason is that the automatic reduction in Social Security benefits resulting from the death of a spouse places many elderly survivors in poverty. Those most affected are survivors of couples with incomes just above the poverty level; moreover, women in this income category are especially vulnerable to poverty because they are much more likely than men to be the surviving spouse.

While spousal death largely accounted for impoverishment among widows, it appears that retirement was the primary antecedent of poverty for elderly couples. Nearly half of all descents into poverty among elderly couples were directly associated with drops in the husband's wage earnings. In fact, the descent into poverty by elderly couples was most likely to occur within the first 2 years of retirement. Thereafter, the likelihood of becoming poor decreased sharply.

Notably, the possession of a pension plan decreased the likelihood of falling into poverty for both widows and couples. Only 5 percent of couples with pensions became poor, compared with 18 percent of couples without pensions. Similarly, about 15 percent of widows with pensions became poor versus 28 percent of those without pensions.[2]

RELATIONSHIP OF POVERTY TO HEALTH, HOUSING, AND NUTRITION

Health

How is poverty associated with health insurance coverage, health care expenditures, and health status among the elderly? We addressed these issues primarily by examining data from the

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[2]While those with pensions were clearly at a lower risk of falling into poverty than those without pensions, the effect of pensions must be interpreted cautiously because couples with pensions had higher incomes prior to retirement.

1987 National Medical Expenditure Survey, the 1991 Current Population Survey, and the 1990 National Health Interview Survey.[3]

Health Insurance Coverage and Health Care Expenditures

We found that 95.7 percent of the poor elderly population had health insurance coverage through the Medicare program in 1990.[4] However, this does not mean that Medicare paid for all or nearly all of their health care costs. Medicare recipients must pay premiums (for Part B, the outpatient component of Medicare), copayments, deductibles, and physician charges in excess of Medicare's reimbursement rate. Further, Medicare generally does not cover prescription drugs, preventive care, or long-term care. These limitations largely account for the fact that Medicare paid only half of the health care expenses of all noninstitutionalized elderly persons in 1987.

Although most nonpoor elderly persons obtained private, supplemental health insurance to fill some of the Medicare gaps in 1990, only about 1 in 3 poor elderly persons did so. In addition, although Medicaid fills many of the gaps in Medicare coverage, only about 1 in 3 poor elderly persons were enrolled in this program in 1990. As we have reported elsewhere, this low rate of coverage in Medicaid is partly due to the complexity of enrolling in this program and the wide variety of eligibility criteria across states.[5]

About 38 percent of the poor elderly population were covered only by Medicare in 1990. This group was largely responsible for paying premiums, copayments, and deductibles, as well as the

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[3]Data published from the National Health Interview Survey are not tabulated by poverty status. Instead, they are tabulated by the following family income categories: under $10,000; $10,000 to $19,999; $20,00 to $34,999; and $35,000 or more. Families with incomes under $10,000 roughly correspond to families that are poor or near poor.

[4]All data on health-related issues refer to the noninstitutionalized elderly population.

[5]See Hispanic Access to Health Care: Significant Gaps Exist, GAO/PEMD-92-6 (Washington, D.C.: January 15, 1992).

costs of prescription drugs and preventive care.[6]

Given their mix of Medicare, Medicaid, and private health insurance coverage, to what extent were poor elderly persons burdened by out-of-pocket health care expenses? Data from the 1987 National Medical Expenditure Survey reveal that, although poor elderly persons paid a relatively small portion of their health care costs themselves, these costs represented a relatively large proportion of their income. As shown in figure 4, poor elderly persons paid 16 percent of their total health care costs themselves, compared with up to 24 percent for nonpoor elderly persons. However, these costs represented nearly 20 percent of their total income, compared with less than 13 percent of the total income of nonpoor elderly persons.[7] Clearly, out-of-pocket expenses represented a greater financial drain on poor elderly persons due to their limited resources.

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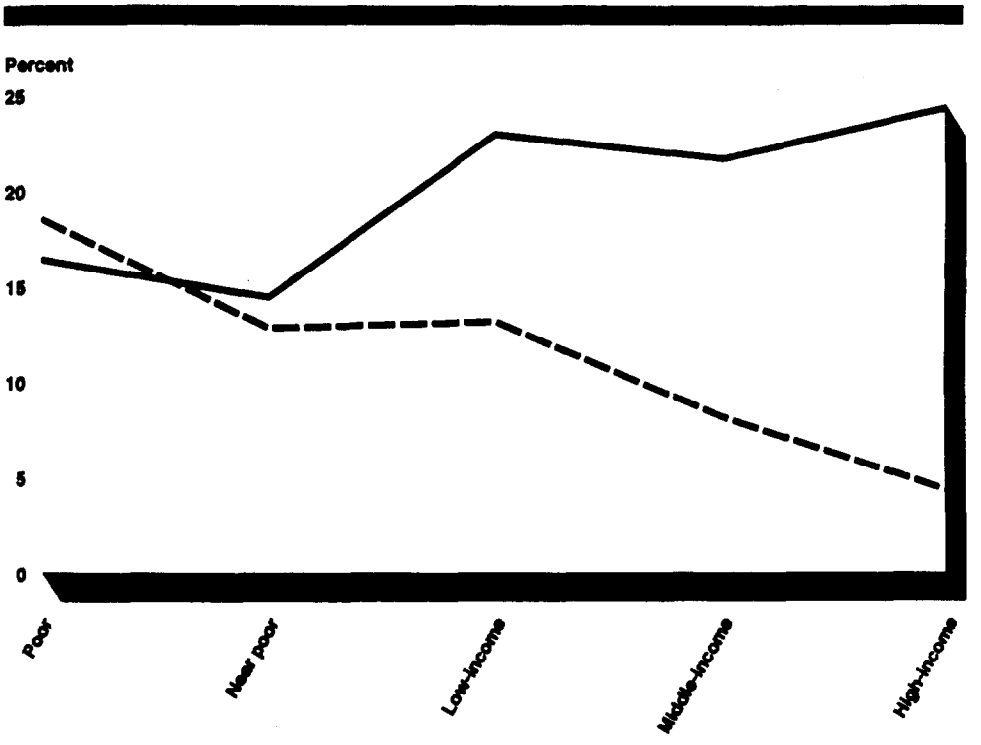
[6]As of January 1991, states have been mandated to provide limited Medicaid coverage for "qualified Medicare beneficiaries." These are aged and disabled persons who are receiving Medicare and whose income is below the federal poverty level. States must pay premiums for Medicare Part B, along with required Medicare copayments and deductibles.

[7]Agency for Health Care Policy and Research, special data runs from the National Medical Expenditure Survey, 1987.

Figure 4: Out-of-Pocket Expenses as a Percent of Total Health Care Costs and Income, 1987



Note: Low-income is 126 to 200 percent of the poverty level; middle-income is 201 to 400 percent of the poverty level; and high-income is over 400 percent of the poverty level.

Source: Special data runs conducted by the Agency for Health Care Policy and Research from the National Medical Expenditure Survey, 1987

Health Status

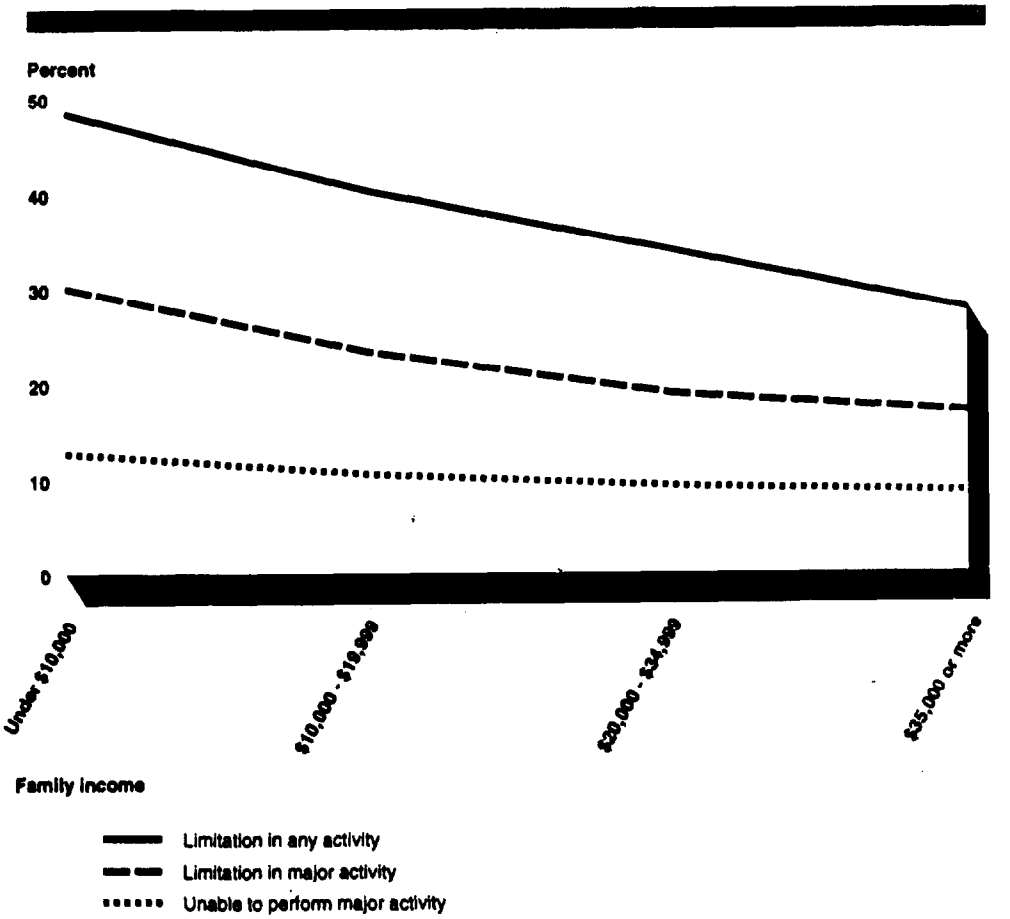
Not only were poor elderly persons more burdened by their health care expenditures than nonpoor elderly persons, they also lagged behind them in health status. In general, elderly persons in families with incomes below $10,000 experienced more acute conditions and had higher rates of chronic--and potentially costly--conditions, such as hearing impairment, diabetes, heart disease, and hypertension, than elderly persons in higher income families. (See table 1.) Further, low-income elderly persons were more likely than their higher income counterparts to endure more limitations in their daily activities and to assess their health as being fair or poor. (See figures 5 and 6.) Do these data mean that poverty caused the negative health status of these elderly persons? Not necessarily--It may be the case that their negative health status caused these persons to become poor, by straining their resources. In either case, these data dispel the notion that all elderly persons have adequate economic security to ensure their good health.

Table 1: Incidence of Selected Health Problems per Thousand Elderly Persons, by Family Income, 1990

Measure of health status	Under $10,000	$10,000 to $19,999	$20,000 to $34,999	$35,000 or more
Acute conditions	1122	1120	994	948
Chronic conditions				
Hernia of abdominal cavity	67	56	72	38
Diabetes	118	92	83	94
Heart disease	317	346	274	313
Hypertension	427	376	399	354

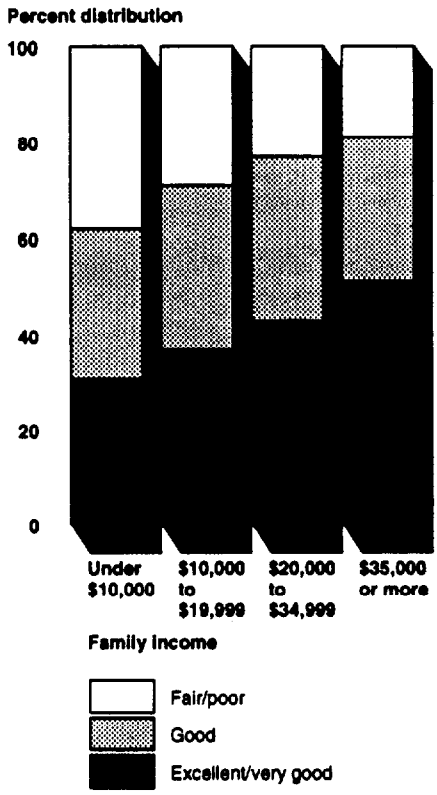
Source: National Center for Health Statistics, unpublished data from the National Health Interview Survey, and National Center for Health Statistics, Current Estimates from the National Health Interview Survey, 1990, Series 10, No. 181 (Washington, D.C.: U.S. Government Printing Office, 1991), pp. 88-91.

Figure 5: Percent of Elderly With Limitations in Activities, by Family Income, 1990



Source: National Center for Health Statistics, Current Estimates From the National Health Interview Survey, 1990, Series 10, No. 181 (Washington, D.C.: U.S. Government Printing Office, 1991), p. 109.

Figure 6: Distribution of Respondent-Assessed Health Status, by Family Income, 1990



Source: National Center for Health Statistics, Current Estimates From the National Health Interview Survey, 1990, Series 10, No. 181 (Washington, D.C.: U.S. Government Printing Office, 1991), p. 113.

Housing

How does poverty affect the elderly's ability to pay for housing, and how does it relate to such issues as access to adequate housing and home ownership? In addressing these questions, we will first discuss the relationship between poverty and housing costs for poor elderly renters and homeowners and then go on to describe the federally subsidized rental options available to poor elderly persons. To address these issues, we reviewed the literature, as well as data from the 1991 Current Population Survey and the 1989 American Housing Survey.

Elderly Poverty and Housing Costs

We found that housing expenses were a major budget item for poor elderly persons, including both home owners and renters.[8] Although 6 out of 10 poor elderly householders owned their homes, home ownership did not prevent them from incurring substantial housing expenses. In fact, half of all poor elderly home owners spent more than 45 percent of their income for housing in 1989--evidently because real estate taxes, insurance, and utilities are a drain on the limited resources of poor elderly persons.[9] Moreover, there are only a few federal programs to help low-income elderly home owners rehabilitate deteriorating homes, or to help them alter their homes to fit their changing needs as they age and become frail.

Like home owners, poor elderly renters also experienced high housing costs relative to their incomes. Half of all poor elderly renters spent more than 45 percent of their income on housing, although many lived in public housing or received federal subsidies.[10]

Federally Subsidized Housing for the Elderly

There are several federally subsidized rental options available to poor elderly persons and, in 1989, nearly 40 percent of all poor elderly renters (that is, households) were benefiting from one of these options. What follows is a brief description of the principal forms of rental subsidies for elderly persons.

Public Housing. Low-rent public housing is one of the most extensive of the programs that provide housing to low-income

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[8]These households may contain occupants under the age of 65.

[9]Joint Center for Housing Studies, Harvard University, special data runs from the American Housing Survey, 1989.

[10]Joint Center for Housing Studies, Harvard University, special data runs from the American Housing Survey, 1989.

elderly persons. Operated by local public housing authorities, these units are not mandated specifically for the elderly; however, as of 1988, elderly persons occupied nearly 45 percent of the 1.2 million public housing units.[11] Over the last decade, most new public housing projects have been designed only for the elderly, primarily because there tend to be fewer management problems with, and less local opposition to, the construction of such projects.

Section 8 Certificates and Vouchers. Section 8 certificates and vouchers are federal subsidies provided to income-eligible households for use on the private market to help defray their housing costs. Persons who benefit from certificates must occupy units in which rents at initial occupancy do not exceed federal guidelines, known as a fair market rents (FMR). The subsidies generally cover the difference between FMR and 30 percent of the occupant's adjusted income. Voucher holders, in contrast, may occupy units with rents above FMR, provided they pay the difference. Section 8 units are not restricted to elderly persons, although it was estimated that about 44 percent of the approximately 2.5 million certificate and voucher holders in 1988 were elderly.[12]

Section 202 Housing for the Elderly. Section 202 housing is primarily for elderly renters, although 25 percent of the current appropriations is set aside for handicapped persons.[13] Section

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[11]Congressional Research Service, "Federal Housing Programs Affecting Elderly People," CRS Report for Congress, August 18, 1988. This figure includes persons who are not elderly by age, but who are defined in housing legislation as being elderly. The U.S. Housing Act of 1937 defines nonelderly persons with mental or physical disabilities as elderly and thus grants them eligibility for elderly housing units. A 1990 GAO survey estimated that 83 percent of public housing units for the elderly were occupied solely by persons who were elderly by age. Further, 1992 data from HUD suggest that persons who are elderly by age may be a shrinking proportion of persons who are defined as elderly and admitted to public housing.

[12]Congressional Budget Office, Current Housing Problems and Possible Federal Responses (Washington, D.C.: U.S. Government Printing Office, December 1988).

[13]Some of the data on section 202 housing are drawn from "The 1988 National Survey of Section 202 Housing for the Elderly and Handicapped," issued by the Chairman of the Subcommittee on Housing and Consumer Interest of the Select Committee on Aging. We are presenting this information because it continues to be the most recent and comprehensive survey of section 202 housing and, therefore, is germane to this report.

202 housing is designed to provide elderly and handicapped persons with an independent living environment that includes provisions for necessary services, such as health, recreation, and transportation. However, prior to 1974, the Department of Housing and Urban Development (HUD) guidelines did not emphasize supportive services for this purpose. Statutory revisions enacted since then require that HUD seek to assure that projects have a range of necessary services or that they facilitate access to supportive services, and that the projects encourage and assist recipients to use these services. However, HUD has never required on-site services, nor has HUD provided funding for these services.

The availability of section 202 housing was significantly affected by budget cuts in the 1980s. Appropriations peaked in the mid 70s, with the Congress funding approximately 20,000 new units per year. Funding declined substantially over the next decade, and in 1989 funds were appropriated for only 9,500 new units. As of 1988, there were 138,000 units of section 202 housing, 94 percent of which were occupied by elderly persons.[14]

The decline in funding for new units does not signify that the demand for section 202 housing has been met. On the contrary, the demand for these units is still quite high. For instance, only 8.2 percent of the units that were surveyed in 1988 had no waiting lists. The ratio of elderly persons waiting to annual vacancies was 8:1 across the country.[15] Of those elderly persons on waiting lists, one third had been on a list for less than 1 year, while 37 percent had been on a waiting list for longer than 2 years.

Nutrition

Information on the relationship between poverty and nutrition among the elderly is limited, but available data indicate that poor elderly persons consume less of some essential nutrients than do nonpoor elderly persons. Up to one half of poor elderly persons consume less than two thirds of the recommended daily allowance of vitamin C, calcium, and other nutrients. However, these data are limited in that they (1) are more than 10 years old and (2) either do not contain or do not report on the nutritional status of important elderly

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[14]Congressional Research Service, "Federal Housing Programs Affecting Elderly People," CRS Report for Congress, August 18, 1988.

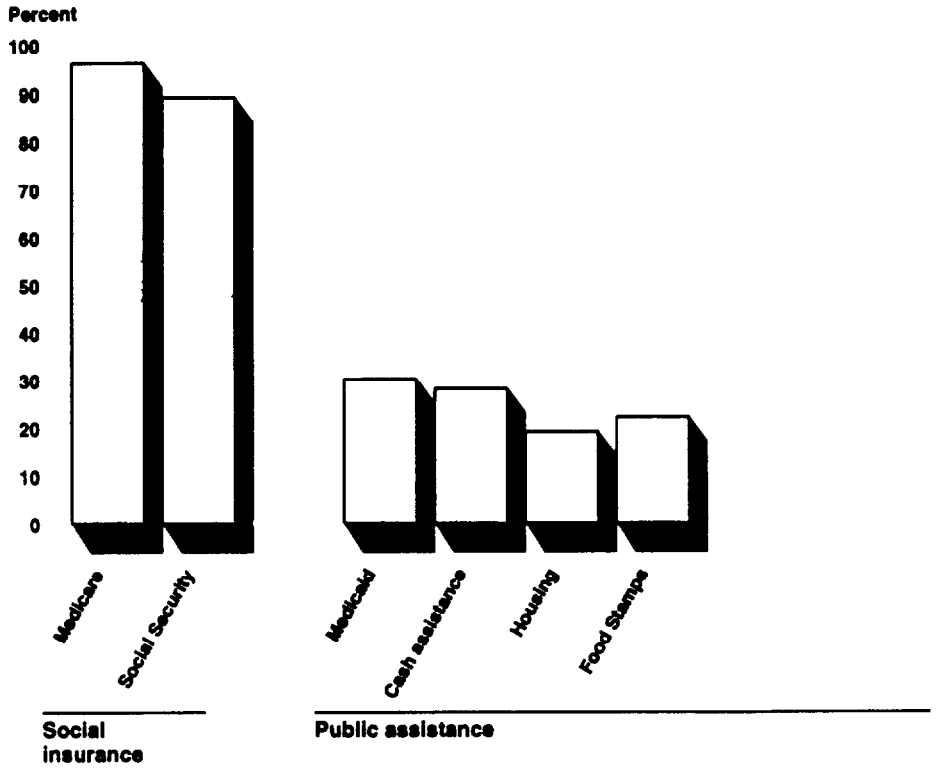
[15]We must note that these lists are likely to inflate the number of elderly persons waiting for housing because of double counting. That is, an individual may be on more than one waiting list for 202 housing.

subpopulations (such as persons over the age of 75 and institutionalized elderly). Additionally, there are no adequate guidelines as to what the actual nutritional needs of the elderly are. Current guidelines do not specifically address the needs of persons aged 65 and over, nor do they address the particular needs of elderly subpopulations, such as pharmaceuticals users or those who are aged 75 and above. Improvements are needed in both nutrition data and nutritional guidelines before definitive conclusions can be drawn about the poor elderly population's nutritional status.

Participation in Federal Programs

With regard to participation in federal programs by poor elderly persons, we found high rates of participation in social insurance programs--that is, programs with no income requirements, such as Social Security and Medicare. For instance, nearly all poor elderly have health insurance coverage through Medicare, and nearly all receive Social Security benefits. (See figure 7.) These programs are available to elderly persons, regardless of their income. However, participation is much lower in public assistance programs--that is, programs that are targeted to low-income persons. Public assistance programs, such as Supplemental Security Income and Medicaid, have income-eligibility requirements and are means-tested. As shown in figure 7, in 1990, the participation rates of poor elderly persons were no higher than 30 percent in public assistance programs that provided housing, food stamps, or cash assistance. In all, only 49 percent of the poor elderly population lived in households that participated in federal public assistance programs in 1990. This means that about one half of the poor elderly population--or 1.9 million poor persons--lived in households lacking any form of public assistance.

Figure 7: Percent of Poor Elderly Persons Participating in Selected Federal Programs, 1990



Note: Cash assistance consists primarily of Supplemental Security Income.

Source: 1991 Current Population Survey

SUMMARY AND CONCLUSIONS

We found that about 19 percent of the elderly population continues to be poor or near poor, despite the economic gains made by the elderly population as a whole over the last 30 years. Further, certain elderly subpopulations (for instance, women, minorities, and persons over the age 75) experience rates of poverty that are unacceptable by most standards. Although Social Security benefits have largely accounted for the dramatic drop in the elderly poverty rate, the fact that most poor elderly persons receive such benefits indicates that this program is not enough to sustain some persons above the poverty level.

We found that many poor elderly persons are burdened by health care and housing costs and, at the same time, tend to be in poorer health than those with higher incomes. Additionally, poor elderly persons appear more likely to have inadequate nutritional intake, although there are limitations to the nutrition data and there are no clear standards for nutritional adequacy for the elderly population.

Although poor elderly persons have high participation rates in federal programs aimed at the general elderly population, they have low participation rates in federal programs geared to providing public assistance to the poor. We do not know the extent to which this gap between needs and services is the result of (1) the inability of federal programs with limited resources to serve all needy elderly, (2) the lack of effective federal outreach efforts to enroll the eligible population, or (3) differential eligibility criteria for some programs, such as Medicaid, across states. The Congress may wish to consider the question of why this gap exists and then identify ways to close it.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you or Members of the Committee may have.